



IN HCBS Environmental Scan

Summary Tables

12/31/2016

The Lewin Group

Contents

1915(c), 1915(i) & 1915(k)	2
Federal Guidance on Determining Waiver Slots	2
1915(i) – State Examples.....	4
1915(k) – State Examples.....	5
Home Health	12
Benefit.....	12
Scope of Service	19
Prior Authorization.....	27
Nurse Delegation	31
Housing with Services	35
Room and Board Definition – Federal Guidance	35
Coverage of Meals within Assisted Living Service Definition – State Examples	36
Dementia Facility Requirements.....	43
Dementia Training Requirements.....	48
Egress Standards	55
Bed Holds – Federal Guidance	57
Bed Holds – State Examples.....	58
Assisted Living Licensing/Certification Standards (Duration and Fee Structure)	60
Bringing Assisted Living into Compliance.....	69

1915(c), 1915(i) & 1915(k)

Federal Guidance on Determining Waiver Slots

Source	Guidance
1915 (c) Technical Guidance	<p>“The number specified for each waiver year constitutes the maximum limit on the unduplicated number of participants that the waiver will serve (also known as Factor C). It is up to the state to specify this maximum. Until the maximum number of unduplicated participants in the approved waiver is reached, a state may not deny entry to the waiver of otherwise eligible individuals unless the state elects to establish a point-in-time enrollment limit, adopts a phase-in or phase-out schedule, or reserves capacity for specified purposes. As a consequence, the number of persons who will be served should be based on a careful appraisal of the resources that the state has available to underwrite the costs of waiver services.</p> <p>Post-approval, the maximum number of unduplicated participants may be modified by submitting a waiver amendment to CMS to increase or decrease the maximum. An amendment to increase the maximum may be made effective to the beginning of the current waiver year. When more individuals are served in the waiver than the maximum, submit an amendment to align the waiver with the number of individuals served. An amendment to reduce the maximum number of waiver participants below the number currently being served may only be made effective on the date that CMS approves the amendment. Consequently, when a reduction is necessary, an amendment should be submitted as soon as the need for a change to the participant limit is identified. When a reduction in the maximum number of participants is requested, the amendment request must include information concerning the impact of the reduction on existing waiver participants.</p> <p>A state may find it necessary to reduce the maximum number of participants because legislative appropriations are insufficient to support the number of persons specified in the approved waiver. In order to effect such a reduction, a state must submit a waiver amendment and the amendment must be formally approved by CMS. As previously noted, in the past, states have been permitted to tie the number of participants to legislative appropriations and notify CMS in writing of the reduction in the number of participants due to legislative appropriations without submitting an amendment. This alternative is no longer available. The waiver is considered to be in effect as approved unless CMS has formally approved an amendment submitted by the state. If a state finds it necessary to freeze waiver enrollment or place a moratorium on new entrants to the waiver, the state also must submit an amendment to CMS to revise the unduplicated participant cap for the affected waiver year.” (pg 85-86)</p> <p>[Source]</p>
Federal Register Notice: Final Rule Jan 14, 2016	<p>Section 12. State Plan HCBS Administration: State Responsibilities and Quality Improvement (§ 441.745) (Proposed § 441.677)</p> <p>a. State Responsibilities: States are required to provide CMS annually with the projected number of individuals to be enrolled in the benefit, and the actual number of unduplicated individuals enrolled in the State plan HCBS benefit in the previous year. Section 1915(i) of the Act authorizes a state to elect not to apply comparability requirements, thus permitting states to target the entire section 1915(i) of the Act benefit, specific services within the benefit, or both. Under § 441.745(a)(1)(ii), we specify that the state may not limit enrollee access to services in the benefit for any reason other than assessed need or targeting criteria. This includes the requirement that services be provided to all individuals who are assessed to meet the targeting criteria and needs-based criteria, regardless of income. This is an important distinction between the limits states place on the services to be offered when they design the benefit, as opposed to limiting access to the services that are in the benefit for particular enrolled individuals. As discussed in the proposed rule, states have a number of permitted methods to control utilization. We proposed that once an individual is found eligible and enrolled in the benefit, access to covered services can be limited on the basis of the needs-based criteria as evaluated by the independent assessment and incorporated into the person-centered service plan. By not limiting access, we mean that an enrollee must receive any or all of the HCBS offered by the benefit, in scope and frequency up to any limits on those services defined in the state plan, to the degree the enrollee is determined to need them. Enrollees should receive no more, and no fewer, HCBS than they are determined to require.</p> <p>b. Administration: We proposed in § 441.677(a)(2)(i) an option for presumptive payment. In accordance with section 1915(i) of the Act, the state may provide for a period of presumptive payment, not to exceed 60 days, for evaluation of eligibility for the State plan HCBS benefit and assessment of need for HCBS. This period of presumptive payment</p>

Source	Guidance
	<p>would be available for individuals who have been determined to be Medicaid eligible, and whom the state has reason to believe may be eligible for the State plan HCBS benefit. We proposed that FFP would be available for evaluation and assessment as administration of the approved state plan prior to an individual’s determination of eligibility for and receipt of other section 1915(i) of the Act services. If the individual is found not eligible for the State plan HCBS benefit, the state may claim the evaluation and assessment as administration, even though the individual would not be considered to have participated in the benefit for purposes of determining the annual number of individuals served by the benefit. FFP would not be available during this presumptive period for receipt of State plan HCBS.</p> <p>In § 441.677(a)(2)(ii), we proposed that a state may elect to phase-in the provision of services or the enrollment of individuals if the state also elects not to apply comparability requirements and to target the benefit to specific populations. However, there is no authority to limit the numerical enrollment in the benefit or to create waiting lists. Therefore, we proposed that any phase-in of services may not be based on a numerical cap on enrollees. Instead, a state may choose to phase-in the benefit or the provision of specific services based on the assessed needs of individuals, the availability of infrastructure to provide services, or both. Infrastructure is defined as the availability of qualified providers or of physical structures and information technology necessary to provide any service or set of services. A state that elects to phase-in the benefit must submit a plan, subject to CMS approval, that details the criteria used for phasing in the benefit. In the event that a state elects to phase-in the benefit based on needs, all individuals who meet the criteria described in the phase-in plan must receive covered services. If a state elects to phase-in services based upon infrastructure, the plan must describe the capacity limits, strategies to increase capacity, and must assure that covered services will be provided to all individuals who are able to acquire a willing and qualified provider. Any phase-in plan must provide assurance that the benefit, and all included services, will be available statewide to all eligible individuals within the first 5-year approval period.</p> <p>[Source]</p>
<p>Kaiser Family Foundation: Eligibility and Cost Containment Policies Used in Medicaid HCBS Programs in 2014</p>	<p>The Medicaid § 1915(c) waiver authority allows states to use a range of cost-containment strategies to meet federal cost neutrality requirements and limit spending so that expenditures do not exceed state budgetary restrictions. To understand how states controlled spending on HCBS waivers in 2014, we surveyed all state § 1915(c) waiver program administrators to assess financial and functional eligibility standards, use of enrollment and/or expenditure caps, and waiting list status (i.e., number of individuals on the list(s) and average waiting time). The survey finds that every state used some type of cost-containment tool in its § 1915(c) waivers beyond the federal cost neutrality requirement that average annual per participant waiver spending not exceed average per participant spending if services were provided in an institutional setting under the state plan absent the waiver. The following summary of the 2014 survey findings illustrates how states use cost control policies to limit access to § 1915(c) waivers.</p> <p>Financial Eligibility: Most states set their Medicaid financial eligibility standard for nursing facility services at 300 percent of the federal Supplemental Security Income (SSI) federal benefit rate (\$2,163/month for an individual in 2014). States may set financial eligibility standards for Medicaid § 1915(c) waivers at the same level as that for nursing facilities. There is, however, wide variation in financial eligibility standards across states and HCBS waiver programs as shown in Table 11. Twenty-five percent of reporting waiver programs used more restrictive financial eligibility standards (e.g., 100% of SSI) than used for nursing facilities (300% of SSI) in 2014 (Table 11 and Figure 12).</p> <p>Cost Controls: Approximately 88 percent (42 states) of all states with § 1915(c) waivers utilized some form of cost controls above and beyond the federally mandated cost neutrality formula in 2014. Many states used a mixture of fixed expenditure caps, service provision and hourly caps, and geographic limits (Table 12). Of the states with waiver cost controls in place, half (21 states) utilized more than one form, such as a combination of expenditure caps and service limitations (Table 12).</p> <p>Waiting Lists: States often have more individuals who need Medicaid home and community-based waiver services than the number of available spaces, called “slots,” in a § 1915(c) waiver (Table 13). Many states maintain waiting lists when their program slots are filled or when state legislatures do not fully fund the maximum number of slots approved by CMS. In 2014, 39 states reported waiver waiting lists while 8 states and DC reported no such lists (Table 14). In 2014, there were 582,066 individuals on waiver waiting lists across 154 § 1915(c) waivers. Section 1915(c) waivers for people with I/DD had the greatest number of individuals on waiting lists (349,511 individuals, or 60% of</p>

Source	Guidance
	total waiting list enrollment) followed by waivers serving people who are aged and aged or disabled (155,697 individuals, or 27% of total waiting list enrollment) (Table 14, Figure 13). The maintenance and length of state waiver waiting lists has implications for states' compliance with the <i>Olmstead</i> decision which requires states to provide services outside of institutions if beneficiaries are able to live in the community and do not oppose doing so. [Source]

1915(i) – State Examples

State	Services	Assisted Living Guidelines
CT	<ul style="list-style-type: none"> • Elderly and disabled individuals: minimum of 65 years and require assistance with 1 or 2 critical needs (bathing, dressing, toileting, eating/feeding, transferring, meal preparation, medication administration). Person with needs beyond 2 critical needs will be served under a 1915c waiver. • Residence in home or community (can be provider owned if it meets standards for community living as defined by the State) • Implemented statewide by the SMA • No annual limit on number of individuals served during the year or at any one time, the state will not maintain a waitlist • Individuals receiving state plan HCBS have income up to 150% of the FPL • Person centered planning requirements - care manager conducts the assessments, develops care plans and provides ongoing monitoring • Services: <ul style="list-style-type: none"> ○ Adult Day Health ○ Care Management ○ Homemaker ○ Personal Care Assistant ○ Respite ○ Assistive Technology ○ Chore Services ○ Companion ○ Environmental Accessibility Adaptations ○ Home Delivered Meals ○ Mental Health Counseling ○ Personal Emergency Response Systems ○ Transportation ○ Assisted Living <p>[Source]</p>	<p>Assisted Living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming, provided in a home-like environment in a Managed Residential Community, in conjunction with residing in the community. A managed residential community is a living arrangement consisting of private residential units that provides a managed group living environment including housing and services. A private residential unit means a living arrangement rented by the participant that includes a private full bath within the unit and facilities and equipment for the preparation and storage of food. Each unit has lockable access, is free to receive visitors and leave the setting at times of durations of the individual's choosing, access to the greater community is easily facilitated and individuals can choose whether to share a living space. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the Managed Residential Community, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Mental health counseling and the Personal Emergency Response System are services available to assisted living clients above and beyond the assisted living service. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix 1-5.</p> <p>Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each living unit is separate and distinct from each other. The communities have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms</p>

State	Services	Assisted Living Guidelines
		<p>or dining rooms). The consumer retains the rights to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.</p> <p>Care plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional which is 1-3.75 hours per week of service, limited which is 4-8.74 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service. Level of service assigned depends upon the volume an extent of services needed by each individual and is not a limitation of service.</p> <p>Assisted living services are provided statewide in Private Assisted Living Facilities under CGS 17b-365 and in 17 state funded congregate and 5 HUD facilities under CGS 8-206e(e). Additionally, Assisted Living Services are provided in 4 demonstration sites under 19-13-D105 of the regulations of CT state agencies. (Not participant-directed)</p>
MS	<ul style="list-style-type: none"> • Habilitation Services – Day Habilitation Services, Prevocational Services and Supported Employment Services • Operated by the Mississippi Department of Mental Health • 2,000 projected participants each year of the 5 year plan • [Source] 	<ul style="list-style-type: none"> • Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). The state does not provide State plan HCBS to the medically needy. • The state is targeting Individuals with Intellectual Disabilities (IID). Commencing November 1, 2013, in addition to the needs identified above, the individual must also have a Certificate of Developmental Disability as defined in the Developmental Disabilities Assistance Act.

1915(k) – State Examples

State	Services	Assisted Living Guidelines
TX	<p>"Texas is the fifth state to implement the Community First Choice Option, Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. The Texas Medicaid State Plan Amendment to add Community First Choice services was approved on April 2, 2015, with an effective date of June 1, 2015. As specified in the ACA and regulations, the Texas program covers: home and community-based attendant services and supports to assist individuals with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health-related related tasks, voluntary management training, emergency response services, and related support services. By implementing CFC, Texas is able to cover some of the HCBS services under its State Plan which were previously covered through 1915(c) waivers and other State Plan options. Texas retained the</p>	<p>Texas does not allow CFC services in assisted living settings.</p>

State	Services	Assisted Living Guidelines
	<p>existing State Plan personal care services to serve individuals who need assistance with activities of daily living but do not meet the institutional level of care. Texas retained its existing 1915(c) waivers for individuals with intellectual and developmental disabilities (IDD) to cover services that are not permissible for coverage under CFC. Older adults and individuals with physical disabilities receive HCBS waiver services through STAR+PLUS, a statewide managed care program under an 1115 waiver. Some STAR+PLUS waiver participants are excluded from CFC because they are eligible for Medicaid under the 1115 waiver rather than under the State Plan.” [Source]</p> <p>Community-based attendant services and supports: Three models of delivery</p> <ul style="list-style-type: none"> • Agency-Provider Model: Services delivered by provider agencies under contract with state • Service Responsibility Option: individual is responsible for selecting and managing their attendant under a provider agency • Directed Services Model: individuals or legally authorized representatives hire, train, manage and fire attendants, and have budget authority over consumer-directed services <p>CFC Services are provided in a home or community setting, which includes individual homes, apartment buildings, and non-residential settings that meet the settings criteria in 42 CFR 441.530. CFC Services may not be provided in institutions, settings with characteristics of an institution, or in provider-owned or controlled residential settings. [Source]</p>	
MT	<p>Montana is the fourth state to implement the Community First Choice Option, Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Montana’s Medicaid State Plan Amendment adding Community First Choice services was approved on July 8, 2014, with an effective date of October 1, 2013. Montana’s program covers home and community-based attendant services and supports to assist individuals with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health-related related tasks, and related support services, as specified in the ACA and regulations. By implementing the CFC option, Montana is able to cover a range of home and community-based services under its State Plan, which were previously covered through 1915(c) waivers and State Plan PAS. Montana retained its existing HCBS waivers to cover services that are not permissible for coverage under CFC. The existing agency-based and self-directed State Plan personal assistance services were retained to provide services to individuals who need assistance with activities of daily living but do not meet the institutional level of care.</p> <p>Community-based attendant services and supports</p> <ul style="list-style-type: none"> • Traditional Agency Model: Services and supports provided by provider agencies directly 	<p>Montana does not allow CFC services in assisted living facilities.</p>

State	Services	Assisted Living Guidelines
	<p>through their employees</p> <ul style="list-style-type: none"> Agency-with-choice: provider agencies provide services through co-employment relationships with individuals. <p>Services may not be provided in institutions or in developmental disability or mental health group homes, adult foster homes, or assisted living facilities.”</p> <p>[Source]</p>	
MD	<p>Maryland is the third state to implement the Community First Choice Option, Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Maryland’s Medicaid State Plan Amendment adding Community First Choice services was approved on April 2, 2014, with an effective date of January 1, 2014. As specified in the ACA and regulations, Maryland’s program covers home and community-based attendant services and supports to assist individuals with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks. By implementing the CFC option, Maryland is able to cover a range of home and community-based services under its State Plan, which were previously covered through 1915(c) waivers. Concurrent with implementation of CFC, the state merged two 1915(c) waivers that offered similar services to different populations, to create a new waiver which covers services that are not permissible under CFC. State Plan personal assistance was retained to provide services to individuals who do not meet the institutional level of care but need assistance with at least one ADL. The State will align procedures in the State Plan personal care program (Medical Assistance Personal Care, or “MAPC”) with those in CFC in order to facilitate transitions between the two programs. For example, a common assessment tool will be used to determine participants’ level of care needs. Participants in CFC and MAPC will also receive select services—including supports planning and nurse monitoring—from the same pool of service providers, Area Agencies on Aging, and health department nursing staff.</p> <p>Community-based attendant services and supports</p> <ul style="list-style-type: none"> Agency Model Agency-with-choice <p>CFC services can be provided in “single family homes, duplexes, apartment, and congregate settings serving three or few people. Assisted Living remains a waiver service and is not concluded in CFC”</p> <p>[Source]</p>	Maryland does not allow CFC services in assisted living.
CA	<p>On December 1, 2011, the California Department of Health Care services submitted the first state plan amendment to implement Section 2401 (the Community First Choice Option) of the</p>	California allows CFC services in congregate independent living communities.

State	Services	Assisted Living Guidelines
	<p>Affordable Care Act (ACA), providing the provision of medical assistances for home and community-based attendant services including Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLS), and health related tasks, teaching and demonstration for ADLs, IADLS, and other health-related tasks, back-up systems to ensure the continuity of services and training on the hiring and maintenance of attendants. California has developed a quality assurance plan to monitor the implementation and efficacy of the Community First Choice Option at the county-and-state- levels.</p> <p>[Source]</p>	<p>Community-based attendant services and supports</p> <ul style="list-style-type: none"> • Agency Model • Self-Directed Model <p>CFC services can be provided in single family home, apartment and congregate independent living communities</p> <p>Providers include relatives (who can be paid service providers) and under the self-directed model, participants can hire anyone who meets their own established qualifications.</p> <p>Person centered planning to direct course of care.</p>
OR	<p>Oregon is the second state to implement the Community First Choice Option, Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Oregon’s Medicaid State Plan Amendment adding Community First Choice services was approved on June 27, 2013, with an effective date of July 1, 2013. By implementing this option, which Oregon refers to as “K Plan” or “K Option,” the State is able to cover a range of home and community-based services under the State Plan, rather than through 1915(c) waivers. As specified in the ACA and regulations, Oregon’s program will cover home and community-based attendant services and supports, to assist individuals with activities of daily living (ADLs), instrumental activities of daily living (IADLS), and health-related related tasks.</p> <p>[Source]</p>	<p>Oregon allows CFC services in assisted living, adult foster care, residential care facilities, resident treatment facilities, supporting living providers, group homes, foster care.</p> <p>Community-based attendant services and supports</p> <ul style="list-style-type: none"> • Agency-provider model: providers are contractors or in a provider agreement with the state to deliver services. Individuals can still play a role in selecting services and attendants yet do not managed a self-directed service budget. <p>Community settings may include assisted living facilities, adult foster care, adult day centers, day habilitation providers, residential care facilities, residential treatment facilities, supported living providers, and several types of group homes and foster care. Provider own or controlled settings may not be located on the grounds of public institutions or disability-specific housing.</p> <ul style="list-style-type: none"> • Individual must have a person centered plan to help determine setting in which they choose to receive services • Community settings must have; lease agreement with eviction protections; provide individuals with privacy in rooms; allow individual to decorate and furnish; and allow individual to have visitors of their choosing. <p>Service Match for:</p> <ul style="list-style-type: none"> • Assistances with ADLs, IADLS, and health related tasked through supervision/hands of assistance • Acquisition, maintenance and enhancement of skills • Back-up systems or mechanisms to ensure continuity of services and supports • Voluntary training on how to select, manage, dismiss attendants • Support system activities • Expenditures that substitute for human assistance (assist devices, environmental enhancements etc.)

State	Services	Assisted Living Guidelines
		<ul style="list-style-type: none"> Expenditures for transition costs for an individual to transition from institutions to community setting Person centered planning
CT	<p>In accordance with the provisions of section 17b-8 of the Connecticut General Statutes, notice is hereby given that the Commissioner of DSS intends to amend the Medicaid State Plan to remove self-directed Personal Care Assistance services from the Personal Care Assistant (PCA), Acquired Brain Injury (ABI), Acquired Brain Injury Waiver II and Elder waivers. Those services will be offered in a new Medicaid State Plan Option (Community First Choice). Effective on or after April 1, 2015, pursuant to section 1915(k) of the Social Security Act, SPA 15-012 will amend the Medicaid State Plan by establishing a new Attachment 3.1-K to set forth the Community First Choice State Plan Option. The services available under the Community First Choice State Plan include assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and health-related tasks through hands on assistance, supervision, and/or cueing, acquisition, maintenance, and enhancement of skills necessary to accomplish ADLs, IADLS, and health related tasks, backup systems, and training. In addition, SPA 15-012 will amend Attachment 4.19-B of the Medicaid State Plan to set forth the reimbursement methodology for Community First Choice.”</p> <p>Community-based attendant services and supports</p> <ul style="list-style-type: none"> Self-Directed Model: individual can hire, supervise, train staff and manage own budget or with support of someone else <p>Services:</p> <ul style="list-style-type: none"> ADLs, IADLs, and health related tasks through hands on assistance or supervision Teaching skills to accomplish ADLs, IADLs, health related tasks Transitional services to help individual transition from institutional care back to the community (only if individual is unable to meet expenses or if expenses cannot be found through other sources) Home delivered meals Environmental Accessibility Adaptations (max \$10,000 over 5 years) Assistive Technology Backup systems Training Person centered planning <p>CFC Services will be provided in residential settings that meet criteria outlined in 42.CFR 441.530. CFC residential settings include individual homes, apartment buildings, retirement homes, and</p>	<p>Connecticut does not allow CFC services in assisted living settings.</p>

State	Services	Assisted Living Guidelines
	<p>group living environments that meet CFC Residential Criteria</p> <p>Residential criteria:</p> <ul style="list-style-type: none"> • Choice of CFC providers • Choice of CFC workers in setting • Choice of attendant schedule and skill-set in the setting • Ability to plan and actively participate in setting • Option of signing a rent/lease agreement if individual is with more than four residents and in a non-owned group setting <p>[Source]</p>	
<p>WA</p>	<p>The Health Care Authority in conjunction with the Department of Social and Health Services (DSHS) intends to submit Medicaid State Plan Amendment (SPA) 16-0031 to make amendments to the Community First Choice Program SPA 15-0037 that was initially approved by CMS effective July 1, 2015.</p> <p>SPA 16-0031 will amend the Community First Choice program to:</p> <ul style="list-style-type: none"> • Clarify language for personal care providers regarding state and federal background checks. <ul style="list-style-type: none"> ○ A state background check must be completed prior to contracting ○ A federal background check must be completed within 120 days of the provider being hired. • Remove the link to the rate schedule listed on Attachment 4.19-B page 49. • Add provider types eligible to provide the following services: <ul style="list-style-type: none"> ○ Voluntary training on how to select, manage and dismiss attendants ○ Community Transition ○ Assistive Technology 1. Expand the scope of the “voluntary training on how to select, manage and dismiss attendants”. Currently this service is provided through self-study materials. Upon approval from CMS, participants who employ and manage multiple care providers may choose to receive training directly from listed provider types. 2. Expand the scope of the Backup System service to receive federal matching funds for bed hold retainer payments to residential providers during a participant’s short term hospital or nursing home stay. • Remove references to the Social Service Payment System. • Increase the fiscal year monetary limit available to participants to \$550.00 for the purchase of Assistive Technology and Skills Acquisition Training. • Clarify that the scope of assistive technology services includes assistive equipment that increases the individual’s independence or substitutes for human assistance.” 	<p>Washington allows CFC services in assisted living facilities.</p> <p>Community Based-attendant services and supports</p> <ul style="list-style-type: none"> • Agency Model: Based on person-centered assessment of need. Entities are under contract with State to provide services and supports • CFC services can be provided in private homes, Licensed Assisted Living Facilities that hold an Assisted Living Contract, Adult Residential Care contract, and Enhanced Adult Residential Care contract, and Adult Family Homes. <ul style="list-style-type: none"> ○ Individual providers must contract with the Department before being paid for personal care services and must complete basic training ○ Home Care Agencies, Assisted Living Facilities, and Adult Foster Care must contract with the Department to provide person care • No CFC services can be provided in a nursing facility, hospital providing long-term care services, institution for mental diseases, or an immediate care facility for the intellectually disabled. • Services include: <ul style="list-style-type: none"> ○ Assistance with ADLs, IADLs and health related tasks with choice of residential-based care or in-home care ○ Nurse delegation ○ Assistance with acquisition, maintenance, and enhancement of skills necessary for ADLs, IADLs, or health related tasks ○ Back-up systems to ensure continuity of services and supports ○ Voluntary training on how to manage attendants ○ Expenditures for services that can substitute for human assistance (including assistive technology) ○ Transition costs for individuals transitioning from institution for community setting <p>[Source]</p>

State	Services	Assisted Living Guidelines
	[Source]	
NY	<p>Community based-attendant services and supports</p> <ul style="list-style-type: none"> • Agency Model • Agency with choice model <p>Settings can include an individual’s home or family member’s home</p> <p>Settings that are provider owned or controlled must have a lease with resident and resident must have privacy in sleeping or living unit, freedom and support to control their own schedules and activities, access to food, visitors of choice at any time, and be physically assessable.</p> <p>Residents may only live in congregate foster home when awaiting placement in family home Cannot be provided in nursing facility, hospital providing LTSS, institution for mental disease, intermediate care facility for individuals with disabilities or relation condition or setting with characteristics of an institution.</p> <p>[Source 1] [Source 2]</p>	<p>New York does not allow CFC services in assisted living settings (provider-owned, provider-controlled). [Source]</p>

Home Health

Benefit

The language included in the following table reflects language pulled from source documents to illustrate how the home health benefit is constructed in the state with particular focus on state specific additions and/or limitations. Federal regulations require services under the Home Health Benefit be available to individuals who are entitled to nursing facility care—eligible persons age 21 or older. State may opt to cover other Medicaid beneficiaries under age 21. Under the Federal regulations, Home Health services include nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home. States may provide additional services and may establish reasonable standards for determining the extent of such coverage using criteria based on medical necessity or utilization control. In doing so, a state must ensure that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service. Home Health services must be medically necessary and authorized by a physician’s order as part of a written plan of care. [\[Source\]](#)

State	Eligibility and Payment Structure	Benefits and Duration
PA	<p>Definition: <i>Home health agency</i>—A public or private agency or organization, or part of an agency or organization that is licensed by the Commonwealth and certified for participation in Medicare. The agency shall be staffed and equipped to provide skilled nursing care and at least one therapeutic service—physical therapy, occupational therapy or speech pathology—or home health aides to a disabled, aged, injured or sick recipient on a part-time or intermittent basis in his residence.</p> <p><i>Home health services</i>—Nursing services, home health aide services, physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency and medical supplies, equipment and appliances suitable for use in the home. For the purpose of this chapter, medical supplies, equipment and appliances do not include dentures, prosthetic devices, orthoses or eyeglasses.</p> <p>Scope: Home Health services are offered to the categorically needy that have medical necessity for home health. [Source]</p> <p>Payment for medical supplies, equipment, and appliances that are needed for the home health care, as directed by the physician, are paid through via the rules and guidelines in chapter 1123 of PA code (relating to medical supplies).</p> <p>Payment for home health services provided by participating home health agencies is subject to § 1249.52—1249.59 and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program Fee Schedule. Home Health agencies are reimbursed for skilled nursing care, home health aide services, physical and occupational therapy, speech pathology and audiology services, and medical/surgical supplies via the fee schedule as long as the following are met:</p>	<p>Medical supplies, equipment, and appliances—which are typically not covered for medically needy—are covered if they are provided in conjunction with nursing or home health aide services and are part of the treatment plan of the physician. Other benefits include skilled nursing care, home health aide services, physical and occupational therapy, speech pathology and audiology services.</p> <p><i>Skilled Nursing Care</i>- includes, but is not limited to, observation and evaluation, teaching and training the recipient or family member to provide care (giving injections, irrigating a catheter, applying dressings to wounds involving medications and aseptic techniques, and teaching proper use of medications), insertion and sterile irrigation of catheters, bladder training, administering injections, administering enteral and intravenous total parenteral nutrition, treating decubitus ulcers and other skin disorders.</p> <p>Duration: The total plan of treatment shall be reviewed by the attending physician and home health care agency personnel as often as the severity of the patient’s condition requires, but at least once every 60 days. Agency professional staff shall promptly alert the physician to changes that suggest a need to alter the plan of treatment. [Source]</p> <p><i>Skilled Nursing Facility</i>- covered 365 days per calendar year</p> <p>Unique Feature: <i>Home health Care (including nursing, aides, and therapy services)</i> - unlimited for the first 28 days, limited to 15 days every month thereafter. [Source]</p> <p>Duration: There is a plan authorized by the attending physician, reviewed at least every 60 days, and any changes have been made in writing (or verbally if made to a registered nurse, licensed practical nurses, physical therapists, speech therapist). Written changes must be signed within 30</p>

State	Eligibility and Payment Structure	Benefits and Duration
	<ol style="list-style-type: none"> 1. The services are ordered by and included in the plan of treatment established by the recipient's physician 2. The physician certifies that the treatment in home is required and that <ol style="list-style-type: none"> a. The home health services would avoid or delay the need for treatment in a hospital or institutional setting b. The recipient has an illness, injury, or mental health condition that justifies providing the services in home instead of a physician office, clinic, or outpatient setting. 3. The physician certifies the need for a skilled nurse, physical therapist, speech therapist, or home health aide. 4. There is a plan authorized by the attending physician, reviewed at least every 60 days, and any changes have been made in writing (or verbally if made to a registered nurse, licensed practical nurses, physical therapists, speech therapist) 5. All services have been prior authorized by the Department. [Source] <p>Service is FFS [Source]</p>	<p>days. After the first 28 days of unlimited home health care, payment is limited to the number of home visits specified on the MA Program Fee Schedule. [Source]</p>
<p>KY</p>	<p>A home health service shall be provided in accordance with 907 KAR 1:030 to be eligible for reimbursement. Payment to an In-state HHA. (1) Except as provided in Section 14 of this administrative regulation, the department shall reimburse a Medicaid participating in-state HHA on the basis of an interim rate established pursuant to subsection (2) of this section for the following services:</p> <ol style="list-style-type: none"> (a) Speech therapy; (b) Physical therapy; (c) Occupational therapy; (d) Medical social services; (e) Home health aide services; and (f) Skilled nursing services. <p>Unique Features: Kentucky has a cost containment incentive payment system. If the Home Health Agency's costs are below the Medicaid upper limits they shall receive a cost containment incentive payment:</p> <ul style="list-style-type: none"> • 90.01%-95% receives \$1 per visit • 85.01%-90% receives \$1.50 per visit • 80.01%-85% receives \$2.00 • 80% and below receives \$2.50 	<p>Scope: Home health services shall be prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient, be consistent with the plan of care.</p> <p>Nursing services includes part-time intermittent nursing services. If provided daily, be limited to 30 days unless additional days are prior authorized by the department.</p> <p>Therapy services include physical therapy provided by a physical therapist, occupational therapy provided by an occupational therapist, speech-language pathology services provided by a speech language pathologist, and must be provided pursuant to the plan of care. [Source 1] [Source 2]</p> <p>Duration: The plan of care, which is how services for home health are prior authorized, must be reviewed and signed by a physician and home health agency staff at least every 60 days. Home health aides must be supervised at least every 14 days by an RN, Physician, occupational therapist, or speech-language pathologist. [Source]</p> <p>Unique features: None identified</p>

State	Eligibility and Payment Structure	Benefits and Duration
	<p>[Source]</p>	
<p>KS</p>	<p>Eligibility: Categorically needy and the medically needy are eligible for home health services through the state plan. [Source]</p> <p>Providers billing KMAP for home health agency services rendered to Medicare-eligible beneficiaries must either bill Medicare first and obtain a denial or use the GY (statutorily excluded) modifier to bypass the Medicare-denial requirement. The GY modifier may only be used if the beneficiary has a Medicaid-covered benefit plan. Providers can bill KMAP for services rendered to a dually eligible beneficiary if the beneficiary is not “homebound.” Dually eligible beneficiaries have both Medicare and Medicaid coverage. A beneficiary will be considered homebound if he or she has a condition due to an illness or injury which restricts his or her ability to leave the home without assistance. The beneficiary is dependent on the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person. A beneficiary is also considered homebound if his or her condition is such that leaving the home is medically contraindicated. If a beneficiary is a qualified Medicare beneficiary (QMB) but does not meet eligibility for Medicaid coverage, providers cannot bill KMAP for home health agency services rendered. The beneficiary must have a Medicaid-covered benefit plan such as TXIX in addition to Medicare coverage to be eligible for fee-for-service home health visits. Medical assistance benefits are provided through the Medicare program for QMBs. Medicaid will consider payment for Medicare coinsurance and deductible amounts only. If providers bill KMAP for home health agency services rendered to QMB-only beneficiaries, the money will be recouped. [Source]</p> <p>Scope: Nothing outside of normal Medicaid requirements for the state health plan.</p> <p>Health coverage and long-term care for people over age 65 and people with disabilities is available through KanCare. To be eligible, you must be a Kansas resident. You also must be a U.S. citizen or an eligible non-citizen. For example, home health services with limitations on durable medical equipment and supplies are covered for MediKan beneficiaries when medically necessary and a physician has established a treatment plan and certified the need for the service [Source 1] [Source 2].</p> <p>Amount: According to the Kasier Family Foundation, Kansas only allows 2 home health aide visits per week and limits therapies to six months. [Source]</p> <p>Payment Structure: Home health services require a copayment of \$3 per skilled nursing visit.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> • Skilled nursing services provided in accordance to 42 CFR 440.70 • Restorative and rehabilitative occupational therapy provided in accordance with 42 CFR 440.110 • Restorative and rehabilitative occupational therapy provided in accordance • Restorative and rehabilitative speech therapy provided in accordance • DME and supplies provided in accordance • HHA services provided in accordance • Restorative aide services provided in accordance • Immunizations • Respiratory therapy for Kan Be Healthy program participants within limitations • Kan Be Healthy (EPSDT) medical screening by a certified RN or ARNP within the limitations in Attachment 3.1-A #4-b • Home Telehealth services within the limitations of Attachments 3.1-A #7a <p>[Source]</p> <p>HH Nursing limitations Medically necessary skilled nursing services provided in the home or via interactive audio and video telecommunications systems by the RUN or LPN are included. Skilled nursing services are those services requiring substantial and specialized nursing skills. Home telehealth services are delivered as a supplement to enhance home health services and not as a substitute for face to face visits. Home telehealth services must be ordered by a physician as indicated in the plan of care and the patients must agree to participate in the program.</p> <p>DME services provided by parenteral administration of total nutritional replacements and intravenous medications in the recipient’s home require the participation of nursing services from a local home health agency. In areas not served by a HHA, the services of a local health department or advanced RNP are required.</p> <p>HHA Services HHA services are limited to one visit per day per recipient HHA services are not covered on the same date or service as restorative aide services for the same recipient. [Source]</p>

State	Eligibility and Payment Structure	Benefits and Duration
	<p>[Source]</p> <p>Unique features: Providers can bill KMAP for services rendered to a dually eligible beneficiary if the beneficiary is not “homebound.” Dually eligible beneficiaries have both Medicare and Medicaid coverage. [Source]</p>	<p>Scope: All home health nursing and therapy services require prior authorization. Skilled nursing services require a physician's order. The agency is required to maintain plans of care containing the physician’s signature on file in the medical record located at the home health agency. Skilled nursing services must be prior authorized for all beneficiaries. If a service can be safely and effectively performed by a nonmedical person (or self-administered) without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. All long-term care home health services are for the provision of reasonable and medically necessary health maintenance tasks to assist beneficiaries in managing chronic health conditions in the home setting and thereby avoid placement in nursing facilities or other institutions. Long-term care home health visits must not duplicate other resources available to the beneficiary [Source]</p> <p>Duration: If the plan of care includes procedures and services that, according to professional practice acts, require a physician’s authorization, the plan of care shall be signed by a physician and shall be renewed every 62 days. Hours of care are determined individually by the MCO (fee schedule downloaded). A supervisory visit of a home health aide is required at least every two weeks when the patient is under a skilled service plan of care. Home health services must be under the general supervision of an RN. Services are considered part-time when less than eight hours each day and 28 or fewer hours each week. Long-term care home health services can be prior authorized for up to six months for beneficiaries who require this level of care until placement in a nursing facility. [Source 1] [Source 2] [Source 3] [Source 4] [Source 5]</p>
NJ	<p>Eligibility: Medicaid or NJ FamilyCare fee-for-service beneficiaries. [Source]</p> <p>Costs: When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the Division retains the right to limit or deny the provision of home care services on a prospective basis. Fee Schedule: Physical Therapy \$24.06, Occupational Therapy \$23.81, Speech Therapy \$20.27, Skilled Nursing \$29.14, Medical Social Services and Dietary/ Nutritional Services \$25.90, Home Health Aide \$ 6.22. [Source]</p>	<p>Services: The types of home health agency services covered include professional nursing by a public health nurse, registered professional nurse, or licensed practical nurse; homemaker home health aide services; physical therapy; speech-language pathology services; occupational therapy; medical social services; nutritional services; certain medical supplies; and personal care assistant services, as defined in this section.</p> <p>The home health agency shall provide comprehensive nursing services under the direction of a public health nurse supervisor/director as defined by the New Jersey State Department of Health and Senior Services. These services shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> i. Participating in the development of the plan of care with other health care team members, which includes discharge planning; ii. Identifying the nursing needs of the beneficiary through an initial assessment and periodic reassessment; iii. Planning for management of the plan of care particularly as related to the coordination of other needed health care services;

State	Eligibility and Payment Structure	Benefits and Duration
		<ul style="list-style-type: none"> iv. Skilled observing and monitoring of the beneficiary's responses to care and treatment; v. Teaching, supervising and consulting with the beneficiary and family and/or interested persons involved with his or her care in methods of meeting the nursing care needs in the home and community setting; vi. Providing direct nursing care services and procedures including, but not limited to: <ul style="list-style-type: none"> (1) Wound care/decubitus care and management; (2) Enterostomal care and management; (3) Parenteral medication administration; and (4) Indwelling catheter care. vii. Implementing restorative nursing care measures involving all body systems including, but not limited to: <ul style="list-style-type: none"> (1) Maintaining good body alignment with proper positioning of bedfast/chairfast beneficiaries; (2) Supervising and/or assisting with range of motion exercises; (3) Developing the beneficiary's independence in all activities of daily living by teaching self-care, including ambulation within the limits of the treatment plan; and (4) Evaluating nutritional needs including hydration and skin integrity; observing for obesity and malnutrition; viii. Teaching and assisting the beneficiary with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered; ix. Providing the beneficiary and the family or interested persons support in dealing with the mental, emotional, behavioral, and social aspects of illness in the home; x. Preparing nursing documentation including nursing assessment, nursing history, clinical nursing records and nursing progress notes; and xi. Supervising and teaching other nursing service personnel. <p>If two health care workers are required to provide care and the second worker is not in a supervisory capacity, two or more units of service may be covered for the simultaneous care. If two health care workers are present, but only one is needed to provide the care, only the unit(s) of service for the one worker providing the care shall be covered.</p> <p>Homemaker-home health aide services shall be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Services include personal care, health related tasks and household duties. In all areas of service, the homemaker-home health aide shall encourage the well members of the family, if any, to carry their share of responsibility for the care of the beneficiary in accordance with the written</p>

State	Eligibility and Payment Structure	Benefits and Duration
		<p>established professional plan of care.</p> <p>Household duties shall be considered covered services only when combined with personal care and other health services provided by the home health agency. Household duties may include such services as the care of the beneficiary's room, personal laundry, shopping, meal planning and preparation. In contrast, personal care services may include assisting the beneficiary with grooming, bathing, toileting, eating, dressing, and ambulation. The determining factor for the provision of household duties shall be based upon the degree of functional disability of the beneficiary, as well as the need for physician prescribed personal care and other health services, and not solely the beneficiary's medical diagnosis.</p> <p>Special therapies include physical therapy, speech-language pathology services and occupational therapy. Special therapists/ pathologists shall review the initial plan of care and any change in the plan of care with the attending physician and the professional nursing staff of the home health agency. The attending physician shall be given an evaluation of the progress of therapies provided as well as the beneficiary's reaction to treatment and any change in the beneficiary's condition. The attending physician shall approve of any changes in the plan of care and delivery of therapy services.</p> <p>When the agency provides or arranges for medical social services, the services shall be provided by a social worker, or by a social work assistant under the supervision of a social worker. These shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> i. Identifying the significant social and psychological factors related to the health problems of the beneficiary and reporting any changes to the home health agency; ii. Participating in the development of the plan of care, including discharge planning, with other members of the home health agency; iii. Counseling the beneficiary and family/interested persons in understanding and accepting the beneficiary's health care needs, especially the emotional implications of the illness; iv. Coordinating the utilization of appropriate supportive community resources, including the provision of information and referral services; and v. Preparing psychosocial histories and clinical notes. <p>When the agency provides or arranges for nutritional services, the services shall be provided by a registered dietitian or nutritionist. These services shall include, but are not limited to, the following:</p> <ul style="list-style-type: none"> i. Determining the priority of nutritional care needs and developing long and short-term

State	Eligibility and Payment Structure	Benefits and Duration
		<p>goals to meet those needs;</p> <p>ii. Evaluating the beneficiary's home situation, particularly the physical areas available for food storage and preparation;</p> <p>iii. Evaluating the role of the family/interested persons in relation to the beneficiary's diet control requirements;</p> <p>iv. Evaluating the beneficiary's nutritional needs as related to medical and socioeconomic status of the home and family resources;</p> <p>v. Developing a dietary plan to meet the goals and implementing the plan of care;</p> <p>vi. Instructing beneficiary, other home health agency personnel and family/interested persons in dietary and nutritional therapy; and</p> <p>vii. Preparing clinical and dietary progress notes.</p> <p>Medical supplies, other than drugs and biologicals, including, but not limited to, gauze, cotton bandages, surgical dressing, surgical gloves, ostomy supplies, and rubbing alcohol shall be normally supplied by the home health agency as needed to enable the agency to carry out the plan of care established by the attending physician and agency staff. [Source]</p> <p>Duration: The plan shall be re-evaluated by the nursing staff at least every two months and revised as necessary, appropriate to the beneficiary's condition. [Source]</p>
ND	<p>Eligibility: No age restrictions, no other non-medical eligibility restrictions. [Source]</p> <p>Costs: Copay of \$2 per visit [Source]; appears to be FFS. [Source]</p>	<p>Services: Skilled nursing services, medical supplies and equipment; medications and treatment, when applicable, special dietary or nutritional needs when applicable and medical tests including labs tests and x-rays. [Source]</p> <p>"Supportive services" includes the use of medical appliances; medical supplies, other than drugs and biologicals prescribed by a physician; the collection of blood and other samples for laboratory analysis; and nutritional guidance, homemaker, or companion services. [Source]</p> <p>"Homemaker services" include preparing meals, shopping, assistance with bill paying, housework, laundry, transportation, communication, and mobility outside the patient's residence. [Source]</p> <p>Duration: The physician must review the care plan and reorder care every 60 days. [Source]</p>
SD	<p>Definition: "Home health agency," an organization which is primarily engaged in providing skilled nursing, medical social services, or home health aide services and which meets the requirements of a home health agency under 42 C.F.R. §§ 484.1 to 484.55, inclusive (October 1, 2005). This does not include an agency or organization whose function is primarily the care and treatment of mental</p>	<p>Services: Skilled nursing services, which may include</p> <ul style="list-style-type: none"> • visits by a student nurse enrolled in a school of nursing, • Medical social services provided by a licensed social worker who is not an employee of the

State	Eligibility and Payment Structure	Benefits and Duration
	<p>illness;</p> <p>"Home health aide services," those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician and provided on an intermittent basis;</p> <p>"Home health services" or "services," skilled nursing services, medical social services, or home health aide services provided by a home health agency;</p> <p>Eligibility: Home health services are available to an individual in the individual's place of residence. The individual must be eligible for medical assistance and the required services must meet the appropriate conditions. [Source]</p> <p>Costs: If the actual or projected cost of all home health services over a period of three months exceeds 135 percent of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The department shall send the notice to the home health agency and to the individual. If within 30 days after the notice the home health agency provides documentation that the future home health service costs will decline and be within 135 percent of the cost of long-term care, the department shall reconsider its decision. Fee schedule (FFS) [Source]</p>	<p>department;</p> <ul style="list-style-type: none"> • Medical supplies used incidental to the visit when necessary to administer the attending physician's prescribed plan of care; • Multiple visits of the same discipline on the same day if the medical necessity for the multiple visits is documented by the attending physician in the individual's medical record; • Daily visits if the medical necessity for the visits is documented by the attending physician in the individual's medical record. The daily visits are limited to four weeks but may be extended beyond the four-week period if the attending physician documents the need for the visits in the individual's medical record; • Therapy services unless restricted by § 67:16:05:05.05; and • Postpartum services meeting the requirements of § 67:16:05:05.06. [Source] <p>Duration: Services must be provided intermittently but not more than once a day and no more frequently than five days a week. The attending physician must periodically review the individual's plan of care and recertify the need for services. For medical social work, the recertification must be completed at least every 30 days following service initiation. For nursing, home health aide, and therapy services, the recertification must be completed at least every 60 days following service initiation. The home health agency must obtain the recertification. [Source]</p>

Scope of Service

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
PA	<p>Scope of Service: The assignment of a home health aide to a case shall be made in accordance with a written plan of treatment established by the recipient's attending physician. The plan shall indicate the recipient's need for personal care services. The specific personal care services to be furnished by the home health aide shall be determined by a registered nurse and not by the home health aide. If skilled care is not required, the recipient's attending physician shall certify that the personal care services furnished are medically necessary.</p> <p>Services include bathing and personal hygiene, ambulation and transfer, exercise, administering medications specifically ordered by a physician that are ordinarily self-administered, retraining the recipient in necessary self-help skills. In addition to Domestic and housekeeping services which are unrelated to recipient care are not covered home health services. For example, the services include the following:</p> <ul style="list-style-type: none"> • Vacuuming, dusting, floor mopping, kitchen and bathroom maintenance. 	<p>Pennsylvania only provides personal care attendant services through its waiver program.</p> <p>Scope of Service: PA allows legally responsible relatives to provide a limited number of extraordinary care services under the HCBS waiver; extraordinary care is defined as care that exceeds the range of activities that a legally responsible individual would ordinarily perform in the household or on the behalf of a person to assure the health welfare of the person and avoid institutionalization. Family members can be paid for certain services such as home and community habilitation and transportation, under certain circumstances in the PA Consolidated Waiver and Person/Family-Directed Support Waiver program [Source]</p> <p>Training: PCAs must complete an agency-based training and competency evaluation program meeting certain state-specified subject requirements.</p>

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
	<ul style="list-style-type: none"> Washing, ironing and mending clothes. Childcare. [Source] <p>Training: Must do 1 of 3: 1) Pass a competency exam developed by the home health agency that employs them, 2) Pass a nurse aid certification and training program sponsored by the PA dept. of Education, 3) Complete a program approved by the PA dept. of health and published in the PA bulletin.</p> <p>PA has eight different home health training programs available for people to earn certification. A nonprofessional person who has completed a minimum of 60 hours of classroom instruction prior to or during the first three months of employment. Once training is completed, aides need to pass criminal background checks, child abuse clearances, and if direct consumer contact is required need to pass TB screening.</p> <p>The term includes aids who are carefully trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, changes in patient’s condition that should be reported, work of the agency and the health team, ethics, confidentiality and record keeping [Source]</p>	<p>The Home and Community Based Waiver for Individuals Aged 60 and Older has the same requirements for agency-employed aides. [Source]</p> <p>The State does not make payment to legally responsible individuals for furnishing personal care or similar services. [Source 1] [Source 2]</p>
KY	<p>A HHA is also called a State Registered Nurse Aide (SRNA).</p> <p>Scope of Service: “The duties of the aide include: the performance of simple procedures as an extension of therapy services; personal care (i.e. bathing, shampoo, special foot care); range of motion exercises and ambulation; assistance with medications that are ordinarily self-administered and which have been specifically ordered by the physician; reporting changes in the recipient’s condition and needs; and completing appropriate records. The home health aide may also perform incidental household services which are essential to the recipient’s health care at home WHEN PROVIDED IN THE COURSE OF A REGULAR VISIT (i.e., straightening room, or changing linens). Domestic or housekeeping services which are unrelated to the recipient’s care are not covered under the Medicaid Home Health Program.” [Source]</p> <p>“There are other instances where the nature of the service and the condition of a recipient would affect whether the service may only be performed safely and effectively by the nurse or is able to be performed by the home health aide or a non-medical person. For example, the giving of a bath does not generally require that it be performed by the RN or LPN.” [Source]</p>	<p>Kentucky only provides personal care attendant services through its waiver program.</p> <p>Scope of Service: Personal care attendants are permitted to provide the following services: turning, repositioning, transferring, assistance with oxygen, hygiene, grooming, washing hair, skin-care, shopping, transportation, chores, light correspondence, equipment cleaning and emergency procedures (as necessary).[Source]</p> <p>Training: Under the HCBS Waiver, PCAs must be employed by certified home health agencies, which means they must complete the state’s home health aide training and competency evaluation. The Michelle P. Waiver and Supports for Community Living Waiver provide only participant directed services.</p> <p>Mandatory training in abuse, neglect, and exploitation is required for PCAs in these programs and the participant-directed program under the HCBS Waiver [Source]</p> <p>Personal care can be consumer directed [Source]</p>

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
	<p>Training: 75 hours of classroom training, 16 hours of supervised practical training.</p> <p>The home health agency shall require that home health aides receive or have received a basic training program for home health aides. Must be able to read and write, understand instructions, keep simple records, record messages, have emotional and mental maturity, and interest in sympathetic attitudes toward caring for the sick at home.</p> <p>Home health aides are trained by the agency and must be trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal prep and the aging process and the emotional problems of illness, procedures for maintaining clean, healthful and pleasant environment, awareness of changes in patients condition, work of that agency and the health team and ethics, confidentiality and record keeping to be certified, must complete a state approved training program and competency evaluation, comprised of a written and clinical skills exam. [Source 1] [Source 2]</p> <p>Must be renewed every two years. Additionally, each HHA is also responsible for maintaining an annual 12 hours of continuing in-service education [Source]</p>	
KS	<p>Scope of Service: Home Health Aid services include: personal hygiene, linen change, maintenance exercises, medication (assistance, check compliance, apply over the counter topical meds), vital signs (if addressed in care plan), bowel/bladder procedures, simple/nonsterile dressing changes, other procedures which specific and adequate training has been provided [Source].</p> <p>Each home health aide shall be supervised by a registered nurse and shall be given written instructions for patient care prepared by a qualified health professional. [Source]</p> <p>Training: Home health aide services need not be related to skilled nursing visits. Home Health Aids must be a Kansas certified Nurse aid, complete 20-hour home health aid course approved by licensing agency [Source]</p>	<p>Kansas only provides personal care attendant services through its waivers.</p> <p>Scope of Service: PCS focuses on assistance with Activities of Daily Living (ADLs) such as bathing, grooming, toileting, transferring, and eating and Instrumental Activities of Daily Living (IADL) such as shopping, laundry, housekeeping, and meal preparation.</p> <p>A participant may receive PCS services in the participant’s place of employment if the participant requires a need for assistance in the work environment. The participant’s need for assistance in a work environment must be noted in the ISP. PCS services provided in a work environment cannot be duplicative of other waiver services such as supported employment or day supports.</p> <p>Up to twelve (12) hours of PCS can be provided for every twenty-four (24) hour day and reimbursed based on the assessed needs of the participant. Agency-directed and self-directed PCS may be combined to meet the participant’s needs, but the total combination of PCS hours shall not exceed 12 hours per 24-hour period.</p> <p>PCS is not a default level of care for technology dependent and medically fragile children served on this program. This service should only be accessed when the participant is medically stable and the level of care needs can be fully met by the PCS.</p>

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
		<p>Training: There are no formal training requirements outlined by the state for agency-employed or participant-directed providers. At most, PCAs are required to have “general knowledge of the necessary tasks.” For participant-directed services, training is left to the discretion of the participant. [Source 1] [Source 2]</p>
<p>NJ</p>	<p>Scope of Service: Home-making activities, administer meds. Homemaker-home health aide services shall be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse.</p> <p>Helps registered nurse in any way they can, meaning they must:</p> <ul style="list-style-type: none"> • Keep patient’s room tidy • Prepare meals and feed patient if necessary • Wash and dress them • Aide them in washroom • Occasionally launder patient’s clothes • Exercise the patient, as required • Run errands [Source] <p>HHAs will not be required to regularly do laundry, cook or shop for their patients. Certified Housemaker-Home Health Aides may not work privately without an agency in New Jersey.</p> <p>Training: 76 minimum training hours and 16 minimum clinical hours. Must be renewed every two years, as federal regulated. Overseen by the registered professional nurse. [Source]</p> <p>Training topics include:</p> <ul style="list-style-type: none"> • The role of unlicensed assistive personnel in nursing care settings, • procedures relating to musco-skeletal system, • examples of conditions and symptoms to report to nurses, • procedures related to the integumentary system, • nutrition, procedures related to upper and lower gastrointestinal system, • procedures related to the urinary system, • procedures related to cardiovascular and respiratory systems, • procedures related to the neurological system, [Source] 	<p>New Jersey provides personal care attendant services through both their Medicaid State Plan and multiple waivers. States that provide personal care attendant services under their state plan must abide by additional federal requirements compared to states that only offer personal care attendant services through their waivers.</p> <p>Scope of Service: Personal care assistant services are described as follows:</p> <p>1. Activities of daily living shall be performed by a personal care assistant, and include, but not be limited to:</p> <ul style="list-style-type: none"> i. Care of the teeth and mouth; ii. Grooming such as, care of hair, including shampooing, shaving, and the ordinary care of nails; iii. Bathing in bed, in the tub or shower; iv. Using the toilet or bed pan; v. Changing bed linens with the beneficiary in bed; vi. Ambulation indoors and outdoors, when appropriate; vii. Helping the beneficiary in moving from bed to chair or wheelchair, in and out of tub or shower; viii. Eating and preparing meals, including special therapeutic diets for the beneficiary; ix. Dressing; x. Relearning household skills; and xi. Accompanying the beneficiary to clinics, physician office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment or to otherwise serve a therapeutic purpose. <p>2. Household duties that are essential to the beneficiary's health and comfort, performed by a personal care assistant shall include, but not be limited to:</p> <ul style="list-style-type: none"> i. Care of the beneficiary's room and areas used by the beneficiary, including sweeping, vacuuming, dusting; ii. Care of kitchen, including maintaining general cleanliness of refrigerator, stove, sink and floor, dishwashing; iii. Care of bathroom, including maintaining cleanliness of toilet, tub, shower and floor; iv. Care of beneficiary's personal laundry and bed linen, which may include necessary

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
		<p>ironing and mending;</p> <p>v. Necessary bed-making and changing of bed linen;</p> <p>vi. Re-arranging of furniture to enable the beneficiary to move about more easily in his or her room;</p> <p>vii. Listing food and household supplies needed for the health and maintenance of the beneficiary;</p> <p>viii. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands; and</p> <p>ix. Planning, preparing and serving meals.</p> <p>3. Health related activities, performed by a personal care assistant, shall be limited to:</p> <p>i. Helping and monitoring beneficiary with prescribed exercises which the beneficiary and the personal care assistant have been taught by appropriate personnel;</p> <p>ii. Rubbing the beneficiary's back if not contraindicated by physician;</p> <p>iii. Assisting with medications that can be self-administered;</p> <p>iv. Assisting the beneficiary with use of special equipment, such as walker, braces, crutches, wheelchair, after thorough demonstration by a registered professional nurse or physical therapist, with return demonstration until registered professional nurse or physical therapist is satisfied that beneficiary can use equipment safely;</p> <p>v. Assisting the beneficiary with simple procedures as an extension of physical or occupational therapy, or speech-language pathology services; and</p> <p>vi. Taking oral and rectal temperature, radial pulse and respiration. [Source]</p> <p>Training: PCAs are required to complete one of the following:</p> <ol style="list-style-type: none"> 1. Homemaker/home health aide training, 2. A certified personal care assistant training program in a hospital or long-term care facility, 3. A training course offered by the Department of Human Services, <i>or</i> 4. One year of experience working as a personal care aide. [Source]
ND	<p>Definition: Individual who renders personal related service under the supervision of a registered professional nurse.</p> <p>Scope of Service: Provide patient care and services that home health aides are permitted to provide by state statute and rules which are consistent with the physician's orders, assigned by the registered nurse for a specific patient, contained in the patient's plan of care and written instructions from the registered nurse or other appropriate professionals, and agency policies and procedures. [Source]</p>	<p>North Dakota provides personal care attendant services through both their Medicaid State Plan and multiple waivers. States that provide personal care attendant services under their state plan must abide by additional federal requirements compared to states that only offer personal care attendant services through their waivers.</p> <p>Scope of Service: Medicaid State Plan - Personal Care Services (MSP-PC) helps people with daily living activities such as bathing, dressing, transferring, toileting, cooking meals, housework and laundry so they can continue to live in their homes and communities. Three levels of care – 120</p>

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
	<p>Services must include the services of a currently licensed registered professional nurse and at least one other therapeutic service and may include additional support services. These services may only be provided with the approval of a licensed physician. [Source]</p> <p>Training: Any individual employed by an agency to provide home health aide services directly or by contract must complete a nurse aide training and competency evaluation program or a competency evaluation program that is 75 hours (including 16 clinical hours) in duration and that consists of successful completion of competency evaluation. "Supervised practical training" means training in a laboratory or other setting in which the home health aide trainee demonstrates tasks on an individual under the direct supervision of a registered or licensed practical nurse. [Source]</p> <p>Skills included in training program: Communication, Observation, reporting, and documentation of patient status and care or services furnished; Reading and recording of temperature, pulse, and respiration; Basic infection control procedures; Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor; Maintenance of a clean, safe, and healthy environment; Recognizing emergencies and knowledge of emergency procedures; the physical, emotional and developmental needs of and ways to work with patients served; Appropriate and safe techniques in personal hygiene and grooming which include: Safe transfer techniques and ambulation; Normal range of motion and positioning; Adequate nutrition and fluid intake; patient rights; and Any other tasks the agency may choose to have the home health aide perform. [Source]</p> <p>An individual may provide home health aide services on behalf of the agency only after that individual has successfully completed a competency evaluation that consists of the following:</p> <ol style="list-style-type: none"> a. The competency evaluation must be conducted by a registered nurse. b. The competency evaluation must address each of the items listed in subdivision b of subsection 1. <ol style="list-style-type: none"> (1) The items listed in paragraphs 3, 10, 11, and 12 of subdivision b of subsection 1 must be completed by observation of the aide's performance of the tasks with a patient or other live individual. (2) All other items listed in subdivision b of subsection 1 can be evaluated through written or oral examination or observation of the aide with a patient. c. A home health aide is not considered to have successfully passed a competency evaluation program if the aide has an unsatisfactory rating in more than one of the required areas. <ol style="list-style-type: none"> (1) A home health aide cannot perform any task for which the aide is evaluated to perform unsatisfactorily unless under the direct supervision of a licensed nurse. 	<p>hours, 240 hours, and 300 hours per month. [Source]</p> <p>Personal care services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), so that the individual is able to live at home. Personal care services are provided so as to assist the eligible individual with as many activities of daily living and instrumental activities of daily living as needed and as permitted in order to maintain independence and self-reliance to the greatest degree possible. Personal care services are appropriate when service activities are essential either on an intermittent or ongoing basis and the need for personal care services is expected to continue for an extended period of time in excess of 30 days.</p> <p>The following activities and tasks, as defined on SFN 663, may be authorized to be performed by a personal care service provider:</p> <ol style="list-style-type: none"> 1. Bathing 2. Dressing/Undressing 3. Feeding 4. Toileting 5. Continence/Incontinence Care 6. Transferring, Turning, Positioning 7. Mobility 8. Meal Preparation 9. Housework 10. Laundry 11. Shopping 12. Medication Assistance 13. Eye Care 14. Nail Care 15. Skin Care 16. Hair Care 17. Teeth, Mouth, Denture Care 18. Money Management 19. Communication 20. Exercises 21. Indwelling Bladder Catheter Care

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
	<p>(2) The home health aide must receive training in the areas determined unsatisfactory and pass a subsequent evaluation satisfactorily prior to performing the task without supervision.</p> <p>d. The agency must maintain documentation that the competency evaluation requirements of this section have been met by each home health aide. [Source]</p>	<p>22. Medical gases assistance</p> <p>23. Suppository assistance</p> <p>24. Temperature, Blood Pressure, Pulse, Respiration Rate</p> <p>25. Prosthesis/Orthotics assistance</p> <p>26. Hoyer Lift/Mechanized Bath Chairs assistance</p> <p>27. Ted Socks assistance</p> <p>28. Ostomy Care</p> <p>29. Postural/Bronchial Drainage</p> <p>30. Jobst Stockings assistance</p> <p>31. Ric Bed Care (Specialty Bed) [Source]</p> <p>Training: Individuals wishing to provide personal care services must be enrolled as a qualified service provider (QSP). QSP must be at least 18 years of age and must provide evidence that he or she meets the general QSP standards included at NDAC 75-03-23-07 (see below for competencies). [Source]</p> <p>Competencies include:</p> <ul style="list-style-type: none"> a. Infection control and proper handwashing methods; b. Handling and disposing of body fluids; c. Tub, shower, and bed bathing techniques; d. Hair care techniques, sink shampoo, and shaving; e. Oral hygiene techniques of brushing teeth and cleaning dentures; f. Caring for an incontinent client; g. Feeding or assisting a client with eating; h. Basic meal planning and preparation; i. Assisting a client with the self-administration of medications; j. Maintaining a kitchen, bathroom, and other rooms used by a client in a clean and safe condition, including dusting, vacuuming, floor care, garbage removal, changing linens, and other similar tasks; k. Laundry techniques, including mending, washing, drying, folding, putting away, ironing, and related work; l. Assisting a client with bill paying and balancing a check book; m. Dressing and undressing a client; n. Assisting with toileting; o. Routine eye care;

State	Scope of Service: Home Health Aides	Scope of Service: Personal Care Attendants
		<p>p. Proper care of fingernails; q. Caring for skin, including giving a back rub; r. Turning and positioning a client in bed; s. Transfer using a belt, standard sit, or bed to wheelchair; t. Assisting a client with ambulation; and u. Making wrinkle-free beds. [Source]</p>
SD	<p>Scope of Service: "Home health aide services," those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician and provided on an intermittent basis. [Source]</p> <p>The curriculum of the nurse aide training program shall address the medical, psychosocial, physical, and environmental needs of the patients or residents served by the nursing facility. Each unit of instruction shall include behaviorally stated objectives with measurable performance criteria. The nurse aide training program shall consist of at least 75 hours of classroom and clinical instruction, including the following:</p> <p>(1) Sixteen hours of training in the following areas before the nurse aide has any direct contact with a patient or resident:</p> <ul style="list-style-type: none"> (a) Communication and interpersonal skills; (b) Infection control; (c) Safety/emergency procedures, including the Heimlich maneuver; (d) Promoting patients' and residents' independence; (e) Respecting patients' and residents' rights; and (f) Abuse, neglect, and misappropriation of resident property; <p>(2) Sixteen hours of supervised practical training, with enough instructors to ensure that nursing care is provided with effective assistance and supervision. The ratio may not be less than one instructor for each eight students in the clinical setting; [Source]</p> <p>Training: 75 minimum training hours (16 must be clinical) for HHAs. Training most occur in an organization that is approved by the state and meets the nurse competency program standards.</p> <p>Four regulations to abide by:</p> <ol style="list-style-type: none"> 1. Completion of a training program and the competency evaluation program. 2. Current registry status or eligibility verification. 3. You must be able to work as a nurse aide as documented by a supervisor. 4. Every year, you must partake in 12 hours of in-service education corresponding to the results of a performance review or special residence needs. [Source] 	<p>South Dakota provides personal care attendant services through both their Medicaid State Plan and multiple waivers. States that provide personal care attendant services under their state plan must abide by additional federal requirements compared to states that only offer personal care attendant services through their waivers.</p> <p>Scope of Service: Basic personal care and grooming, including bathing, shaving, dressing, and assisting the recipient with hair and teeth care; Assistance with bladder or bowel requirements, which does not include administration of a bowel program; Assisting the patient with medications which are ordinarily self-administered; Assistance with food, nutrition, and diet activities if they are incidental to a medical need; Performing those household services, if related to a medical need, that are essential to the patient's health and comfort in the patient's residence; or Maintenance nursing. [Source]</p> <p>Training: A personal attendant must have completed a basic nurse aide or home health aide training course, as evidenced by a certificate of completion signed by the director of the training program, provided the trainee also received training in disability awareness and in the philosophy of consumer direction; a personal attendant training program supervised by a registered nurse at an approved agency, as evidenced by a certificate of completion signed by the director of the training program; or a personal attendant competency assessment as evidenced by a certificate of competency signed by a licensed nurse, a physician, or the consumer.</p> <p>PCAs employed by CHHAs are required to be competent in certain skill areas, but there is no formal requirement for competency evaluation. [Source]</p>

Prior Authorization

State	Summary
KS	<p>Almost entire Medicaid population is enrolled in comprehensive managed care program called KanCare (provides all acute, primary, specialty, and LTSS). Individual MCOs responsible for home health prior authorization.</p> <p>Fee-for-service requirements:</p> <ul style="list-style-type: none"> • Prior authorization is required for all home health services. • Home health services are prior authorized depending upon the skill level of care, frequency, and duration of visits and chronicity of the beneficiary’s condition. • Providers use the Acute Care Home Health Service Plan to render services for time-limited conditions and the Long-Term Care Service Plan for beneficiaries who require assistance to manage chronic conditions. Providers use the Diabetes Management Home Health Service Plan to care for beneficiaries with diabetes. <p><u>Service Limits:</u></p> <p>Home Health Aide Service Beneficiaries not on a waiver can receive reasonable and medically necessary home health aide visits with PA. Home health aide visits are included in the combined total of 120 acute home health visits per year. Long-term care and diabetic management service plans are limited to up to one-hour visits no more than twice per week. Providers must submit documentation supporting medical necessity to exceed two home health visits per week to ensure effective and efficient use and accurate reimbursement. This will be considered on a case-by-case basis. Providers cannot bill more than one home health aide visit per date of service.</p> <p>Skilled Therapy Services Speech, occupational, and physical therapy are limited to one unit per day. Services should not exceed six months duration and require PA. Respiratory therapy is limited to KBH-eligible beneficiaries and is limited to one unit per day.</p> <p>[Source 1] [Source 2] [Source 3]</p>
PA	<p>Nearly all Medicaid enrollees enrolled in MCOs (90%). Individual MCOs responsible for home health prior authorization.</p> <p>Prior authorization policies from MCO agreement:</p> <ul style="list-style-type: none"> • MCO may establish individual policies and procedures for prior authorization of any services • MCOs required to process each request within 2 business days and must notify member at least orally. Written approval/denial must be mailed within 2 business days after decision is made. • If additional information is needed, MCOs must make the request within 48 hours of receiving request <ul style="list-style-type: none"> ○ If providers fail to respond with additional info within 14 days, the request will be approved or denied based on available information • MCOs must provide written communication of the approval or denial of the request no later than 21 days following the request <ul style="list-style-type: none"> ○ If MCO fails to respond within this time frame, request will be deemed approved and the MCO will be responsible for the payment <p>Prior authorization process for Medicaid Fee-for-Service delivery system (less than 10% of Medicaid beneficiaries): Prior authorization requests for home health services may not exceed any existing limits established by the MA Program as defined in 55 Pa. Code, Chapter 1249 (relating to Home Health Agency Services), §1249.59 (relating to Limitations on payment).</p>

State	Summary
	<p>When requesting prior authorization, the home health agency must indicate all disciplines prescribed by the practitioner (Nurse (RN or LPN), Home Health Aide, Occupational Therapist, Speech Therapist, Physical Therapist, Audiologist) The home health agency must specify the number of visits for each discipline.</p> <p>DHS will approve or deny any request on the telephone, followed by a Prior Authorization Notice that identifies the procedure code(s) for the services approved, the number of visits approved, and any modifiers that are applicable. The Prior Authorization Notice will also identify those services DHS denied, including the reason for the denial, and the services approved other than requested. DHS's prior authorization system has the capability to approve multiple lines of medically necessary services per authorization number. Each line item approved is for a procedure code and includes the number of visits approved for that code, plus the approved modifiers.</p> <p>[Source 1] [Source 2] [Source 3]</p>
KY	<p>Most individuals will be enrolled in an Medicaid MCO but some Medicaid members cannot be in managed care. This includes people who have Medicaid Savings Plans, who are in nursing facilities and other long term care, who get time-limited Medicaid, or who are in a waiver program. For individuals in managed care, MCOs responsible for home health prior authorization.</p> <p>From Kentucky Medicaid:</p> <ul style="list-style-type: none"> • Home health must be prior authorized by the department to ensure that the service or modification of the service is <u>medically necessary</u> and adequate for the needs of the recipient; • If home health is provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department; <p>Source : http://www.lrc.state.ky.us/kar/907/001/030.htm</p> <p>Definition for medical necessity and clinically appropriate in State code (907 KAR 3:130):</p> <p>(1) The determination of whether a covered benefit or service is medically necessary shall:</p> <ol style="list-style-type: none"> (a) Be based on an individualized assessment of the recipient's medical needs; and (b) Comply with the requirements established in this paragraph. To be medically necessary or a medical necessity, a covered benefit shall be: <ol style="list-style-type: none"> 1. Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; 2. Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; 3. Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; 4. Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; 5. Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard; 6. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 C.F.R. Part 441 Subpart B for individuals under twenty-one (21) years of age; and 7. Provided in accordance with 42 C.F.R. 440.230. <p>(2) The department shall have the final authority to determine the medical necessity and clinical appropriateness of a covered benefit or service and shall ensure the right of a recipient to appeal a negative action in accordance with 907 KAR 1:563.</p> <p>[Source]</p> <p>Other sources: Managed Care Benefits Chart [Source]</p>

State	Summary
	Home Health Services Manual [Source]
NJ	<p>MCOs responsible for home health prior authorization.</p> <p>Prior authorization policies must comply with Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352 [Source]</p> <ul style="list-style-type: none"> • MCOs must develop specific prior authorization process and the criteria/guidelines used for the prior authorization of individual services • Denials and limitations must be provided to the provider in writing, including requests for additional information required to approve or deny the request for authorization. <ul style="list-style-type: none"> ○ If providers fail to respond with additional info within 72 hours, the request will be withdrawn • MCOs communicate the approval or denial of the request or limitation imposed on services based on the medical need of each case but no later than the 15 days following the request <ul style="list-style-type: none"> ○ If MCO fails to respond within this time frame, request will be deemed approved and the MCO will be responsible for the payment of covered services outlined in provider contract <p>Home Health Services</p> <p>To qualify for payment of home health services by the New Jersey Medicaid and NJ FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency by the attending physician. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.</p> <p>Personal Care Assistant Services</p> <p>To qualify for payment of personal care assistant services by the New Jersey Medicaid and NJ FamilyCare fee-for-service program, the beneficiary's need for services shall be certified in writing to the home health agency or homemaker agency by the attending physician. The nurse shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.</p> <p>§ 10:60-3.9 Prior authorization for personal care assistant (PCA) services</p> <p>(a) All personal care assistant (PCA) services shall be prior authorized, regardless of the number of hours requested per week.</p> <p>(b) Prior approval for PCA services shall be obtained in accordance with the following procedures:</p> <ol style="list-style-type: none"> 1. A registered nurse employed by the PCA provider agency shall complete a face-to-face evaluation of the beneficiary and shall complete the PCA Assessment form (FD-410), including information regarding the beneficiary's; <ol style="list-style-type: none"> i. Supportive service/living environment needs; ii. Cognitive/mental status; iii. Ambulation/mobility; iv. Ability to transfer (for example, from wheelchair to bed); v. Ability to feed himself or herself; vi. Ability to bathe himself or herself; vii. Ability to toilet himself or herself; viii. Ability to perform grooming and dressing tasks; ix. Ability to perform shopping tasks; and x. Ability to perform laundry tasks.

State	Summary
	<p>2. The provider agency shall total the numerical elements related to the need areas in (b)1 above;</p> <p>3. The provider agency shall submit the PCA Assessment form (FD-410), in electronic or paper format, and the prior authorization request form (FD-365) to the Division of Disability Services; and</p> <p>4. Upon completion of the review of a prior authorization request, Division of Disability Services staff shall make a determination regarding the hours of PCA services to be authorized.</p> <p>(c) Failure to comply with the prior authorization requirements shall result in denial of Medicaid reimbursement and recoupment of funds for any services provided without documented prior authorization. [Source]</p>
SD	<p>No prior authorization needed unless extended home health services/private duty nursing for individuals under 21 years of age Private Duty Nursing & Extended Home Health Services Prior Authorization Request Form completed along with plan of care for prior authorization. (Plan of care = physician's orders prescribing the needed services.)</p> <p>SKILLED HOME CARE SERVICES / PRIVATE DUTY NURSING</p> <p>South Dakota Medicaid covers medically necessary Skilled Home Care and extended home health aide services for children under 21 years old when a prior authorization has been obtained. These services may be performed by an enrolled private duty nursing agency pursuant to the plan of care developed in collaboration with the primary care provider. The intent is to allow/maintain the care of individuals in their place of residence, as long as it is safe to do so. To be medically necessary, the covered service must meet the following conditions (ARSD 67:16:01:06.02):</p> <ul style="list-style-type: none"> • It is consistent with the recipient's symptoms, diagnosis, condition, or injury; • It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group; • It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; r to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; • It is not furnished primarily for the convenience of the recipient or the provider; and • There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly. <p>[Source 1] [Source 2]</p>
ND	<p>Home Health Agency visits are limited to an initial 50 visits per member, per calendar year, for all covered home health services. These visits are <u>not</u> subject to prior approval. These visits do not apply to extended hour visits as these requests must be prior authorized by ND Medicaid.</p> <p>Prior authorization for services required when member must exceed the Home Health 50 visit limitation.</p> <ul style="list-style-type: none"> • ND Medicaid uses utilization review parameters for evaluating and determining medical necessity for the type of service(s) requested and the number of visits required to appropriately treat the member's condition. • Each Service Authorization is valid for 60 days. • Requests for additional visits beyond the initial 50 visits must be submitted prior to the last visit of the 50-day limitation. • Home Health providers are required to track and request additional home health visits prior to the utilization of the 50-visit limit. • If the same level of care or a more intense level of care (i.e. more skilled nurse visits, addition of another service) is necessary beyond the initial 50 visits, the agency must submit a service authorization. • Subsequent requests after the first 60-day period must also have prior authorization. <ul style="list-style-type: none"> ○ Requests for additional visits must be submitted by the Home Health Agency. ○ The additional visits must substantiate medical necessity and be received by the Department prior to the service being provided, or before the next 60 day period request. ○ If the service authorization is not received by ND Medicaid prior to the 60 day time period the visits will be denied.

State	Summary
	<ul style="list-style-type: none"> ○ All requests for authorization of additional visits must be submitted with the service authorization, copy of the current home health plan of treatment/original physician's order, any pertinent documentation to substantiate the need for additional visits <p>[Source]</p>

Nurse Delegation

State	Summary
KS	<p>According to the LTSS scorecard, Kansas allows nurses to delegate 6 health maintenance tasks (administer glucometer test, insert suppository, administer eye/ ear drops, administer enema, perform intermittent catheterization, administer oxygen therapy) [Source]</p> <p>All nursing procedures, including but not limited to administration of medication, delegated by a licensed nurse to a designated unlicensed person shall be supervised. The degree of supervision required shall be determined by the licensed nurse after an assessment of appropriate factors which may include:</p> <ol style="list-style-type: none"> (1) The health status and mental and physical stability of the individual receiving the nursing care; (2) the complexity of the procedure to be delegated; (3) the training and competency of the unlicensed person to whom the procedure is to be delegated; and (4) the proximity and availability of the licensed nurse to the designated unlicensed person when the selected nursing procedure will be performed. [Source #2] <p>a. Nursing assistance can be provided without delegation or supervision if provided for free by friends or members of the participant's family (informal supports), as incidental care of the ill participant by a domestic servant, or in the case of an emergency.</p> <p>b. Nursing assistance can be provided as part of PCS directed by a participant, or on behalf of a participant in need of in home care, when the nursing procedure has been delegated via a written physician/RN statement to a participant who the physician or nurse knows or has reason to know is competent to perform those activities.</p> <p>c. If authorized on the participant's ISP, a licensed physician or nurse shall provide a written delegation for the following health maintenance activities:</p> <ol style="list-style-type: none"> (1) Monitoring vital signs (2) Supervision and/or training of nursing procedures (3) Ostomy care (4) Catheter care (5) Enteral nutrition (6) Wound care (7) Range of motion (8) Reporting changes in functions or condition (9) Medication administration and assistance <p>For agency-directed PCS workers:</p> <ol style="list-style-type: none"> a. An attendant who is a certified home health aide or a certified nurse aide shall not perform any health maintenance activities without delegation and supervision by a licensed nurse or physician pursuant to K.S.A. 65-1165. b. A certified home health aide or certified nurse aide shall not perform acts beyond the scope of their curriculum without delegation by a licensed nurse.

State	Summary
	<p>c. An agency shall maintain documentation of delegation by a licensed physician or nurse not employed by the agency. Agencies are responsible for ensuring appropriate supervision of delegated health maintenance activities.</p> <p>d. Failing to properly supervise, direct or delegate acts that constitute the healing arts to persons who perform professional services pursuant to such licensee’s direction, supervision, order, referral, delegation or practice protocols could result in discipline by the Board of Healing Arts.</p> <p>For self-directing participants:</p> <p>a. A participant who chooses to self-direct care is not required to have the PCS supervised by a nurse or physician to perform health maintenance activities if:</p> <p>(1) Health maintenance activities can be provided without direct supervision “. . . if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.” K.S.A. 65-6201(d); and</p> <p>(2) Health maintenance activities and medication administration and assistance are authorized, in writing, by a physician or licensed professional nurse.</p> <p>b. The participant’s failure to properly supervise or direct health maintenance activities delegated to the participant by a physician or licensed professional nurse could result in the termination of self-direction for those activities.</p>
<p>KY</p>	<p>According to the LTSS scorecard, Kentucky allows nurses to delegate health maintenance tasks (administer glucometer test, gastrostomy tube feeding, administer enema, perform ostomy care including skin care and changing appliance). Kentucky defines nurse delegation under 312.011 as a nurse directing a competent person to perform a selected nursing activity or task in a selected situation under the nurse’s supervision and pursuant to administrative regulations promulgated by the board in accordance with the provisions of KRS chapter 13A. A registered nurse can delegate a task to a paramedic employed in a hospital emergency department; prior to delegation to an unlicensed person, the nurse shall determine the nursing care needs of the client and retain responsibility and accountability for the nursing care. The nursing task cannot require the delegate to exercise independent nursing judgement or intervention. Kentucky provides a decision tree for delegation to unlicensed assistive personnel to assist nurses in determining if a task can be appropriately delegated. [Source 1] [Source 2] [Source 3] [Source 4]</p> <p>Tasks that can be delegated include:</p> <ul style="list-style-type: none"> • Collection, documentation, and reporting of data (e.g. vital signs, oxygen saturation, height, weight, intake and output) • Assisting patients to perform self-care tasks, including assistance with a patient’s self-administered medication. • Performing tasks of a routine nature that do not require ongoing nursing assessment and nursing judgement such as non-sterile dressing changes, external care to urinary catheters enema administration, and colostomy appliance changes on mature stoma sites with sustained skin integrity. • Selected ambulation, positioning, turning, activities of daily living, or exercise programs • Providing and maintaining a safe, comfortable environment • Selected nutritional activities, such as feeding and meal preparation. • Socialization activities • Transportation of client [Source] <p>The statute was difficult to locate, however, it appears the board of nursing says that registered nurses can delegate activities relating to nursing care. [Source]</p>

State	Summary
PA	<p>No data on nurse delegation was available in the LTSS scorecard. [Source]</p> <p>A licensed registered nurse, responsible for administering a drug, may supervise a graduate nurse or a nursing student in an approved nursing education program in the administration of the drug. In this section, “supervise” means the licensed registered nurse is physically present in the area or unit where the student or unlicensed graduate is practicing. [Source]</p>
SD	<p>In South Dakota a registered nurse or a licensed practical nurse may delegate selected nursing tasks to unlicensed assistive personnel. Unlicensed assistive personnel may complement the licensed nurse in the performance of nursing functions but may not substitute for the licensed nurse. The registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction. The delegating nurse is accountable for assessing a situation and making the final decision to delegate. The task delegated must be a task that can be safely performed by unlicensed assistive personnel and the nurse must verify that the unlicensed person is competent to perform the task. [Source]</p> <p>A licensed nurse can delegate administration of medication to unlicensed personnel, but there are prescribed limitations. For example, unlicensed assistive personnel cannot administer medication by way of tube inserted in a body cavity or calculate any medication dose. A licensed nurse may also only delegate the administration of medications authorized to unlicensed assistive personnel who have a minimum of a high school education or the equivalent and who are registered with the Board. Unlicensed assistive personnel have to complete a prescribed curriculum to administer medication. This includes at least 16 hours of classroom instruction and 4 hours of laboratory instruction. The unlicensed assistive personnel must also complete a skills evaluation and pass Nursing Board approved examination. South Dakota also sets out additional rules for medications that can be delegated. [Source]</p> <p>In total, according to the AARP LTSS scorecard, South Dakota allows nurse to delegate 11 tasks (including administration of oral meds, administration of meds per diem, administration of glucometer test, and insertion of suppository). [Source]</p> <p>The South Dakota Board of Nursing has made available a decision making tool for nurses to use for delegating tasks. This tool is provided here.</p>
NJ	<p>A registered nurse can delegate selected nursing tasks to licensed practical nurses and ancillary nursing personnel. Ancillary nursing personnel includes but is not be limited to aides, assistants, attendants and technicians. A registered professional nurse should not delegate if the nurse, in his or her professional judgment, determines that such delegation is not consistent with standards of practice. The degree of supervision the registered nurse provides should be based on the condition of the patient, the education and skill of the person to whom the delegation is being made, and the nature of the tasks. [Source]</p> <p>A certified homemaker-home health aide (CHHA) may perform home-making activities, as requested or assigned by the patient, the patient’s family or a registered professional nurse responsible for the patient’s care. A CHHA shall review the plan of care with a delegating registered professional nurse after the assessment has been conducted and a plan of care developed and whenever changes have been made to the plan of care by the registered professional nurse. The registered professional nurse and CHHA shall meet face-to-face if the registered professional nurse determines that the CHHA is not yet adequately prepared to perform the tasks that he or she would perform for the patient pursuant to a delegation from the registered professional nurse, so that the registered professional nurse may provide instruction to the CHHA as to the manner in which the tasks shall be performed. [Source]</p> <p>A registered nurse can delegate administration of medication to a CHHA. To delegation medication administration, however, the registered nurse must document the specific medication whose administration has been delegated, the duration of delegation, a timeframe for the registered nurse to reevaluate the patient, among other detailed information. The CHHA has to document every time he or she administers the medication and report and errors in administering the medication immediately. [Source]</p> <p>According to the AARP LTSS scorecard, New Jersey allows 7 tasks to be delegated. They include gastrostomy tube feeding, administering an enema, performing intermittent catheterization,</p>

State	Summary
	among others. [Source]
ND	<p>Licensed Nurses in South Dakota can delegate tasks that the person whom the task is delegated has the necessary skills and competence to accomplish safely. This includes unlicensed personnel, but they must be on a statewide registry and have the education and demonstrated competency to complete the task. Unlicensed assistive persons complement the licensed nurse in the performance of nursing interventions but may not substitute for the licensed nurse. Interventions that require any assessment, interpretation, or independent decision making during its performance or at completion cannot be delegated. [Source]</p> <p>To be listed on the unlicensed personnel registry, an individual must complete a recognized formal training program or hold a current registration or certification by a recognized national body. [Source]</p> <p>According to the AARP LTSS scorecard, North Dakota allows 13 tasks allowed to be delegated (including administration or oral meds, administration of meds per diem, administration of insulin, draw up insulin for dosage measurement, administration of intramuscular injections, administration of glucometer test, administration of meds through tubes, and insertion of suppository.</p>

Housing with Services

Room and Board Definition – Federal Guidance

Source	Guidance
National Center for Assisted Living	<p>From 42 U.S. Code § 1396n</p> <p>(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term “room and board” shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.</p> <p>For Medicaid purposes, room and board means real estate costs (debt service, maintenance, utilities, and taxes) and food. Board means three meals a day or any other full nutritional regimen. Room means hotel or shelter-type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. However, states can limit the amount charged for room and board.</p> <p>The majority of assisted living residents pay privately for room, board and services. While Medicaid does not cover room and board, it may cover certain services for residents and is important for ensuring that seniors can receive care in their preferred setting. An estimated 47 percent of communities are Medicaid home and community-based service (HCBS) providers and 15 percent of residents rely on Medicaid to cover services in assisted living. [Source]</p>
Office of The Assistant Secretary for Planning and Evaluation	<p>States can limit the amount that can be charged for room and board by setting a combined rate for Medicaid beneficiaries that includes service costs and room and board costs, essentially capping the room and board rate that Medicaid beneficiaries pay. 26 states do so. Medicaid programs that specify how much facilities may charge Medicaid beneficiaries for room and board usually limit the charges to the state's SSI payment for a single elderly beneficiary living in the community, plus a state supplement, if any. This approach guarantees that Medicaid beneficiaries can afford room and board costs.</p> <p>HUD's housing subsidy rules do not allow residential care settings to impose an additional charge for rent and utilities, but they can charge the resident for board (i.e., meal costs) or for services that are not covered by the Medicaid state plan in a residential care setting. The amount of the permitted meal charge depends on the scope of the Medicaid service payment (i.e., whether it includes the cost of meal preparation). In all cases, Medicaid may not pay for raw food.</p> <p>Under HCBS waivers, the cost of preparing and serving food may be covered under the service payment. If preparing and serving meals is covered, the meal cost charged to tenants would be lower. If not, charges for a meal program would include raw food, preparation, and serving. States covering personal care in residential care settings under the state plan may also allow payment for the preparation and serving of meals but may not include the cost of food.</p> <p>Medicaid beneficiaries with incomes over the SSI level must contribute income above the amount of room and board (minus a small personal needs allowance) to pay for services. Medicaid then pays the difference between the resident's payment and the maximum service rate. Because beneficiaries in this category have more income than SSI beneficiaries, when they live in subsidized units, they will pay a higher rent, because the rent is calculated as a percentage of income. They also may have more income available after the rental payment is made. [Source]</p>
1915(c) Waiver	<p>FFP may not be claimed for the cost of room and board except in certain circumstances. The term “room” means shelter type expenses, including all property-related costs such as</p>

Source	Guidance
Technical Guidance	rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen. [Source]

Coverage of Meals within Assisted Living Service Definition – State Examples

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
AR	<p>Basic Living Choices Assisted Living direct care services are:</p> <ol style="list-style-type: none"> 1. Attendant care services (including housekeeping, laundry, preparation and serving of meals) 2. Therapeutic social and recreational activities 3. Periodic nursing evaluations 4. Limited nursing services 5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing 6. Medication oversight to the extent permitted under Arkansas law 7. Assistance obtaining non-medical transportation specified in the plan of care <p>The daily rate pays for all direct care services in the participant’s plan of care. There are four tiers of need in the Living Choices Program, each tier progressively requiring more bundled services. The rate increases with the need for each higher tier and more services. These rates are exclusive of room and board.</p> <p>Potential overlap of the scope of services is managed and monitored through MMIS.</p> <p>Care must be furnished in a way that fosters the independence of each client to facilitate aging in place. Routines of care provision and service delivery must be consumer driven to the maximum extent possible and treat each person with dignity and respect.</p> <p>Food Service and Dietary Provisions:</p> <p>Assisted Living facilities must provide three meals a day. [Source]</p>	<p>Paying for Room and Board:</p> <p>State does not provide supplement to SSI payment, but limits the room and board payment to the SSI payment less a personal needs allowance (PNA). Family supplementation is not allowed. [Source]</p>
CA	<p>Assisted living services include:</p> <ul style="list-style-type: none"> • Safe and healthful living accommodations and services • 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs (Provision of awake staff at night is waived in 6-bed RCFs as per CCL); • Regular observation of the resident's physical and mental condition • Provision and oversight of personal and supportive services including assistance with ADLs and IADLs; • Assistance with self-administration of medications and/or administration by licensed 	<p>If the resident is on Supplemental Security Income (SSI), the SSI rate covers the full charges for all basic services. Extra charges for a resident on SSI can only be made for special food services or a private room. This shall not preclude the acceptance by the facility of voluntary contributions from relatives or others on behalf of an SSI/SSP recipient. California does not provide optional state supplemental funds.</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
	<p>nursing staff as needed;</p> <ul style="list-style-type: none"> • Recreational activities (Referral to recreational activities in a PSH setting); • Provision of three nutritionally balanced meals per day plus snacks in the RCF setting; or, • Coordination of three meals and snacks in a PSH setting; • Housekeeping and laundry (Participant provides cleaning products and coins for laundry equipment); • Licensed nursing staff, as necessary, to meet the skilled nursing needs of the participants. This does not include 24-hour skilled nursing care or continuous skilled nursing supervision. • Arrangement to meet health needs including transportation, or arrangement of transportation, to medically necessary appointments and to other needed services as identified on the ISP. The use of public transportation, when safe and appropriate, is an option • A planned activities program which includes social and recreational activities appropriate to • the interests and capabilities of the resident <p>Food Service and Dietary Provisions: Facilities that have responsibility for all food arrangements must provide at least three meals per day and snacks. If the meal service within a facility is elective, the facility must ensure the availability of an adequate daily food intake for all residents who purchase the meal service. [Source]</p>	
IA	<p>“Assisted living” or “program” means provision of housing with services, which may include but are not limited to:</p> <ul style="list-style-type: none"> • Health-related care, personal care, and assistance with instrumental activities of daily living, to three or more tenants in a physical structure which provides a homelike environment. <p>“Assisted living” also Includes:</p> <ul style="list-style-type: none"> • Encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence • The provision of housing and assistance with instrumental activities of daily living only if personal care or health-related care is also included • Includes 24 hours per day response staff to meet scheduled and unscheduled or 	<p>Because the Medicaid waiver program pays only for the costs of personal and medical services, the cost of rent and board are paid by the tenant. Innovative funding sources that can be used to cover the “board” portion of assisted living can include OAA funds, food stamps, or direct payment from the tenant.[Source]</p> <p>Paying for Room and Board: Iowa provides an optional state supplement based on allowable costs of residential care, plus PNA that is retained by the resident, minus the federal SSI payment. Family supplementation is permitted.</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
	<p>unpredictable needs in a manner that promotes maximum dignity and independence and provides supervision, safety, and security. [Source]</p> <ul style="list-style-type: none"> • Unanticipated and unscheduled personal care and supportive services that are provided to waiver participants who reside in a homelike, non-institutional setting. <p>Restrictions on Service:</p> <ul style="list-style-type: none"> • AL service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendance care (CDAC) agreement • A unit of service is one day • A day of service is billable only if the follow requirements are met <ul style="list-style-type: none"> ○ The member was present in the facility during that day’s bed census [Source] <p>Food Service Provisions: Facilities must provide hot meals at least once a day or coordinate with other community providers to make arrangements for the availability of meals.</p> <p>Home Delivered Meals Guidance: Individuals can receive home delivered meals while in Assisted Living facilities. Services, however, are monitored by the case manager to prevent any duplication.</p>	
MA	<p>Assisted Living Services Includes:</p> <ul style="list-style-type: none"> • Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to participants who reside in an MFP qualified assisted living residence (ALR) that includes: 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. • Services may also include: <ul style="list-style-type: none"> ○ Social and recreational programs ○ Medication assistance (consistent with ALR certification and to the extent permitted under State law). <p>Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living Services. Intermittent skilled nursing services and therapy services may be provided to the extent allowed by applicable regulations. [Source]</p> <p>Food Service Provisions: The assisted living facility has to provide or arrange up to three regularly scheduled meals daily and a minimum of one meal per day. All Assisted Living Residences shall use daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research</p>	<p>The state divides their residency agreement charges with lodging, meals, and services. [Source]</p> <p>Paying for Room and Board: The state provides optional state supplements to SSI payment. The state does not have a policy on family supplementation.</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
	<p>Council of the National Academy of Sciences set forth in the Title III of the Older Americans Act as amended (42 USC 3030g) as a minimum dietary standard. In addition to the foregoing, at a minimum an Assisted Living Residence shall provide or arrange for the availability of food selections that would permit a Resident to adhere to a diet consistent with the most recent edition of Dietary Guidelines for Americans and dietary plans that do not require complex calculations of nutrients or preparation of special food items [Source].</p> <p>Home Delivered Meals Guidance: Home delivered meals are not offered under the MFP-Residential Supports waiver which offers assisted living services.</p>	
MN	<p>Minnesota’s assisted living service is called customized living, provided in housing with services establishments. All housing with services establishments in Minnesota must register with the state (similar to Indiana) and they are only required to provide two meals a day. [Source]</p> <p>Customized living services include individualized supports that the person and his/her team choose and design specifically to meet his/her needs. The services include:</p> <ul style="list-style-type: none"> • Arranging for or providing transportation • Assisting the person with personal funds • Assisting the person with setting up meetings or appointments • Home care aide tasks • Home management tasks including laundry and meal prep • Socialization • Up to 24-hour supervision and oversight • Help with personal care or mobility • Help with medication • Delegated nursing tasks as ordered by a physician and described in the plan • Active behavioral, mental health or cognitive support which requires: <ul style="list-style-type: none"> ○ Support needs that an appropriate professional has assessed ○ A plan to implement and monitor the support ○ Feedback on the efficacy of the support ○ Training for staff that is specific to the person’s needs. <p>[Source]</p> <p>Food Service Provisions: Includes all food preparation and service of a meal for the participant done simultaneously with</p>	<p>Room and Board: Room and board, or raw food (groceries), and rent, while a recipient receives customized living services, are paid by the recipient’s income, which may include Supplemental Security Income. If the recipient has inadequate income for room and board or rent charges, he or she may be eligible for a Group Residential Housing (GRH) payment to the provider. [Source]</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
	<p>food preparation for other participants. This includes but is not limited, preparing specialized diets, cutting up food and buttering bread. Tray delivery is also covered when required by the participant. Raw food costs are not covered under congregate meal prep within customized living. [Source]</p> <p>Home Delivered Meals Guidance: Home delivered meals are not covered for enrollees who live in settings licensed for foster care or board and lodge (but does not prohibit home delivered meals in housing with services establishments). No more than one meal per day will be paid for under HDM by the waiver. [Source]</p>	
ND	<p>Assisted Living Facilities and Basic Care Facilities: The Department of Health establishes rules for basic care facilities and the Department of Human Services oversees licensing and rules for assisted living facilities (ALFs), which must also meet some Department of Health rules. The primary differences between these licensure categories are: (1) the extent to which they are regulated--the ALF regulations are very brief; and (2) only basic care facilities are required to provide meals.</p> <p>Assisted living facility: Means a building comprising at least five living units in which individualized support services are provided to five or more adults. An ALF is not a congregate housing facility or a basic care facility.</p> <p>Assisted living facilities must provide or coordinate individualized support services, including assistance with ADLs. Facilities may provide health services, described as services provided to an individual for the purpose of preventing disease and promoting, maintaining, or restoring health or minimizing the effects of illness or disability. Residents pay for individual services, not a service package.</p> <p>Basic care facility: Means a facility that provides room and board, and health, social, and personal care to assist five or more residents to attain or maintain their highest level of functioning.</p> <p>Basic care facilities provide personal care (assistance with ADLs and instrumental activities of daily living); observation and documentation of changes in physical, mental, and emotional functioning; arrangements for health care when needed; arrangements for transfer and transportation; assistance with functional aids; housekeeping and laundry; medication services; and social and recreational activities. Nursing services must be available if needed. Residents</p>	<p>Payment for residential services are not made for room and board, items of comfort or convenience, or the costs of building maintenance, upkeep and improvement.</p> <p>Paying for Room and Board: Limits room and board rate to SSI minus PNA. Allows for family supplementation.</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
	<p>purchase a package of services.</p> <p>Adult residential care (or assisted living) under the 1915(c) HCBS waiver must be provided in basic care facilities. [Source]</p> <p>Food Service Provisions: Basic care facilities must serve a minimum of three meals and snack per day that meet the recommended dietary allowances of the National Academy of Science’s Food and Nutrition Board. Assisted living facilities are not required to provide meal [Source]</p>	
OH	<p>Assisted living services include:</p> <ul style="list-style-type: none"> • Personal care • Supportive services (homemaker and chore) • 24 hour on site response capability • Social and recreational programming • Nonmedical transportation • Coordination of the provision of three meals a day and snacks. <p>Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701:17-59 and 3701-17-59.1., when not available through a third party. The scope of the service does not include 24 hour skilled care, one on one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications.</p> <p>Food Service Provisions: Residential care facilities may choose not to provide meals; or to provide 1-3 meals. Facilities that do not provide meals must ensure that each resident unit is appropriately and safely equipped with facility-maintained food storage and preparation appliances. Facility prepared meals must provide the recommended daily allowances. [Source]</p> <p>Ohio’s Assisted Living waiver specifies that the assisted living service includes the coordination of the provision of three meals a day and snacks. [Source]</p>	<p>Paying for Room and Board: Room and board capped at SSI minus a PNA. The state does not address family supplementation [Source].</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
TN	<p>Assisted Facilities Have to Provide:</p> <ul style="list-style-type: none"> • Food preparation, serving, and cleaning up after meals (“raw” food costs are excluded); • Laundry Services • Protective care • Safety when in the facility • The ability and readiness to intervene if crises arise • Room and board • Non-medical living assistance with activities of daily living <p>Food Service Provisions: Assisted living facilities must provide at least three meals constituting an acceptable and/or prescribed diet per day. There shall be no more than fourteen (14) hours between the evening and morning meals. [Source]</p>	<p>Examples of costs that are considered to be room and board which are not covered under the CHOICES program (1115 waiver) include:</p> <ul style="list-style-type: none"> • Rent, mortgage payments, title insurance, mortgage insurance; • Property and casualty insurance; • Property taxes; • Utilities, resident phone, cable TV, etc.; • Building and/or grounds maintenance; • Residents’ “raw” food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals may be covered under the SWW); • Household supplies and equipment necessary for the room and board of the individual; and • Furnishings used by the individual (does not include office furnishings). <p>[Source]</p> <p>Paying for Room and Board</p> <p>Medicaid policy limits the amount that assisted care living facilities can charge for room and board to 80 percent of the maximum personal needs allowance (PNA). The CHOICES program sets the PNA at 300 percent of the federal Supplemental Security Income (SSI) rate. Family supplementation is permitted up to the maximum allowable charges for room and board.</p>
VA	<p>Assisted Living Facilities Services:</p> <p>The facility shall ensure that personal assistance and care are provided to each resident as necessary so that the needs of the resident are met, including but not limited to assistance or care with:</p> <ul style="list-style-type: none"> • The activities of daily living: <ul style="list-style-type: none"> ○ Bathing (at least twice a week, but more often if needed or desired); ○ Dressing ○ Toileting ○ Transferring; ○ Bowel control ○ Bladder control ○ Eating/feeding; 	<p>Paying for Room and Board:</p> <p>The state provides an optional state supplement (OSS) through its Auxiliary Grant Program to needy aged, blind, and disabled persons who live in an ALF or in an approved AFC home and who are eligible for federal SSI benefits or would be eligible except for excess income. The grant program is administered by the Department for Aging and Rehabilitative Services.</p> <p>The state establishes an SSI standard from which the federal SSI payment minus a personal needs allowance (and any countable income are deducted; the remainder is the amount of the auxiliary grant (the OSS). Providers serving residents who receive auxiliary grants may not charge more than the total SSI</p> <p>Family supplementation is not allowed to pay for the cost of a private room but is allowed to pay for goods and services beyond those covered by the total SSI payment. [Source]</p>

State	Assisted Living Service Definition and Home Delivered Meals Guidance	Room and Board Definition
	<ul style="list-style-type: none"> • The instrumental activities of daily living: <ul style="list-style-type: none"> ○ Meal preparation ○ Housekeeping ○ Laundry ○ Managing money • Ambulation • Hygiene and grooming • Functions and tasks: <ul style="list-style-type: none"> ○ Arrangements for transportation ○ Arrangements for shopping ○ Use of the telephone ○ Correspondence <p>Food Service and Dietary Provisions:</p> <p>At least three well-balanced meals, served at regular intervals, shall be provided daily to each resident, unless contraindicated as documented by the attending physician in the resident's record or as provided for in 22 VAC 40-72-580 C.</p> <p>[Source]</p>	

Dementia Facility Requirements

State	Details and Source
IA	<p><i>Iowa instituted many changes, such as: (1) requiring a policy addressing sexual relationships between tenants with a Global Deterioration Scale greater than five, or between staff and tenant; (2) amending dementia-specific training rules to include eight hours of training for direct-care contract staff and two hours for non-care contracted staff; and (3) requiring dementia-specific programs to develop procedures concerning tenants at risk for elopement.</i></p> <p>Dementia-specific assisted living program means a certified assisted living program that: (1) serves fewer than 55 tenants or has five or more tenants who have dementia between Stages 4 and 7 on the GDS; (2) serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS; or (3) holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease in a dedicated setting.</p> <p>A program must be designed to meet the needs of tenants with dementia. Service plans must include planned and spontaneous activities based on the tenant's abilities and personal interests. An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person with a cognitive disorder or dementia, whether in a general or dementia specific setting, shall have written procedures regarding alarm systems and appropriate staff response if a tenant with dementia is missing. A program serving persons with cognitive impairment or dementia must have the means to disable or remove the lock on an entrance door and must do so if the presence of the lock</p>

State	Details and Source
	<p>presents a danger to the health and safety of the tenant. Dementia-specific programs are exempt from some of the structural requirements for general assisted living programs. Exemptions include that self-closing doors are not required for individual dwelling units or bathrooms; dementia-specific programs may choose not to provide bathing facilities in the living units; and square footage requirements for tenant rooms are reduced. A Dementia-specific Assisted Living Program must have one or more staff on duty 24 hours a day in the proximate area.</p> <p>Building Requirements from IA:</p> <ul style="list-style-type: none"> • A program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, shall have the means to disable or remove the lock on an entrance door and shall disable or remove the lock if its presence presents a danger to the health and safety of the tenant. • Programs may have individual cooking facilities within the private dwelling units. Any program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, shall have the means to disable or easily remove appliances and shall disable or remove them if their presence presents a danger to the health and safety of the tenant or others. <p>481—69.36(231C) Dwelling units in dementia-specific programs. Dementia-specific programs are exempt from the requirements in subrules 69.35(2) to 69.35(4) as follows: 69.36(1) For a program built in a family or neighborhood design:</p> <ul style="list-style-type: none"> • Each dwelling unit used for single occupancy shall have a total square footage of not less than 150 square feet of floor area, excluding a bathroom; and • Each dwelling unit used for double occupancy shall have a total square footage of not less than 250 square feet of floor area, excluding a bathroom. • 69.36(2) Dementia-specific programs may choose not to provide bathing facilities in the dwelling units. [ARC 8176B, IAB 9/23/09, effective 1/1/10] 481—69.37(231C) Landlord and tenant Act. Iowa Code chapter 562A, the uniform residential landlord and tenant Act, shall apply to programs under this chapter.¹ • 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). • 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant’s service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants’ service plans.¹ <p>Service plans for residents with dementia must include planned and spontaneous activities based on the resident’s abilities and personal interests.</p>
KY	<p>KRS 216.595: Requirements for assisted-living communities and long-term care facilities claiming to provide special care for persons with Alzheimer’s disease or related disorders</p> <p>(1) (a) Any assisted-living community as defined by KRS 194A.700, long-term care facility as defined in KRS 216.535, or long-term care facility constructed under KRS 216B.071 that claims to provide special care for persons with a medical diagnosis of Alzheimer’s disease or other related disorders shall maintain a written and current manual that contains the information specified in subsection (2) of this section. This manual shall be maintained in the office of the community’s or facility’s director and shall be made available for inspection upon request of any person. The community or facility shall make a copy of any program or service information contained in the manual for a person who requests information about programs or services, at no cost to the person making the request.</p> <p>(b) Any advertisement of the community or facility shall contain the following statement: "Written information relating to this community’s or facility’s services and policies is available upon request."</p>

State	Details and Source
	<p>(c) The community or facility shall post a statement in its entrance or lobby as follows: "Written information relating to this community's or facility's services and policies is available upon request."</p> <p>(2) The community or facility shall maintain and update written information on the following:</p> <ul style="list-style-type: none"> (a) The assisted-living community's or long-term care facility's mission or philosophy statement concerning the needs of residents with Alzheimer's disease or related disorders; (b) The process and criteria the assisted-living community or long-term care facility uses to determine placement into services for persons with Alzheimer's disease or related disorders; (c) The process and criteria the assisted-living community or long-term care facility uses to transfer or discharge persons from special services for Alzheimer's or related disorders; (d) The supervision provided for residents with a medical diagnosis of Alzheimer's disease or related disorders; (e) The family's role in care; (f) The process for assessing, planning, implementing, and evaluating the plan of care for persons with Alzheimer's disease or related disorders; (g) A description of any special care services for persons with Alzheimer's disease or other related disorders; (h) Any costs associated with specialized services for Alzheimer's disease or related disorders; and (i) A description of dementia-specific staff training that is provided, including but not limited to the content of the training, the number of offered and required hours of training, the schedule for training, and the staff who are required to complete the training.
LA	<p><i>Louisiana promulgated new regulations to establish specialized dementia care programs for assisted living communities, which the state refers to as adult residential care providers.</i></p> <p>LAC – Title 488, Chpt 68</p> <p>B.Optional Services</p> <ol style="list-style-type: none"> 1. All levels of ARCPs may provide the services listed below. If these optional services are provided, they must be provided in accordance with the PCSP: <ul style="list-style-type: none"> a. medication administration; b. financial management; and c. specialized dementia care programs. <p>§6851.Specialized Dementia Care Programs</p> <p>Specialized Dementia Care Program—as defined in R.S. 40:1300.123, a special program or unit for residents with a diagnosis of probable Alzheimer’s disease or a related disorder so as to address the safety needs of such residents, and that advertises, markets, or otherwise promotes the ARCP as providing specialized Alzheimer’s/dementia care services.</p> <p>A. Scope and Purpose. The ARCP may establish a separate and distinct program to meet the needs of residents with Alzheimer’s disease or a related disorder. The ARCP shall provide a program of individualized care based upon an assessment of the cognitive and functional abilities of residents who have been included in the program.</p> <p>B. Any ARCP that offers such a program shall disclose this program to the department upon establishing the program or upon its discontinuance.</p> <p>C. Policies and Procedures</p> <ol style="list-style-type: none"> 1. An ARCP that advertises, promotes or markets itself as offering a specialized dementia care program shall have written policies and procedures for the program that are retained by the administrative staff and available to all staff, to members of the public, and to residents, including those participating in the program. 2. The ARCP shall have established criteria for inclusion in the specialized dementia care program. 3. Guidelines for inclusion shall be provided to the resident, his/her family, and his/her legal representative.
MA	<p>651 CMR 12.00:</p>

State	Details and Source
	<p>A residence may designate a distinct part or the entire facility as a Special Care residence to address the specialized needs of individuals, including those who may need assistance in directing their own care due to cognitive or other impairments. There are additional requirements, including policies and procedures and staff training, necessary for certification as a Special Care residence.</p> <p>The Special Care Residences must have sufficient staff qualified by training and experience awake and on duty at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled needs of all residents. The Special Care residence must have at least two awake staff on duty at all times. In addition to requirements for general orientation, all new employees who work in a Special Care Resident and have direct contact with residents must receive seven hours of additional training on the specialized care needs of the resident population. All staff in an assisted living residence must receive at least two hours of training on the topic of dementia/cognitive impairment, including a basic overview of the disease process, communication skills, and behavioral management as part of the general orientation. The manager and service coordinator shall receive an additional two hours of training (at least four hours total) on these topics. In addition, as part of the ongoing in-service training, all staff must receive at least two hours per year of training on dementia/cognitive impairment topics.</p> <p>(a) All Special Care Residences shall be administered in accordance with the following safeguards:</p> <ul style="list-style-type: none"> 1. Entry and exit doors in the common use areas within Special Care Residences shall be secured in accordance with local, state and federal laws and regulations. All doors must automatically unlock in the case of fire, power outage or emergency situation; 2. Staff shall be trained and assigned according to the requirements of 651 CMR 12.06 and 12.07; 3. The Residence shall develop and implement a 24-hour preparedness plan by assessing the needs of each occupant of the, Special Care Residence for emergency assistance, and devise an appropriate method to provide the necessary assistance; 4. The Residence shall develop and implement policies and procedures to assess and reduce the risk of potential hazards in the physical environment related to the special characteristics of the population. Such policies and procedures must include an annual written statement describing in detail how the physical characteristics of the Special Care Residence have been or will be modified to promote the safety of its Residents; <ul style="list-style-type: none"> 1. The Residence shall develop policies and procedures for the Special Care Residence that address unsafe Resident behaviors such as wandering, and verbally or physically aggressive behavior including coercive or inappropriate sexual behavior; 2. The Residence shall develop policies and procedures governing the transition of Residents moving in or out of the Special Care Residence; 3. The Residence shall provide a multipurpose activity space; and 4. All Special Care Residences that commence an initial certification process after October 1 , 2015 shall provide a secure outdoor space. <p>(b) The Special Care Residence shall prepare a planned activity program that includes structured activities with designated staff a minimum of three times within a 24-hour period, seven days per week. The planned activity program shall address Resident needs in the following areas of Resident function, as applicable:</p> <ul style="list-style-type: none"> — Gross motor activities; — Self-care activities; — Social activities; and — Sensory and memory enhancement activities. <p>(5) <u>Special Care Residence Staffing</u>. The Special Care Residence shall have sufficient staff qualified by training and experience awake and on duty at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled needs of all Residents of the Special Care Residence based upon the Resident assessments and service plans. The Special Care Residence's staffing shall be sufficient to respond promptly and effectively to individual Resident emergencies. For the purposes of 651 CMR 12.06(5), it shall never be considered sufficient to have less than two staff members in a Special Care Residence.</p>
OR	<p><u>411-057-0160 Resident Services in a Memory Care Community</u></p> <ul style="list-style-type: none"> (1) Only individuals with a diagnosis of dementia who are in need of support for the progressive symptoms of dementia for physical safety, or physical or cognitive function may reside in a

State	Details and Source
	<p>memory care community. Services must be delivered in a manner that promotes the autonomy and dignity of each resident, to maintain or enhance the resident's remaining abilities for self-care.</p> <p>(2) At time of move-in, the community must make reasonable attempts to identify the customary routines of each resident and the resident's preferences in how services may be delivered. Minimum services to be provided include:</p> <ul style="list-style-type: none"> (a) Assistance with activities of daily living that addresses the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a manner that promotes resident choice, dignity, and sustains the resident's abilities. (b) Health care services provided in accordance with the licensing rules of the facility. (c) A daily meal program for nutrition and hydration must be provided and available throughout each residents waking hours. The individualized nutritional plan for each resident must be documented in the resident's service or care plan. In addition, the memory care community must: <ul style="list-style-type: none"> (A) Provide visual contrast between plates, eating utensils, and the table to maximize the independence of each resident; and (B) Provide adaptive eating utensils for those residents who have been evaluated as needing them to maintain their eating skills. (d) Meaningful activities that promote or help sustain the physical and emotional well-being of residents. The activities must be person directed and available during residents' waking hours. <ul style="list-style-type: none"> (A) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: <ul style="list-style-type: none"> ▪ Past and current interests; ▪ Current abilities and skills; ▪ Emotional and social needs and patterns; ▪ Physical abilities and limitations; ▪ Adaptations necessary for the resident to participate; and ▪ Identification of activities for behavioral interventions. (B) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (C) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: <ul style="list-style-type: none"> ▪ (i) Occupation or chore related tasks; ▪ (ii) Scheduled and planned events (e.g. entertainment, outings); ▪ (iii) Spontaneous activities for enjoyment or those that may help diffuse a behavior; ▪ (iv) One to one activities that encourage positive relationships between residents and staff (e.g. life story, reminiscing, music); ▪ (v) Spiritual, creative, and intellectual activities; ▪ (vi) Sensory stimulation activities; ▪ (vii) Physical activities that enhance or maintain a resident's ability to ambulate or move; and ▪ (viii) Outdoor activities. (e) Behavioral symptoms which negatively impact the resident and others in the community must be evaluated and included on the service or care plan. The memory care community must initiate and coordinate outside consultation or acute care when indicated.

State	Details and Source
	<p>(f) Support must be offered to family and other significant relationships on a regularly scheduled basis not less than quarterly. Examples in which support may be provided include support groups, community gatherings, social events, or meetings that address the needs of individual residents or their family or significant relationships.</p> <p>(g) Access to secured outdoor space and walkways which allow residents to enter and return without staff assistance, except when indicated by OAR 411-057-0170(5)(e).</p> <p>Stat. Auth.: ORS 410.070, 443.886 Stats. Implemented: ORS 443.886</p>
SC	<p>R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES</p> <p>F. Alzheimer’s Special Care Unit or Program. A facility or area within a facility providing a secure, special program or unit for residents with a diagnosis of probable Alzheimer’s disease and/or related dementia to prevent or limit access by a resident outside the designated or separated areas, and that advertises, markets, or otherwise promotes the facility as providing specialized care/services for persons with Alzheimer’s disease and/or related dementia or both.</p> <p>E. A current month’s schedule shall be posted in order for residents to be made aware of activities offered. This schedule shall include activities, dates, times, and locations. Residents may choose activities and schedules consistent with their interests and physical, mental, and psychosocial well-being. If a resident has dementia and is unable to choose for him/herself, staff members/volunteers shall encourage participation and assist when deemed necessary.</p> <p>H. Side rails may be utilized when required for safety and when ordered by a physician or other authorized healthcare provider. When there are special concerns, e.g., residents with dementia, side rail usage shall be monitored by staff members as per facility policies and procedures. (I)</p> <p>I. In semi-private rooms, when personal care is being provided, arrangements shall be made to ensure privacy, e.g., portable partitions or cubicle curtains when needed or requested by a resident.</p> <p>J. There shall be at least one (1) mirror in each resident room or resident bathroom. As an exception, when a resident’s condition is such that having a mirror may be detrimental to his/her well-being, e.g., agitation and confusion associated with dementia, mirrors are not required</p>

Dementia Training Requirements

State	Details and Source
CA	<p><i>California enacted several statutes that changed staffing and training requirements, including requiring that administrator certification include training on managing Alzheimer’s disease and related dementias, as well as including non-pharmacologic, person-centered approaches to dementia care.</i></p> <p>22CCR 87707: Training Requirements if Advertising Dementia Specific Care, Programming and Environments Licensees who advertise, promote, or otherwise hold themselves out as providing special care, programming, and/or environments for residents with dementia or related disorders shall ensure that all direct care staff, described in Section 87706(a)(1), who provide care to residents with dementia, meet the following training requirements:</p> <p>(1) Direct care staff shall complete six hours of orientation specific to the care of residents with dementia within the first four weeks of working in the facility.</p> <p>A) This orientation shall be repeated if either of the following occur:</p> <p>(i) An employee returns to work for the same licensee after a break in service of more than 180 consecutive calendar days; or</p> <p>(ii) An employee goes to work for another licensee to provide dementia special care.</p> <p>B) This orientation shall be separate from other training and be exclusively on the care of residents with dementia.</p> <p>C) Various methods of instruction may be used, including, but not limited to, presenters knowledgeable about dementia; video instruction tapes; interactive material; books; and/or other</p>

State	Details and Source
	<p>materials approved by organizations or individuals specializing in dementia as specified in Section 87707(a)(2)(C).</p> <p>(i) Instruction may include up to two hours of mentoring and hands-on training from direct care staff who have completed six hours of orientation specific to the care of residents with dementia and eight hours of in-service training on the subject of serving residents with dementia as specified in Sections 87707(a)(1) and (2).</p> <p>D) The licensee shall maintain in the personnel records documentation on the orientation that includes the date(s), the hours provided, the names of staff in attendance, and the method(s) of instruction used.</p> <p>(2) Direct care staff shall complete at least eight hours of in-service training on the subject of serving residents with dementia within 12 months of working in the facility and in each succeeding 12-month period. Direct care staff hired as of July 3, 2004 shall complete the eight hours of in-service training within 12 months of that date and in each succeeding 12-month period.</p> <p>A) A minimum of two of the following training topics shall be covered annually, and all topics shall be covered within a three-year period:</p> <p>(i) Effects of medications on the behavior of residents with dementia;</p> <p>(ii) Common problems, such as wandering, aggression, and inappropriate sexual behavior;</p> <p>(iii) Positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living, and social, recreational and rehabilitative activities;</p> <p>(iv) Communication skills (resident/staff relations);</p> <p>(v) Promoting resident dignity, independence, individuality, privacy and choice; and</p> <p>(vi) End of life issues, including hospice.</p> <p>B) Training may be provided at the facility or offsite and may include a combination of observation and practical application.</p> <p>C) The training shall be developed by, or in consultation with, an individual(s) or organization(s) with expertise in dementia care and with knowledge on the training topic areas specified in Section 87707(a)(2)(A).</p> <p>(i) Examples of organizations that specialize in dementia care include, but are not limited to: the Alzheimer's Association, Alzheimer's Disease Diagnostic and Treatment Centers affiliated with the University of California, Family Caregiver Alliance and Caregiver Resource Centers, American Society on Aging, colleges and universities, and individuals with educational and professional qualifications specific to dementia.</p> <ul style="list-style-type: none"> ▪ If the consultant and trainer are the same person(s), the documentation requirements specified in Sections 87707(a)(2)(D) and (F) shall both be met.
IA	<p><i>Iowa amended its dementia-specific training rules to include eight hours of training for direct care contract staff and two hours for non-care contracted staff. All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia specific education and training within 30 days of either employment or the beginning date of the contract. All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia -specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. Specific topic areas must be covered in the training.</i></p> <p>As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule. [ARC 8176B, IAB 9/23/09, effective 1/1/10] 481—</p> <p>69.30(231C) Dementia-specific education for program personnel. 69.30(1)</p> <p>All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.¹</p> <p>69.30(2) The dementia-specific education or training shall include, at a minimum, the following:</p> <ul style="list-style-type: none"> • An explanation of Alzheimer’s disease and related disorders; • The program’s specialized dementia care philosophy and program; • Skills for communicating with persons with dementia;

1

State	Details and Source
	<ul style="list-style-type: none"> • Skills for communicating with family and friends of persons with dementia; • An explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the care-giving role, and family dynamics; • The importance of planned and spontaneous activities; • Skills in providing assistance with instrumental activities of daily living; • The importance of the service plan and social history information; • Skills in working with challenging tenants; • Techniques for simplifying, cueing, and redirecting; • Staff support and stress reduction; and • Medication management and nonpharmacological interventions. <p>69.30(3) Dementia-specific continuing education.</p> <ol style="list-style-type: none"> a. Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. c. Contracted personnel who have no contact with tenants (e.g., persons providing lawn maintenance or snow removal) are not required to receive the two hours of training required in paragraph “a.” d. The contracting agency may provide the program with documentation of dementia-specific continuing education that meets the requirements of this subrule. <p>69.30(4) An employee or contractor who provides documentation of completion of a dementia specific education or training program within the past 12 months shall be exempt from the education and training requirement of subrule 69.30(1).</p> <p>69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program. [ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]</p>
KY	<p>KRS 194A.719 In-service education for staff and management</p> <p>Assisted-living community staff and management shall receive orientation and in-service education on the following topics as applicable to the employee's assigned duties:</p> <ol style="list-style-type: none"> (1) Client rights; (2) Community policies; (3) Adult first aid; (4) Cardiopulmonary resuscitation; (5) Adult abuse and neglect; (6) Alzheimer's disease and other types of dementia; (7) Emergency procedures; (8) Aging process; (9) Assistance with activities of daily living and instrumental activities of daily living; (10) Particular needs or conditions if the assisted-living community markets itself as providing special programming, staffing, or training on behalf of clients with particular needs or conditions; and (11) Assistance with self-administration of medication.
LA	<p>Louisiana mandated that direct care staff complete 12 hours of in-service training each year, in addition to dementia specific training requirements. Any adult-care facility with approved dementia units is required to provide staff training in characteristics and needs of persons with dementia, including behavioral symptoms, and mental and emotional changes. The training should include methods for</p>

meeting the residents' needs on an individual basis. Further, in order to obtain approval for a special needs assisted living residence, an operator must submit a plan to the Department which must include not only proposed staffing levels, but also staff education, training, work experience, and professional affiliations or special characteristics relevant to the population the residence is intending to serve (including Alzheimer's or other dementias).

Staff Training. Training in the specialized care of residents who are diagnosed by a physician as having Alzheimer's disease, or a related disorder, shall be provided to all persons employed by the ARCP in accordance with the provisions established in §6867 of this Chapter.

Training for Direct Care Staff

1. In addition to the topics listed in §6867.A.3 and §6867.B, orientation for direct care staff shall include five days of direct observation of the performance of ADL and IADL assistance. A new employee shall not be assigned to carry out a resident's PCSP until competency has been demonstrated and documented.
2. In addition to the required dementia training in §6867.F, direct care staff shall receive 12 hours of annual training which shall be recorded and maintained in the employee personnel file.

Dementia Training

1. All employees shall be trained in the care of persons diagnosed with dementia and dementia-related practices that include or that are informed by evidence-based care practices. New employees must receive such training within 90 days from the date of hire.
2. All employees who provide care to residents in a specialized dementia care Program shall meet the following training requirements.
 - a. Employees who provide direct face-to-face care to residents shall be required to obtain at least eight hours of dementia-specific training within 90 days of employment and eight hours of dementia-specific training annually. The training shall include the following topics:
 - i. an overview of Alzheimer's disease and other forms of dementia;
 - ii. communicating with persons with dementia;
 - iii. behavior management;
 - iv. promoting independence in activities of daily living; and
 - v. understanding and dealing with family issues.
 - b. Employees who have regular contact with residents, but who do not provide direct face-to-face care, shall be required to obtain at least four hours of dementia-specific training within 90 days of employment and two hours of dementia training annually. This training shall include the following topics:
 - i. an overview of dementias; and
 - ii. communicating with persons with dementia.
 - c. Employees who have only incidental contact with residents shall receive general written information provided by the ARCP on interacting with residents with dementia.
3. Employees who do not provide care to residents in a special dementia care program shall meet the following training requirements.
 - a. Employees who provide direct face-to-face care to residents shall be required to obtain at least two hours of dementia-specific training annually. This training shall include the following topics:
 - i. an overview of Alzheimer's disease and related dementias; and
 - iii. communicating with persons with dementia.
 - b. All other employees shall receive general written information provided by the ARCP on interacting with residents with dementia.
4. Any dementia-specific training received in a nursing or nursing assistant program approved by the department or its designee may be used to fulfill the training hours required pursuant to this Section.
5. ARCPs may offer a complete training curriculum themselves, or they may contract with another organization, entity, or individual to provide the training.

State	Details and Source
	<ol style="list-style-type: none"> 6. The dementia-specific training curriculum shall be approved by the department or its designee. To obtain training curriculum approval, the organization, entity, or individual shall submit the following information to the department or its designee: <ol style="list-style-type: none"> a. a copy of the curriculum; b. the name of the training coordinator and his/her qualifications; c. a list of all instructors; d. the location of the training; and e. whether or not the training will be web-based. 7. A provider, organization, entity, or individual shall submit any content changes to an approved training curriculum to the department, or its designee, for review and approval. <ol style="list-style-type: none"> a. Continuing education undertaken by the ARCP does not require the department's approval. 8. If a provider, organization, entity, or individual, with an approved curriculum, ceases to provide training, the department shall be notified in writing within 30 days of cessation of training. Prior to resuming the training program, the provider, organization, entity, or individual shall reapply to the department for approval to resume the program. 9. Disqualification of Training Programs and Sanctions. The department may disqualify a training curriculum offered by a provider, organization, entity, or individual that has demonstrated substantial noncompliance with training requirements including, but not limited to: <ol style="list-style-type: none"> a. the qualifications of training coordinators; or b. training curriculum requirements. 10. Compliance with Training Requirements <ol style="list-style-type: none"> a. The review of compliance with training requirements will include, at a minimum, a review of: <ol style="list-style-type: none"> i. the documented use of an approved training curriculum; and ii. the provider's adherence to established training requirements. 1. b. The department may impose applicable sanctions for failure to adhere to the training requirements outlined in this Section. [Source]
MA	<p>Massachusetts made revisions to require that at least one hour of general orientation must be devoted to the topic of elder abuse, neglect and financial exploitation. Additionally, no more than 50 percent of training requirements can be satisfied by un-facilitated media presentations.</p> <p>651 CMR</p> <p>(2) Additional General Orientation Requirements.</p> <p>(a) At least one hour of general orientation training shall be devoted to the topic of elder abuse, neglect, and financial exploitation.</p> <p>(b) At least two hours of general orientation training shall be devoted to the topic of dementia and cognitive impairments. All curricula for training related to dementia shall reflect current standards of practice and care.</p> <p>(c) In addition to the requirements relative to the general orientation set forth in 651 CMR 12.07(1)(a) through (m), all personnel providing Personal Care Services shall receive at least one additional hour of orientation devoted to the topic of Self-administered Medication Management.</p> <p>(d) Both the Residence Manager and Service Coordinator shall receive an additional two-hour training devoted to dementia care topics.</p> <p>(e) A Residence may include the use of techniques such as the shadowing of more experienced employees during the first five days of an employee's tenure.</p> <p>(3) Orientation for Staff Working Within Special Care Residences. In addition to completing requirements for general orientation as set forth under 651 CMR 12.07(1)(a) through (m), all new employees who work within a Special Care Residence and have direct contact with Residents must receive seven hours of additional training on topics related to the specialized care needs of the Resident population (e.g., communication skills, creating a therapeutic environment, dealing with difficult behaviors, competency, sexuality, and family issues).</p>

State	Details and Source
	<p>(4) <u>Ongoing In-service Education and Training.</u></p> <p>(a) A minimum of ten hours per year of ongoing education and training is required for all employees, with at least two hours on the specialized needs of Residents with Alzheimer's disease and related dementia.</p> <p>(b) Employees working in a Special Care Residence must receive an additional four hours of training per year related to the Residents' specialized needs. Such training shall include the development of communications skills for Residents with dementia.</p> <p>12:07 Training Requirements</p> <p>(3) <u>Orientation for Staff Working Within Special Care Residences.</u> In addition to completing requirements for general orientation as set forth under 651 CMR 12.07(1)(a) through (m), all new employees who work within a Special Care Residence and have direct contact with Residents must receive seven hours of additional training on topics related to the specialized care needs of the Resident population (e.g., communication skills, creating a therapeutic environment, dealing with difficult behaviors, competency, sexuality, and family issues).</p> <p>In MA – training is necessary for dementia care.</p> <ul style="list-style-type: none"> • At least two hours of general orientation training shall be devoted to the topic of dementia and cognitive impairments. All curricula for training related to dementia shall reflect current standards of practice and care. • Both the Residence Manager and Service Coordinator shall receive an additional two hour training devoted to dementia care topics. <p>Ongoing In-service Education and Training.</p> <ul style="list-style-type: none"> • A minimum of ten hours per year of ongoing education and training is required for all employees, with at least two hours on the specialized needs of Residents with Alzheimer's disease and related dementia. <p>Employees working in a Special Care Residence must receive an additional four hours of training per year related to the Residents' specialized needs. Such training shall include the development of communications skills for Residents with dementia</p>
OR	<p>411-057-0150 Staffing and Staff Training</p> <p>(7) "Dementia Trained Staff" means any employee that has completed the minimum training requirements and has demonstrated knowledge and understanding in supporting individuals with dementia.</p> <p>(1) STAFFING AND STAFF TRAINING. The facility must provide residents with dementia trained staff who have been instructed in the person directed care approach. All direct care and other community staff assigned to the memory care community must be specially trained to work with residents with Alzheimer's disease and other dementias.</p> <p>(a) Only staff trained as specified in sections (2) and (3) of this rule shall be assigned to the memory care community.</p> <p>(b) Staffing levels must comply with the licensing rules of the facility and be sufficient to meet the scheduled and unscheduled needs of residents. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of residents.</p> <p>(c) In an emergency situation when trained staff are not available to provide services, the facility may assign staff who have not completed the required training in accordance with this rule. The particular emergency situation must be documented and must address:</p> <ol style="list-style-type: none"> 1) The nature of the emergency; 2) How long the emergency lasted; and 3) The names and positions of staff that provided coverage. <p>(2) A memory care community must ensure that staff who provide support to residents with dementia have a basic understanding and fundamental knowledge of the residents' emotional and unique health care needs. Direct care and other staff must be trained on the topics outlined in Table 1. These requirements are in addition to the facility licensing requirements for training.</p>

State	Details and Source
	<p>(3) Persons providing or overseeing the training of staff must have experience and knowledge in the care of individuals with dementia.</p> <p>(4) Pre-service and in-service training may include various methods of instruction, for example, classroom style, web-based training, video, or one to one training. The memory care community must have a method for determining and documenting each staff person’s knowledge and understanding of the training provided. All training must be documented.</p> <p>Stat. Auth.: ORS 410.070, 443.886 Stats. Implemented: ORS 443.886</p> <p>Training Requirements for Memory Care Communities (Page 22) – specified for all caregiving staff and all other staff</p>
MN	<p><i>Minnesota established required dementia training for staff, as well required training of managers. For example, direct care employees of a housing with services establishment that has a special program or special care unit must receive eight hours of initial training within 160 hours of the employment start date and two hours of additional training for each 12 months of work thereafter.</i></p> <p>144D.065 TRAINING IN DEMENTIA CARE REQUIRED.</p> <p>(a) If a housing with services establishment registered under this chapter has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the establishment as providing services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the establishment and of the establishment's arranged home care provider must meet the following training requirements:</p> <ol style="list-style-type: none"> 1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; 2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; 3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and 4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. <p>(b) Areas of required training include:</p> <ol style="list-style-type: none"> 1) an explanation of Alzheimer's disease and related disorders; 2) assistance with activities of daily living; 3) problem solving with challenging behaviors; and 4) communication skills. <p>(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).</p> <p>(d) Housing with services establishments not included in paragraph (a) that provide assisted living services under chapter 144G must meet the following training requirements:</p> <ol style="list-style-type: none"> 1) supervisors of direct-care staff must have at least four hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; 2) direct-care employees must have completed at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial four hours of

State	Details and Source
	<p>training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or supervisor meeting the requirements under paragraph (a), clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and</p> <p>4) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months.</p> <p>144D.066 ENFORCEMENT OF DEMENTIA CARE TRAINING REQUIREMENTS.</p>
SC	<p>South Carolina now requires staff and direct care volunteers actively on duty to be in the facility, awake, and dressed at all times. Staff and direct care volunteers must demonstrate a working knowledge of the training received.</p> <p>R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES</p> <p>504. Inservice Training (I).</p> <p>5. Depending on the type of residents, care of persons specific to the physical/mental condition being cared for in the facility, e.g., dementia; cognitive disability; mental illness; or aggressive, violent, and/or inappropriate behavioral symptoms etc., to include communication techniques (cueing and mirroring), understanding and coping with behaviors, safety, activities, etc.</p>

Egress Standards

State	Details and Source
CA	<p>Use of egress alert devices, delayed egress, and locked facility doors and perimeters are also allowed if specified additional requirements are met. Delayed egress and locked doors/perimeters require special fire clearances, and are only allowed with prior approval from CCLD. Resident and/or responsible person consent is also required prior for use of delayed egress devices or locked facility doors.</p> <p>87705: Care of Persons with Dementia</p> <p>The licensee may use wrist bands or other egress alert devices worn by the resident, with the prior written approval of the resident or conservator, provided that such devices do not violate the resident's rights as specified in Section 87468, Personal Rights.</p> <p>(j) The licensee shall have an auditory device or other staff alert feature to monitor exits, if exiting presents a hazard to any resident.</p> <p>(k) The following initial and continuing requirements must be met for the licensee to utilize delayed egress devices on exterior doors or perimeter fence gates:</p> <p>(1) The licensee shall notify the licensing agency immediately after determining the date that the device will be installed.</p> <p>(2) The licensee shall ensure that the fire clearance includes approval of delayed egress devices.</p> <p>(3) Fire and earthquake drills shall be conducted at least once every three months on each shift and shall include, at a minimum, all direct care staff.</p> <p>(4) Without violating Section 87468, Personal Rights, facility staff shall attempt to redirect a resident who attempts to leave the facility.</p> <p>(5) Residents who continue to indicate a desire to leave the facility following redirection shall be permitted to do so with staff supervision.</p> <p>(6) Without violating Section 87468, Personal Rights, facility staff shall ensure the continued safety of residents if they wander away from the facility.</p> <p>(7) For each incident in which a resident wanders away from the facility unsupervised, the licensee shall report the incident to the licensing agency, the resident's conservator and/or other responsible person, if any, and to any family member who has requested notification. The report shall be made by telephone no later than the next working day and in writing within seven calendar days.</p> <p>(8) Delayed egress devices shall not substitute for trained staff in sufficient numbers to meet the care and supervision needs of all residents and to escort residents who leave the facility.</p> <p>(9) The licensee shall not accept or retain residents determined by a physician to have a primary diagnosis of a mental disorder unrelated to dementia.</p>

State	Details and Source
IA	<p>481—69.32(231C) Life safety—emergency policies and procedures and structural safety requirements. (pg 15)</p> <p>69.32(3) The program shall obtain approval from the state fire marshal division of the department of public safety before the installation of any delayed-egress specialized locking systems.</p> <p>69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have:</p> <ol style="list-style-type: none"> a. Written procedures regarding alarm systems, if an alarm system is in place. b. Written procedures regarding appropriate staff response when a tenant’s service plan indicates a risk of elopement or when a tenant exhibits wandering behavior. c. Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing.
LA	<p>Operators may be certified as special needs assisted living to provide dementia care. Dementia units must be designed as self-contained units. Fully locked facilities are prohibited, but units must have a delayed-egress system on all external doors as well as window stops and enclosed courtyards. Facilities must meet additional fire safety rules.</p> <p>Title 48: Chapter 68</p> <ol style="list-style-type: none"> 4. Door locking arrangements to create secured areas may be permitted where the clinical needs of the residents require specialized protective measures for their safety, provided that such locking arrangements are approved by the OSFM and satisfy the requirements established by the OSFM and in accordance with R.S. 40:1300.121 et seq. <ol style="list-style-type: none"> a. If the services are provided in a secured area where special door locking arrangements are used, the ARCP shall comply with the requirements established for limited health care occupancies in accordance with the laws, rules and codes adopted by the OSFM. b. The secured areas shall be designed and staffed to provide the care and services necessary for the resident's needs to be met. c. There shall be sufficient staff to respond to emergency situations in the locked unit at all times. d. PCSPs shall address the reasons for the resident being in the unit and how the ARCP is meeting the resident's needs. e. There must be documentation in the resident's record to indicate the unit is the least restrictive environment possible, and placement in the unit is needed to facilitate meeting the resident’s needs. f. Inclusion in a program on the unit must be in compliance with R.S. 40:1299.53. C. All ARCPs must conduct egress and relocation drills in accordance with the requirements of the OSFM and the applicable edition of the NFPA 101 Life Safety Code published by the NFPA.
MA	<p>651 CMR: DEPARTMENT OF ELDER AFFAIRS</p> <p>(f) An operating plan which shall include the following information:</p> <ol style="list-style-type: none"> — The number of single and double occupancy Units for which Certification is sought, the number of single and double occupancy Units designated as Special Care Units, and the number of Residents per Unit; — The location of Units and Special Care Units, common spaces, and egresses by floor; — The fee structure for lodging, meals and services; <p>The type and extent of services to be offered, arrangements for providing such services, including third party contracts, and linkages with hospital and nursing facilities;</p> <p>5. A Plan for Self-administered Medication Management (SAMM) for Residents, including but not limited to, assistance with as-necessary (PRN) medication when part of the SAMM, and, if offered, Limited Medication Administration;</p>
OR	<p>http://www.dhs.state.or.us/policy/spd/rules/411_057.pdf</p> <p>(5) In addition to the policies and procedures required in the licensing rules for the facility, the memory care community must develop and implement policies and procedures that address:</p> <ol style="list-style-type: none"> (a) Philosophy of how services are provided based upon the memory care community’s values, mission, and the promotion of person directed care and how it shall be implemented; (b) Evaluation of behavioral symptoms and design of supports for intervention plans; (c) Wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (d) Assessment of residents for the use and effects of medications including psychotropic medications;

State	Details and Source
	<p>(e) Use of supportive devices with restraining qualities; (f) Staffing plan for the memory care community; (g) Staff training specific to dementia care; (h) Description of life enrichment program and how activities are implemented; (i) Description of family support programs and efforts on how the family shall remain engaged; (j) Limiting use of public address and intercom systems for emergencies and evacuation drills only; (k) Transportation coordination and assistance to and from outside medical appointments; and (l) Safekeeping of residents possessions. This policy must be provided to residents and the resident's representative at the time of move-in. Stat. Auth.: ORS 410.070, 443.886 Stats. Implemented: ORS 443.886 (6) UNOBSTRUCTED EGRESS. Stairways, halls, doorways, passageways, and exits from rooms and the building must be unobstructed.</p>
SC	<p>R.61-84, STANDARDS FOR LICENSING COMMUNITY RESIDENTIAL CARE FACILITIES</p> <p>G. Residents shall be assured freedom of movement. Residents shall not be locked in or out of their rooms or any common usage areas (e.g., dining, sitting, activity rooms) in the facility, or in or out of the facility building. Exit doors may be equipped with delayed egress locks as permitted by the codes referenced in Section 1902.A. (I) EXCEPTION: Exit doors may be locked with written approval by the Department and as permitted by the codes referenced in Section 1902.</p>

Bed Holds – Federal Guidance

Source	Guidance
<p>Olmstead Update No. 3 Attachment 3-c Guidance</p>	<p>Medicaid regulations at 42 CFR 447.40 permit States to make payment to "hold" an institutional bed open for a resident while that individual is hospitalized or away from the facility for a short period. States which make this payment must indicate their intentions (and applicable time limits) in their State plans. We are writing this guideline to inform you that you may choose to implement a similar policy to allow payment for personal assistance services (such as personal care or attendant services) under HCBS waivers. This would enable beneficiaries to have parity between nursing home care and HCBS care in terms of assuring continuity of care and services.</p> <p>Individuals with disabilities utilize personal assistance services provided under a HCBS waiver to support various activities of daily living. These services are furnished by individuals employed by community-based agencies, or by persons who are self-employed or employed directly by the waiver participant. Typically low payment rates make it unlikely that a provider could afford to give up a day's or week's salary because the waiver consumer is hospitalized or otherwise absent. Rather than wait for the waiver consumer to return, providers are more likely to find permanent employment elsewhere. Those who are employed by agencies are often reassigned to other agency clients - and may not return. Lack of providers can be catastrophic for an individual with disabilities.</p> <p>Personal assistance retainer payments, as described in this attachment, are limited to services furnished under HCBS waivers. To enable waiver participants to continue to receive services in the most integrated setting appropriate to their needs, we will permit continued payment to personal caregivers under the waiver while a person is hospitalized or absent from his or her home. If a State chooses to make such payments, it must clearly indicate this in its HCBS waiver request.</p> <p>States that choose to make payments to be made for personal assistance retainers must also specify the limits that will be applied to this service. The personal assistance retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bedhold" in nursing facilities.</p>

Source	Guidance
	[Source]
National Senior Citizens Law Center Policy Brief	<p>Recommendations for assisted living leave days:</p> <ul style="list-style-type: none"> • States allowed to use Medicaid-funded retainer payments for temporary absences from an assisted living facility under HCBS waivers • States can authorize retainer payments up to federally allowed limits • Room holds apply regardless of reason of absence • Adopt guidance similar to NF bed holds: allow for room holds, room-hold payments, and readmission to the next available room after temporary absence <p>[Source]</p>

Bed Holds – State Examples

State	Category	Duration of bed hold retainer payments	Description
MT	Retainer payments made	30 days/720 hours per year	<p>ASSISTED LIVING RETAINER DAYS Providers of this service may be eligible for a retainer payment if authorized by the case management team. Retainers are days on which the individual is either in the hospital, nursing facility, or on vacation and the team has authorized the provider to be reimbursed for services in order to keep their placement in the residential setting. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition. Payment for retainer days may not exceed 30 days or 720 hours per Person-Centered Plan year (Refer to SDMI HCBS 410). [Source]</p>
WA	Retainer payments made	20 days	<p>Bed or unit holds for Medicaid residents in AL who need short-term care at a nursing home or hospital.</p> <p>(1) An enhanced services facility (ESF) that contracts to provide services under chapter 70.97 RCW and an adult family home (AFH) or assisted living facilities contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL) under chapter 74.39A RCW, must hold a Medicaid eligible resident's bed or unit if:</p> <ul style="list-style-type: none"> (a) The Medicaid resident needs short-term care in a nursing home or hospital; (b) The Medicaid resident is likely to return to the ESF, AFH, ARC, EARC, or AL; and (c) The department pays the ESF, AFH, ARC, EARC, or AL as set forth under subsection (3), (4), or (5) of this section. <p>(4) The department will pay an ARC, EARC, or AL seventy percent of the resident's Medicaid daily rate set at the time he or she left the ARC, EARC, or AL for the first through seventh day of the resident's hospital or nursing home stay and eleven dollars a day for the eighth through twentieth day.</p> <p>(6) A Medicaid resident's short-term stay in a nursing home or hospital must be longer than twenty-four hours for subsection (3) or (4) of this section to apply.</p> <p>(10) An ESF, AFH, ARC, EARC, or AL may seek third-party payment for a bed or unit hold that lasts for twenty-one days or longer or if the department determines that the Medicaid resident's hospital or nursing home stay is not short-term and he or she is unlikely to return. The</p>

State	Category	Duration of bed hold retainer payments	Description
			<p>third-party payment must not exceed the resident's Medicaid daily rate paid to the ESF, AFH, ARC, EARC, or AL.</p> <p>(11) If third-party payment is not available for a bed or unit hold that lasts for twenty-one days or longer, the Medicaid resident may return to the first available and appropriate bed or unit at the ESF, AFH, ARC, EARC, or AL if he or she continues to meet the admission criteria under chapter 388-106 WAC.</p> <p>[Source]</p> <p>From 1915(k) Community First Choice State Plan Option: Bed Hold Retainer Payments: In order to ensure continuity of services and supports, bed hold retainer payments will be made to licensed Assisted Living Facilities and Adult Family Homes when the participant has a short-term stay in a hospital or nursing facility and is likely to return to the home. These payments will ensure the supports needed by the participant remain in place for the participant's return home. The State will compensate the facility for up to twenty days when a participant's bed is retained during the participant's absence. [Source]</p>
OH	No retainer payments but guidance provided for when waiver services are not provided	--	<p>"Bed hold" day reimbursement does not apply in the ALW. Reimbursement for waiver services is not available when services are not delivered. However, the client is responsible for continuation of the room and board payment.</p> <p>[Source]</p> <p>The provider may not charge the waiver participant a security deposit or an additional fee above the maximum monthly room and board rate to hold the living unit during a temporary absence (ie: hospital or short term nursing facility stay).</p>
NJ	No retainer payments but guidance provided for hospitalization/NF	--	<p>AL facility must hold a Medicaid beneficiary's unit until the end of the month in which a person transfers to a hospital/nursing facility</p> <p>AL can collect R&B fee during leave of absence but cannot bill for any services/per diem during leave of absence</p> <p>[Source]</p>
ND	Retainer payments made for medical leave days	15 days	<p>ND Medicaid will cover a maximum of 15 days per occurrence for medical leave. The purpose of the medical leave policy is to ensure that a bed is available when a resident returns to the basic care facility. A basic care facility may not bill for hospital leave days if it is known that the resident will not return to the facility. [Source]</p>
NC	No retainer payments but guidance provided for hospitalization	--	<p>Special assistance (SA) payment for room and board does continue during hospitalization for bed hold purposes.</p>
MD, NM, and Others	Requires providers to include bed hold policy in admission agreements	--	<p>NM [Source]</p> <p>MD [Source]</p>

Assisted Living Licensing/Certification Standards (Duration and Fee Structure)

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
IA	<p>Certification</p> <p>Iowa Department of Inspections and Appeals</p> <p>[Source]</p>	<p>Non-Accredited Programs: Initial Certification: 2 year Re-certification: 2 year</p> <p>Accredited Programs: Initial Certification: The term of the accreditation, not to exceed three years Re-certification: The term of the accreditation, not to exceed three years</p>	<p>For non-accredited initial certification:</p> <ul style="list-style-type: none"> • Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements. • If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept tenants. • Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements. • If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed. • The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction. • The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable. • If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification. 	<ul style="list-style-type: none"> • An assisted living program that is certified by the department on the basis of voluntary accreditation by a recognized accrediting entity shall not be subject to payment of the certification fee, but shall be subject to an administrative fee as prescribed by rule. • The following certification and related fees shall apply to assisted living programs: <ul style="list-style-type: none"> ○ For a two-year initial certification: \$750 ○ For a two-year recertification: \$1000 ○ For a blueprint plan review: \$900 ○ For an optional preliminary plan review: \$500 ○ For accreditation via a national body of accreditation: \$125 <p>[Source]</p>
IL	<p>Licensure</p> <p>Illinois Department of</p>	<p>All regular licenses valid for one year</p>	<p>Documentation requirements:</p> <ol style="list-style-type: none"> 1) The business name, street address, mailing address, and telephone number of the establishment; 	<p>The state doubled the licensure fee between 2015 to 2016:</p> <ol style="list-style-type: none"> 2) From \$1,000 to \$2,000 for an assisted living establishment and \$20 (was \$10) per licensed unit; and

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
	Public Health Division of Assisted Living	At renewal, if establishment is in substantial compliance with all other licensure requirements, the Dept may renew the license for an additional period of 2 years at the request of the licensee	<ol style="list-style-type: none"> 2) Ownership information 3) Financial information establishing that the project is financially feasible, in one of the following forms: 4) The name and mailing address of the managing agent of the establishment, whether hired under a management agreement or lease agreement, if different from the owner or owners, and the name of the full-time manager; 5) Verification that the establishment has entered or will enter into a service delivery contract as provided in Section 295.2030, as required under the Act, with each resident or resident's representative; 6) The name and address of at least one natural person who shall be responsible for dealing with the Department on all matters provided for in the Act and this Part, on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent. Notwithstanding a contrary provision of the Code of Civil Procedure, personal service on the person identified pursuant to this subsection (a)(6) shall be considered service on the owner or owners and the managing agent, and it shall not be a defense to any action that personal service was not made on each individual or entity; 7) The signature of the authorized representative of the owner or owners; 8) Proof of an ongoing quality improvement program in accordance with Section 295.2060 of this Part; 9) Information about the number and types of units and the maximum census; 10) Information about the mandatory and optional services to be provided at the establishment; 11) Proof of compliance with applicable State and local residential standards, as evidenced by completion of the Department's Code Certification of Compliance 	3) From \$500 to \$1,000 for a shared housing establishment.

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<p>form;</p> <p>12) A copy of the standard contract offered to residents;</p> <p>13) Documentation of adequate liability insurance; (Section 30 of the Act)</p> <p>14) A completed Alzheimer's Disease and Related Dementias Special Care Disclosure form; and</p> <p>15) A schematic drawing of the establishment.</p> <p>*If all units are not licensed, the establishment shall maintain documentation of which units are providing assisted living services. This number shall not exceed the number of units on the license. The entire building having any licensed units shall meet the physical plant requirements of this Part.</p> <p>*If the establishment does not have a permit under the Life Care Facilities Act and the establishment requires entrance or application fees in excess of three months of a resident's minimum fees, the establishment shall maintain a bond or restricted account that guarantees the return of the resident's entrance fees or the unused portion of his or her deposit if the establishment ceases to operate.</p>	
KY	<p>Certification</p> <p>Cabinet for Health and Family Services</p>	1 year	<ul style="list-style-type: none"> • Application • Blank Lease Agreement • Marketing materials • Floor plan • On-site review after approval of application materials <p>Re-certification process includes application form and documentation of above if changes have occurred.</p> <ul style="list-style-type: none"> • Unannounced on-site review will be conducted within one year of receiving renewal application <p>On-site review includes:</p>	<p>Assisted-living community certification fee in the amount of twenty dollars (\$20) per living unit that in the aggregate for each assisted-living community is no less than three hundred dollars (\$300) and no more than one thousand six hundred dollars (\$1600).</p> <p>(prorated if not effective as of July 1 of a given year)</p> <p>Same fee for recertification</p>

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<ul style="list-style-type: none"> • Review of employment records • Compliance with state code • Review of client records (functional needs assessment, personal preferences, signed leases) • Policies and procedures (DAILALC-2, Assisted-Living Community Certification Checklist) • Service provision and practices • Compliance with special programming, staffing, training requirements 	
MA	Certification Massachusetts Executive Office of Elder Affairs	2 years	<p>Review of Applications. The EOEA shall not review an Application for an original or renewal Certification unless:</p> <ol style="list-style-type: none"> a) The Application includes all information required by EOEA; b) The Application includes all required attachments and statements that are required for the Certification; and c) The Applicant has paid all required Application fees. <p>Documentation requirements:</p> <ul style="list-style-type: none"> • The name and address of each officer, director, and trustee; and the names and addresses of each owner, general partner, limited partner, or shareholder with a 25% or greater interest in the Assisted Living Residence; • Attestation that none of such individuals has ever been found in violation of any local, state or federal statute, regulation, ordinance, or other law by reason of that individual's relationship to an Assisted Living Residence or health care facility; • A list for each such individual of all multi-family housing or health care facilities or providers in which she or he has been or is an officer, director, trustee, or general partner; • If the Applicant or any person named in the Application as set forth in 651 CMR 12.03(2)(a) has or has had, 	\$200 application fee (for initial and re-certification)

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<p>within the previous five years, an interest in one or more of entities listed below, evidence from the Massachusetts Department of Public Health (DPH) that the entities have substantially met applicable criteria for licensure or Certification and, if applicable, have corrected all cited deficiencies without de-licensure or de-certification being imposed:</p> <ul style="list-style-type: none"> ○ hospital, clinic, long term care facility, mammography facility, institutions for unwed mothers, out of hospital dialysis unit, hospice program, bacteriological laboratory, blood bank, or other entity licensed by the DPH under M.G.L. c. 111; ○ medical provider licensed under other applicable state statutes; including a facility, halfway house or treatment program unit for alcoholism licensed under M.G.L. c. 111B, ambulance service licensed under M.G.L. c. 111C, clinical laboratory licensed under M.G.L. c. 111D, and drug rehabilitation facility licensed under M.G.L. c. 111E; or ○ home health agency in Massachusetts certified under Title XVIII of the Social Security Act. ● A copy of the conversion approval from the DPH, if an Applicant seeks to convert all or part of a premises licensed as a Long Term Care Facility to an Assisted Living Residence or if an Applicant seeks to add Assisted Living Residences to existing premises licensed as a Long-term Care Facility; ● An operating plan which shall include the following information: <ul style="list-style-type: none"> ○ The number of single and double occupancy Units for which Certification is sought, the number of single and double occupancy Units designated as Special Care Units, and the number of Residents per Unit; ○ The location of Units and Special Care Units, 	

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<ul style="list-style-type: none"> common spaces, and egresses by floor; ○ The fee structure for lodging, meals and services; ○ The type and extent of services to be offered, arrangements for providing such services, including third party contracts, and linkages with hospital and nursing facilities; ○ A Plan for Self-administered Medication Management (SAMM) for Residents, including but not limited to, assistance with as-necessary (PRN) medication when part of the SAMM, and, if offered, Limited Medication Administration; ○ A means for Residents to communicate urgent or emergency needs, and a plan to provide timely assistance to them; ○ The number of staff to be employed in the operation of the Assisted Living Residence and their minimum qualifications and responsibilities; ○ A copy of the Residency Agreement that will be used by the Assisted Living Residence. It must clearly describe the rights and responsibilities of the Resident and Sponsor, and comply with all requirements of M.G.L. c. 19D and 651 CMR 12.00; ○ A copy of all required current building, fire safety, and locally approved state sanitary code certificates and permits; ○ Procedures to notify a Resident and his or her Legal or Resident Representative, as appropriate, that the Assisted Living Residence is no longer an appropriate environment for the Resident. Such notice shall describe the changes in the Resident's service needs that justify such a finding, explain when those changes occurred, and describe how the Resident's needs can no longer be satisfied; ○ A copy of all policies and procedures related to the design and operation of a Special Care Residence required under 651 CMR 12.04(4); 	

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<ul style="list-style-type: none"> ○ A copy of the quality improvement and assurance program required under 651 CMR 12.04(10); ○ A copy of the disaster and emergency preparedness plan required under 651 CMR 12.04(11); ○ A copy of the communicable disease control plan required under 651 CMR 12.04(12); ○ A copy of the Controlled Substances policies and procedures required by 651 CMR 12.04(14); ○ A statement citing the beginning and ending dates of the Residence's fiscal year; and ○ Policies and procedures designed to ensure a safe environment for all Residents. ● Applications for renewal Certification must also include a statement that the data required by 651 CMR 12.04(13), information documenting all substantial changes to the operating plan prior to the effective date, and all other information required by EOE, have been submitted.² 	
MD	Licensure Office of Health Care Quality	2 years	<p>Documentation – initial application:</p> <ul style="list-style-type: none"> ● Good standing letter from the State of Maryland, Assessments & Taxation Office if your facility is a corporation. ● Program Directions ● Proof of Workers' Compensation Insurance or a Certificate of Compliance ● Hand Drawn Sketch of your physical site. ● Completed Criminal Background Check or Criminal History Records Check for the owner, ● applicant, manager, alternate manager, household members, and any other staff ● Zoning Approval and/or Use & Occupancy Permit ● Menus & Healthy Meal ● Uniform Disclosure Statement 	<ul style="list-style-type: none"> ● \$400 for 1-4 beds ● \$600 for 5-15 beds ● \$900 for 16-49 beds ● \$1,300 for 50-99 beds ● \$2,000 for 100-149 beds ● \$3,000 for 150 plus beds <p>If a facility is not in compliance with COMAR 10.07.14 and requires the OHCQ to conduct more than one on-site pre-licensure visit, the OHCQ may charge \$250 per additional on-site visit</p>

²[Massachusetts 651 CMR 12](#)

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<ul style="list-style-type: none"> • Food Service Permit • Howard County Rental License • Montgomery County License • Verification of Building Ownership and/or Control • Environmental Report • Fire Inspection Report <p>Scheduled paper review:</p> <ul style="list-style-type: none"> • Verification of Age • Verification of Education and/or Work Experience • Health Record • Communicable Disease Statement • Proof of Assisted Living Manager Training • Proof of Alternate Manager Training Requirements • Policies and Procedures • Resident Agreement • Financial Disclosure • Quality Assurance • Burial Policy • Delegating Registered Nurse (DRN) Information • Documentation Policy 	
MN	<p>Registration and Licensure (Registration as Housing with Services Establishment, Licensed as Class A or Class F Home Care Provider)</p> <p>Minnesota Department of Health</p>	1 year	<p>Documentation requirements:</p> <ol style="list-style-type: none"> (1) the business name, street address, and mailing address of the establishment; (2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners; (3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the 	<p>Annual Housing with Services registration fee of \$155</p> <p>License fees. The license fees for assisted living home care providers shall be as follows:</p> <ol style="list-style-type: none"> 1. \$125 annually for those providers serving a monthly average of 15 or fewer clients, and for assisted living providers of all sizes during the first year of operation; 2. \$200 annually for those providers serving a monthly average of 16 to 30 clients; 3. \$375 annually for those providers serving a monthly average of 31 to 50 clients; and 4. \$625 annually for those providers serving a monthly average of 51 or more clients.

State	Licensure/Certification and Responsible Party	Duration	Key Components	Fee Structure
			<p>owner or owners, and the name of the on-site manager, if any;</p> <p>(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;</p> <p>(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;</p> <p>(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any;</p> <p>(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and whether services are included in the base rate to be paid by the resident.</p>	<p>[Source]</p>

Bringing Assisted Living into Compliance

(Extracted from State Transition Plans [\[Source\]](#))

State	Current State	Promising Strategies for HCBS Settings Rule Compliance	Gaps/Challenges for HCBS Settings Rule Compliance
MD	<p>MD's Home and Community Based Options Waiver (HCBOW) includes services that may be provided in ALs. MD is missing some of the criteria dictated by the Final Rule for its AL facilities, and two of the regulations are noncompliant with the rule related to the freedom to access food at any time and have visitors at any time. As of August 2016, OHCQ (the licensing agency for ALFs) is writing new regulations to address these issues and mandate provider compliance with the federal HCBS rule.</p> <p>Assisted Living:</p> <ul style="list-style-type: none"> • A licensed facility/home that provides housing and supportive services for individuals who need assistance in performing activities of daily living - such as eating, toileting, dressing and, if needed, medication management. • Current regulations COMAR 10.09.54 and 10.07.14 do have two areas in which providers' policies will need to better accommodate resident preferences and rights are enabling ongoing access to food during the day and allowing visitation at any time. • In addition, residential service providers also use various leases or residency agreement that will need further review to determine if these are legally enforceable. • Further review of each site will be necessary to determine compliance. • MD funds 452 AL providers, with 1,509 participants receiving services (including Level II and Level III) 	<p>MD provides orientation for individuals applying to become a Medicaid-funded provider of Assisted Living Facilities (ALF). All ALF providers must attend an orientation prior to being enrolled as an ALF provider. This process is in addition to the 80-hour manager's course that Assisted Living managers must take before the facility and program will be considered for licensure. ALF providers receive CSQ information during orientation. MD is utilizing the following strategies to come into full compliance with the rule:</p> <ul style="list-style-type: none"> • Transition Advisory Teams were created in 2015 and the stakeholder process is ongoing, with meetings on or about a monthly basis. • DHMH already has a process to assure that participants, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice for relocation if they desire or if it becomes necessary. Maryland provides a Freedom of Choice (FOC) form to participants. The form includes an attestation that the participant received a list of all providers. Participants currently sign the FOC prior to enrollment. • Maryland law and all regulations related to the Assisted Living program were reviewed. OHS has determined that nothing in current law or regulations conflicts with the HCBS rule. However, there are some areas of the HCBS rule that are not addressed by current regulations. DHMH will update the regulations accordingly within the next two years. • OHS is in the process of doing a systemic assessment of all providers of facility based or residential services. This includes survey, assessments, and site visits. <p>The following remediation strategies are currently being</p>	<p><i>None identified based on review of publicly available information in state's transition plan.</i></p>

State	Current State	Promising Strategies for HCBS Settings Rule Compliance	Gaps/Challenges for HCBS Settings Rule Compliance
		<p>utilized:</p> <ul style="list-style-type: none"> • Technical assistance from Medicaid staff is available to providers if they have difficulty addressing any of the HCBS requirements. Community Settings Stakeholder meetings are held at least quarterly or when there are significant developments. • As part of the ALF re-validation process, providers are sent educational materials on the HCBS rule as well as policies and procedures. OHS also reviews and provides feedback on residential agreements that are in conflict with the community settings rule. • In July 2016, OHS conducted a mailing to providers who indicated non-compliance on certain questions from the provider survey. DHMH has eliminated any questions that were possibly confusing or were not directly specified in the HCBS rule. The letter is individualized to each provider, and contains responses deemed non-compliance as well as corresponding explanations about the HCBS rule. Any provider who felt that they misunderstood the question(s) or that DHMH misunderstood their response(s) may submit a request for reconsideration within 10 days. Providers who did not submit a request for reconsideration are expected to submit a Corrective Action Plan (CAP) by August 5, 2016 detailing how they plan to come into compliance, when they expect to come into compliance, and who is responsible. 	
NJ	<p>NJ revised their STP to provide clarity on eviction processes in AL lease agreements for individuals participating in MLTSS (four 1915 c waivers combined into one managed care benefit program). NJ's MLTSS managed care serves 2,800 living in 250 residential settings, including Assisted Living Residences (ALR) and Assisted Living Programs (ALP).</p>	<p>NJ randomly conducts unannounced surveys for a percentage of their settings to validate self-assessments. Surveys are based on the HCBS final rule. If documentation cannot be provided, providers are asked to provide a plan for remedial action and a timeline for reaching compliance. Any provider who does not reach compliance within the 5-year transition period will be terminated as a NJ managed care provider under their MLTSS.</p>	<p><i>None identified based on review of publicly available information in state's transition plan.</i></p>
NY	<p>The most challenging aspects of DOH residential and non-residential settings, in light of the federal HCBS rule, are the</p>	<p>New York's ALP Transition Plan was developed through the efforts of the New York State interagency workgroup and</p>	<p><i>None identified based on review of publicly available information in state's transition plan.</i></p>

State	Current State	Promising Strategies for HCBS Settings Rule Compliance	Gaps/Challenges for HCBS Settings Rule Compliance
	<p>transition of New York’s Medicaid Assisted Living Program (ALP) from a state plan personal care program into the 1115 Demonstration project and the Adult Day Health Care (ADHC) Programs.</p> <p>Until they transition into the 1115 Demonstration, ALPs don’t have to comply with the federal rule. A full assessment of these sites will be necessary to determine their level of compliance once they transition into the 1115. It is likely that changes may have to be made in terms of providing each individual with the full range of choice and control over personal space, activities and time envisioned by the federal HCBS rule.</p> <p>As of March 2016, NY had licensed 540 adult care facilities, which operate ALPs. The vast majority of the over 12,700 Medicaid-eligible residents are currently receiving ALP services. The ALP is NY's aging-in-place program for low-income residents.</p> <p>NY believes that there are only a small number of ALPs that do not and cannot, by definition, fully comply with the settings rule. Those facilities are known as Special Needs Assisted Living Programs, and by definition provide services consistent with their license to individuals with cognitive and dementia-related concerns in a “protective” environment. NY has identified 13 ALPs which, by definition of the Rule, are presumed institutional due to the isolation of some ALP residents from the greater community.</p>	<p>significant outreach to and input from multiple stakeholders. It includes the following components:</p> <ul style="list-style-type: none"> • Assessment of ALP provider current compliance with HCBS Rule requirements • Training and education to providers on HCBS Rule requirements • Amendments to align NYS regulations with HCBS Rule requirements • Development and implementation of survey tools and protocols, and surveyor training, to ensure appropriate DOH surveillance of provider compliance with HCBS Rule requirements <p>NY has completed provider self-assessments developed by DOH with input from stakeholders. Providers will also submit pertinent information to DOH to determine their level of compliance. NY will require all newly established ALPs to demonstrate full compliance. If an ALP indicates that they do not meet compliance, NY will work with them to implement remediation strategies.</p> <p>NY will conduct periodic site-specific evaluations for a statistically significant sample of ALPs using the Federal requirements as a basis for the evaluation. Such evaluations will be conducted by State personnel. To compliment this effort, a survey protocol for annual unannounced on-site licensure inspections is under development. Upon completion, the survey protocol will be utilized by survey teams across the State to assess each ALP provider’s efforts towards full compliance. To address ALP regulations that may be “silent or partially compliant”, the State will continue its work with internal and external stakeholders within its established workgroup forum revising regulations to more closely align with the final rule.</p>	
SD	<p>Two A & D waivers:</p> <ol style="list-style-type: none"> 1. Assisted Daily Living Services (ADLS)-- A & D wavier for people living in own homes who can self-direct their personal attendant care. 	<p>From the assessment results, SD determined that many SD AL settings already substantially meet the intent of the federal regulation with minor items to remediate over the course of the transition period. Other AL settings will require modifications or</p>	<p>SD has many small, rural communities. Many settings serve as both LTC facility and AL and are the only HCB option in the area. In some areas, the population can't support separate AL and LTC facilities. A wing/percentage of beds in the LTC facility are</p>

State	Current State	Promising Strategies for HCBS Settings Rule Compliance	Gaps/Challenges for HCBS Settings Rule Compliance
	<p>2. Adult Services and Aging (ASA)-- A & D waiver for people living in own homes or least restrictive setting; includes AL --Assisted Living (132 total settings): 53 require heightened scrutiny review; 47 substantially meet federal requirements; 23 will require modifications; 9 unenrolled since 3/12/15 (survey date); 43 of the 132 AL settings are also a NF --AL are varying sizes, some non-profit/some proprietary; some co-located with hospital or NF: http://dss.sd.gov/asa/services/assistedliving/</p>	<p>heightened scrutiny review in accordance with the federal regulation.</p> <p>Process of compliance is:</p> <ol style="list-style-type: none"> 1. educate providers of state and federal expectations (state expectations guide) 2. providers re-assess compliance (provider change policy or practice) 3. state assessment of expectations (on-site review) 	<p>designated as AL beds, or in some cases, individual rooms or suites are designated as AL. SD asserts that they will need to eliminate AL if these settings don't comply, and SD states in their STP they disagree that settings physically sharing a wall with another institution are presumed not to meet the requirements of an HCB setting. SD is conducting additional analysis on settings and anticipates it will support findings that demonstrate HCB nature of the settings.</p>
<p>TN</p>	<p>Assisted Care Living Facilities is a service option under the 1115 CHOICES waiver. Assisted Care Living Facilities are included in the Heightened Scrutiny Review. Based on provider self-assessments, there are 99 Assisted Care Living Facilities. 5 MCO residential settings are 100% compliant. The STP does not specify how many MCO residential settings have submitted a transition plan (84% of all HCBS settings) or declined to submit a transition plan (2% of all HCBS settings) to come into compliance with the final rule.</p>	<p>The state will facilitate focus groups of non-compliant and compliant providers who can talk through provider-specific issues and problem solve how to achieve compliance together. TN is providing 1:1 TA, as needed. TN is working with MCOs for more uniformity in their HCBS settings rule evaluations by developing a standard HCBS settings compliance tool and process for credentialing/re-credentialing providers. TN is requiring MCOs to monitor initial and ongoing compliance with the HCBS settings rule. TN incorporated questions focusing on presumed institutional characteristics into a provider self-assessment (including "the setting is NOT located in a gated/secured 'community' for people with disabilities" and "the setting is NOT designed specifically for people with disabilities"). The assessment also asked about qualities of an institution (including "do individuals have access to food anytime, as appropriate?"). The state will only submit settings for heightened scrutiny if it believes it has the qualities of an HCB setting.</p>	<p>It is unclear in the transition plan how many Assisted Care Living Facilities are out of compliance, the number in which TN believes have the qualities of an HCB setting, and the specific steps Assisted Care Living Facilities will take to come into compliance.</p>
<p>VA</p>	<p>Alzheimer's Assisted Living Waiver (AAL): The AAL Waiver is a HCBS waiver that provides services and supports in an Assisted Living Facility (ALF) rather than a NF. Individuals receiving AAL Waiver services meet the NF LOC, receive an Auxiliary Grant (Virginia's Social Security Income (SSI) Supplement), and reside in an approved ALF that is licensed by the Virginia Department of Social Services (VDSS). All services provided in this waiver take place in the ALF setting including daily supportive services for activity of daily living (ADL) assistance, medication distribution, recreational activities, meal preparation, laundry, transportation and</p>	<p>DMAS staff conducted site specific assessment activities at each of the 12 identified AAL Waiver settings. As of 1/31/16, 54 of 200 available slots for the AAL Waiver were being used. The site-specific assessment included:</p> <ul style="list-style-type: none"> • the completion of an on-site assessment checklist; • forms and policy review; • observations of services, interactions and activities; • interviews with individuals and staff; and, • DMAS staff attempted to contact by phone family members/emergency contact representative for each 	<p>Based on systemic assessment findings, DMAS found that the AAL Waiver requirement that individuals enrolled in the waiver receive services in a "safe, secure environment" within the ALF has emerged as a compliance issue.</p>

State	Current State	Promising Strategies for HCBS Settings Rule Compliance	Gaps/Challenges for HCBS Settings Rule Compliance
	<p>coordination of medical services. There is no waiting list for this program.</p> <p>Services Impacted by the HCBS Setting Requirements (All): Assisted Living.</p> <p>Based on systemic assessment findings, DMAS has determined that the AAL Waiver’s ALF settings are currently not compliant with the HCBS regulations. The AAL Waiver’s requirement that an individual reside in a secured unit potentially conflicts with the definition of a HCB setting as defined in the CMS regulations. The regulatory requirement that AAL Waiver services be provided exclusively in a setting that is secured may resemble an institutional setting which is fundamentally out of compliance with the HCBS regulations. The systemic assessment in combination with the site-specific assessment findings lend to a determination that the AAL Waiver is not in compliance with the HCBS regulations. DMAS believes changes required to bring each site into compliance with the setting provisions of the HCBS regulations may not be practical or feasible and efforts would likely result in a non-compliance determination by CMS in a heightened scrutiny process.</p>	<p>AAL Waiver participant. Contact was made with the majority of representatives.</p> <p>The AAL Waiver is set to expire June 30, 2018 absent a request for renewal to CMS. It is the intent of DMAS to allow the AAL Waiver to sunset when it comes up for renewal in 2018 and to work with individuals, families, providers and stakeholders on a transition plan. DMAS has convened and held the first meeting with a workgroup as described above inclusive of advocates, stakeholders and other state agencies to review this determination and develop recommendations for serving this population after June 2018. The state's transition plan to discontinue AAL Waiver services in ALF settings is a 13 step plan available on page 15 here.</p>	