State Medicaid Reimbursement Policies and Practices in Assisted Living

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Executive Summary

Assisted living is an important component of the U.S. long-term care system. As state policymakers seek cost-effective alternatives to providing services in nursing homes, assisted living settings provide oversight and access to services that are difficult to schedule for people who live in their own homes. Consumer preferences for options to institutional care and the states' interest in reducing Medicaid expenditure growth rates have created a shift in the supply and utilization of nursing homes over the past several years. This report presents information on state coverage of services in assisted living/residential settings and includes the source of coverage, the number of participating facilities, number of people served, payment rates, and other data.

For this report, information was obtained from two primary sources. Baseline information on state-assisted living reimbursement policies and practices was provided by previous studies sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Policy and Evaluation, and RTI International in 2002, 2004, and 2007. The information was updated through an electronic survey and telephone calls with staff responsible for managing Medicaid services in licensed assisted living/residential care facility settings. Information was also obtained from state Web sites when available. Responses were received from 47 states (including the District of Columbia). Three states—Alabama, Kentucky, and Pennsylvania—do not cover services in residential settings. Information for states that did not respond to the survey was obtained from previous reports and material provided on state Web sites. Data were collected between March and June of 2009.

Major Findings

- Coverage of services in licensed assisted living settings increased compared to previous reports. Participants served through home and community-based services (HCBS) and §1115 waivers and state plan services increased 9.2% between 2007 and 2009 and 43.7% between 2002 and 2009.
- Including state general revenue programs, the number of participants increased 11% between 2007 and 2009 and 44% between 2002 and 2009.
- The number of §1915 (c) and §1115 waiver participants rose 122% between 2002 and 2009.
- Thirty-seven states use §1915 (c) HCBS waivers to cover services in residential settings; 13 states use the Medicaid state plan services (personal care or other state plan service); four include services in residential settings under §1115 demonstration program authority; and six use state general revenues. States may use more than one funding source.
- Tiered rates are the most common method for reimbursing assisted living providers (19 states), and flat rates are used in 17 states.
- Forty states do not include room and board paid by the resident in the assisted living rate.
- Twenty-three states cap the amount that can be charged for room and board.

- Twenty-four states supplement the federal Supplemental Security Income (SSI) payment. Payment standards range from $722 to $1,350 a month.
- Twenty-five states permit family members or third parties to supplement room and board charges.
- Twenty-three states require apartment-style units, 40 states allow units to be shared, and 24 states allow sharing by choice of the residents.
- Screening for mental health needs is performed by case managers and assisted living facility (ALF) staff in nine states, by case managers only in 10 states, and by ALF staff in nine states.
- Mental health services are arranged by ALFs in 16 states and by case managers in 20 states; such services may be provided directly by ALFs in three states.

Medicaid waiver coverage of services in licensed assisted living and residential settings may soon change. The Centers for Medicare & Medicaid Services (CMS) issued an advance notice of proposed rulemaking in June following its earlier issuance of proposed regulations to implement the home and community-based services state plan option under which CMS would set criteria to determine when ALFs can be considered "community settings." The June notice describes a similar approach to residential settings covered under §1915 (c) waivers. The planned changes will "include methods that states may follow to identify financing mechanisms for reducing the size of existing large residences, divesting themselves or helping their providers divest themselves of sizeable properties and assisting providers' transition to small, more individualized settings." The notice further states that "some individuals who receive HCBS in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting."

The process for determining facilities that will be considered community settings could change state contracting practices, especially in states that do not require apartment-style units, and limit which facilities in a state will be able to serve waiver participants.

Background

Assisted living is an important component of the U.S. long-term care system. State policymakers have been seeking cost-effective alternatives to services in nursing homes. Assisted living settings provide oversight and access to services that are difficult to schedule for people who live in their own homes. Consumer preferences for options to institutional care and the states' interest in reducing Medicaid expenditure growth rates have created a shift in the supply and utilization of nursing homes over the past several years.

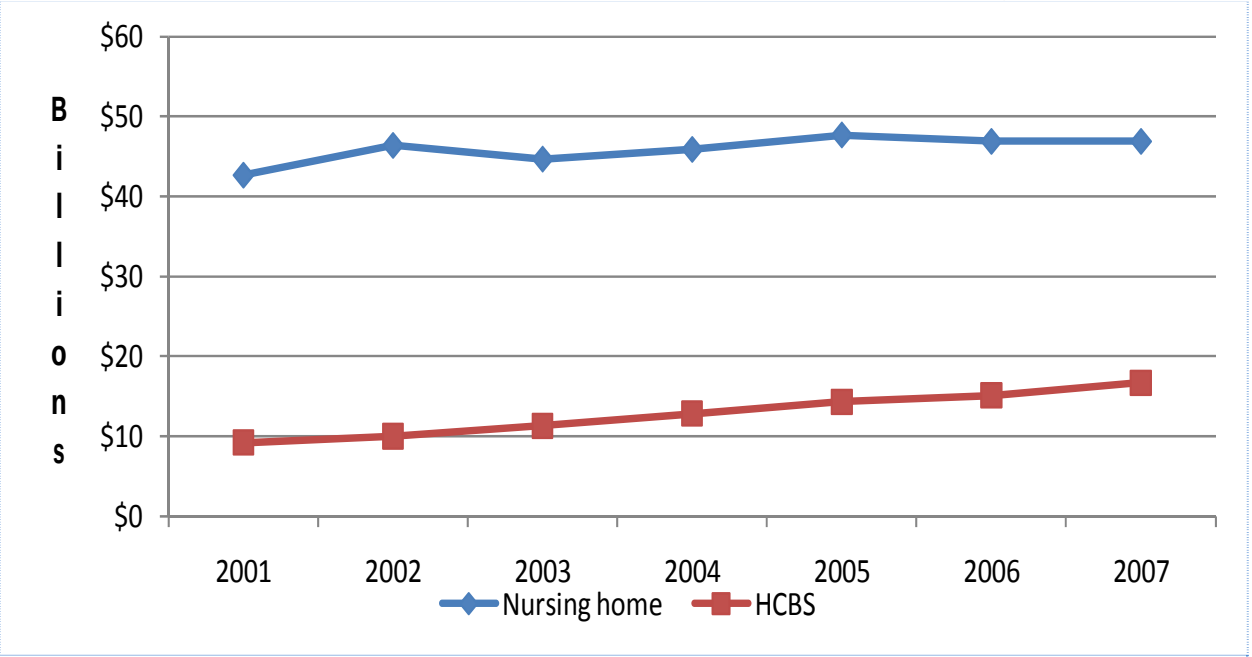
The supply of nursing homes declined 1.6% between 2001 and 2008 nationally. Overall, 16 states experienced an increase in supply and 34 states saw a decline. Supply dropped the most in Wisconsin (17.8%) and Minnesota (15.9%) but increased more than 11% in three states—Delaware, Nevada, and Texas. Although the supply grew in Texas, the occupancy rate in December 2008 was 73.7%. Occupancy rates in Delaware and Nevada were 92.5% and 88.3% respectively.[1] The number of Medicaid beneficiaries served in nursing homes dropped 8.3% nationally. Medicaid occupancy increased in only three states—Delaware (1.6%), Maryland (3%), and Nevada (5.5%).

The gradual trend toward service alternatives is also reflected in the percentage of Medicaid spending for institutional and community services including residential settings. Medicaid spending for nursing home care is considerably greater than spending on personal care and home and community-based services (HCBS) waivers for older adults and adults with physical disabilities. However, spending for personal care and waiver services for these populations rose 81.5% between fiscal year (FY) 2001 and FY2007 while nursing home spending increased 9.8% (figure 1).

Nursing home spending grew from $42.7 billion in FY2001 to $46.9 billion in FY2007. HCBS spending was $9.2 billion in FY2001 and $16.7 billion in FY2007. The figures do not include spending for adult day health care and other state plan services in some states. Although services in residential settings are included in these figures and contribute to spending on HCBS, they are not reported separately.

[1] American Health Care Association (AHCA) based on Online Survey, Certification and Reporting (OSCAR) data.

Figure 1: Nursing home and HCBS spending



Methodology

Information presented in this report was obtained from two primary sources. Baseline information on state-assisted living reimbursement policies and practices was garnered from previous studies by the National Academy for State Health Policy sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Policy and Evaluation, and RTI International in 2002, 2004, and 2007. The information was updated through an electronic survey and telephone calls with staff responsible for managing Medicaid services in licensed assisted living/residential care facility settings. Information was also obtained from state Web sites when available. Responses were received from 47 states (including the District of Columbia). Information for states that did not respond to the survey was obtained from previous reports and material provided on state Web sites. Data were collected between March and June 2009. Surveys were not returned by Mississippi, North Dakota, South Dakota, or Virginia. Alabama and Kentucky do not yet cover services in assisted living. Louisiana and Oklahoma submitted applications to the Centers for Medicare & Medicaid Services (CMS) to cover services under a §1915 (c) waiver and are included in the report. Pennsylvania plans to cover assisted living when regulations creating a new licensing category are promulgated.

The report has four sections: (1) a discussion of the topics reported on the survey; (2) individual state summaries; (3) tabulated state survey responses; and (4) state and national statistics on nursing homes and assisted living facilities.

Section 1: Summary of Survey Findings

Medicaid options for covering services in residential settings

States use three approaches to pay for services in residential care settings under Medicaid: §1915 (c) home and community-based services (HCBS) waivers, the Medicaid personal care state plan option, and §1115 demonstration programs. States most often use the HCBS waiver option. Fewer states use the personal care state plan option. Florida, Maine, Massachusetts, South Carolina, and Vermont use nontraditional state plan coverage, that is, services that are not specifically listed as state plan services under Title XIX.

§1915 (c) waivers

Congress authorized HCBS waivers in 1981 to serve individuals who meet the state's criteria for admission to an institution. HCBS waivers cover services that are not covered by the Medicaid state plan, such as personal care not covered by the state plan (home delivered meals; adult day care; personal emergency response systems; respite care; or environmental accessibility adaptations and other services that are required to prevent, delay, or substitute for admission to an institution).

The waiver authority allows states to limit services to specific counties or regions of a state and to target services to certain groups—strategies that are not normally allowed under Medicaid. State Medicaid agencies must ensure that waiver programs have provisions to ensure the health and welfare of participants. Unlike regular Medicaid state plan services, except for HCBS services under §1915 (i), waiver programs may have waiting lists.

Finally, average expenditures for waiver beneficiaries must be the same or less than they would have been without the waiver (no more than average Medicaid nursing home costs).[2] Medicaid cannot cover room and board in residential settings. Medicaid can cover room and board only in an institution, such as a nursing home, an intermediate care facility for persons with mental retardation (ICFs-MR), or a hospital.

The HCBS waiver application template (version 3.5) allows states to list services in assisted living and other residential settings under "other."[3] The CMS instructions for reviewing waivers define assisted living as follows: "An assisted living facility provides residents personal care and other assistance as needed with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) but does not provide round-the-clock skilled nursing services. Assisted living facilities generally provide less intensive care than nursing facilities and emphasize resident privacy and choice."

[2] States can use either a fixed per capita amount for each beneficiary or average the expenditures across all waiver beneficiaries. Aggregate caps provide more flexibility because they allow some beneficiaries to exceed the nursing facility costs that are offset by lower costs for other participants and the average waiver cost does not exceed the average nursing facility cost. States have the option of setting a cap on waiver services at a percentage of nursing home costs (e.g., 80%).

[3] Available at: https://www.hcbswaivers.net/CMS/faces/portal.jsp.

The waiver application template also requires that states describe the standards that apply such as the services provided and how "a home and community character is maintained in these settings." Standards have to address admission policies, physical environment, sanitation, safety, staff/resident ratios, staff training and supervision, staff supervision, resident rights, medical administration, use of restrictive interventions, incident reporting, and provisions of or arrangement for necessary health services. Criteria for standards that meet "home and community character" are not described. The application must also include a description of the methodology states use to exclude Medicaid payment for room and board costs.

See appendix B for the guidelines related to assisted living that are used by CMS staff to review waiver applications.

HCBS waivers and state plan services differ in several important ways. First, waiver services are available only to beneficiaries who meet the state's nursing home level of care criteria; that is, they would be eligible for Medicaid payments in a nursing home if they applied for admission. Nursing home eligibility is not required for beneficiaries using state plan services.

Second, states may set limits on the number of beneficiaries that can be served through waiver programs. The limits are defined as expenditure caps that are part of the cost neutrality formula required for CMS approval. Waivers are only approved if the state demonstrates that Medicaid expenditures under the waiver will not exceed expenditures that would have been made in the absence of the waiver. States do not receive federal reimbursements for waiver expenditures that exceed the amount stated in the cost neutrality calculation. In contrast, state plan services are an entitlement, meaning that all beneficiaries who meet the eligibility criteria must be served. Federal reimbursement is available for all state plan expenditures without any cap.

Perhaps the most significant difference between the two options is the ability under HCBS waivers to use more generous income eligibility standards. To be eligible for personal care under the state plan, individuals must meet Medicaid's community-based eligibility standards, which (depending on the state) are the Supplemental Security Income (SSI) level of income ($674 per month in 2009), the state SSI supplement payment standard, if any, an amount above the SSI standard up to 100% of the federal poverty level, or the state's medically needy income standard.[4]

For nursing home and HCBS waiver applicants, states may use the special income level, which is an optional eligibility category that allows individuals with income up to 300% of the federal SSI benefit ($2,022 a month in 2009) to be eligible. However, states can only cover this option through HCBS waivers if they also cover it in a nursing home. Offering the higher income eligibility standard in the waiver program levels the playing field between institutional and noninstitutional services. See table 1 for a comparison of the major differences between waiver services and state plan services.

Although the majority of states cover services in residential care settings through Medicaid, the number of Medicaid beneficiaries who receive such services is considerably lower than might be

[4] Except in 209(b) states, which have a Medicaid income or resource eligibility threshold that is lower than the federal SSI payment.

expected because many states limit the number of people served under waivers. States using personal care under the state plan to cover services have higher participation rates than states using the waiver because states cannot cap the number of beneficiaries that receive state plan services (except for §1915 (i) HCBS state plan services if covered; see below).

§1115 demonstration programs

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under §1115 allows states to test new policies for coverage and delivery of services to Medicaid beneficiaries. Projects are approved if a state demonstrates and evaluates a policy or approach that has not been tested on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.[5]

The Secretary may approve federal financial participation for costs that otherwise cannot be matched under §1903. Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be budget neutral over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver. Historically, this authority was used to implement capitated managed care programs.

Table 1: Differences between state plan and waiver services

Factor	State Plan Service	§1915 (c) Waiver Services
Entitlement	States must provide services to all beneficiaries who qualify for Medicaid	States may limit the number of individuals served and restrict services to specific groups (e.g., age 65 or older, persons with mental retardation or other developmental disabilities)
Scope	Must be available in the same amount, scope, and duration to all beneficiaries across the state	May limit amount, scope, and duration to specific geographic areas or beneficiary groups
Duplication	Services provided in accordance with state plan	May not duplicate services available in the state plan; may have different limits, definitions, or providers than state plan services
Service Criteria	Must meet state plan requirements for services	Must meet the state's nursing home level-of-care criteria
Income	Must be SSI eligible or meet the state's community-based income eligibility standard	State may set eligibility up to 300% ($2,022 in 2009) of the monthly federal SSI payment standard ($674) if also used for nursing home eligibility
Approval Period	Continuous unless amended by the appropriate state agency	Initial waivers approved for three years; renewals for five years

[5] http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp.

§1915 (i) HCBS state plan option

The Deficit Reduction Act (DRA) of 2005 created a new HCBS option, §1915 (i), which allows states to provide HCBS through a state plan amendment (SPA) to individuals who are eligible for medical assistance under the state plan and whose income does not exceed 150% of the federal poverty level. This provision does not establish a new eligibility group. Rather, the 150% income limit is an eligibility requirement that must be met in addition to meeting the requirements of the eligibility groups covered under the state plan.

The DRA allows states to cover services that are specifically listed in §1915 (c): case management, homemaker, personal care, adult day health, habilitation, respite care, and day treatment. The DRA statute does not include language that allows states to cover "other services approved by the Secretary, which is permitted under §1915 (c)."

At the time of this report, no state covered personal care in residential settings using this option.

Coverage

States cover services in assisted living settings through §1915 (c) HCBS waivers, the Medicaid state plan, §1115 demonstration program waivers, and state general revenue programs. HCBS waivers may cover assisted living services among a broad menu of service options or waivers that only cover assisted living services.

Thirty-seven states use §1915 (c) waivers, the most common source of coverage (see table 2 and the appendix). A §1915 (c) HCBS waiver was approved by CMS in Missouri but has not been implemented due to budget and revenue constraints. Michigan submitted an amendment to its MIChoice waiver to cover services in two licensed residential settings—adult foster care and homes for the aged. Waiver amendments are pending for Louisiana and Oklahoma, and waivers are planned in North Carolina and Pennsylvania. Maine is exploring options for shifting coverage from private nonmedical institutions, which are licensed as residential care facilities. Maine currently covers services in these settings under the rehabilitation services option.

Personal care is the most common state plan option used. However, three states (Florida, South Carolina, and Vermont) cover services in residential settings as assistive community care, assistive care, and integrated personal care. Massachusetts lists group adult foster care as a service under its state plan.

Three states—Arizona, Hawaii, and Vermont—cover services under §1115 waiver programs, and Rhode Island expects to shift coverage to its §1115 waiver by the end of 2009.

Nine states cover services using more than one source of funding. For example, six states (Arkansas, Idaho, Florida, South Dakota, Vermont, and Washington) cover services through §1915 waivers and the state plan personal care option, and three states (Connecticut, Iowa, and Maryland) use §1915 (c) waivers and state general revenues.

Six states (Connecticut, Iowa, Maryland, North Dakota, Virginia, and West Virginia) reported that they use state general revenues to support services in residential settings without federal assistance.

Table 2: Sources of coverage reported by responding states

§1915 (c)		Medicaid state plan	§1115	State revenues
Assisted living only	Broad waiver			
13	24	13	4	6

Participation rates

Despite state budget reductions, states reported serving 134,345 people in ALFs through Medicaid and state general revenue programs in 2009. The number of Medicaid participants grew 43% between 2002 and 2009 and 9% between 2007 and 2009. When state general revenue programs are included, participation rose 44% between 2002 and 2009 and 11% over 2007 (see table 3). Notable growth in the number of participants occurred in HCBS waiver programs in Arizona, California, Idaho, Illinois, and Minnesota compared to 2007. The number of waiver participants (§1915 (c) and §1115) rose 122% between 2002 and 2009—from 33,750 to 74,970. The number of beneficiaries served under Medicaid state plan options was slightly lower in 2009 (56,238) than in 2002 (57,521). Participation peaked at 71,117 in 2004 but dropped to slightly below 56,000 in 2007. Three states (Michigan, Missouri, and North Carolina) accounted for the decline. The reasons for the decline were not available.

HCBS waivers limit the number of participants that can be served based on funding and the cost neutrality formula. States specify the maximum number of unduplicated participants that may be served in each waiver year. States may also reserve slots for specific purposes, such as ensuring that HCBS are available for individuals who transition from an institution or serving individuals experiencing a crisis subject to CMS review and approval.

The number of facilities that served Medicaid participants rose 27% between 2002 and 2009 and 16% between 2007 and 2009. Significant growth was reported in Alaska, Florida, Georgia, Illinois, and New Jersey. Participation by program authority (waiver or state plan) changes over time. Seventy-six percent of all participating facilities received payments from §1915 (c) or §1115 programs, up from 40% in 2002. Between 2002 and 2009, the percentage of participating facilities receiving payments for Medicaid state plan services dropped from 58% to 23%.

State respondents offered a range of comments on the factors that affect participation rates. Arkansas revised its policies to make it easier for facilities and applicants to enroll in the program. Growth occurred over time as more facilities participated in more geographic areas. The state views ALFs as a viable alternative to nursing home placement. Officials in Arizona suggested that participation increased because consumers prefer ALFs to nursing homes, especially those who cannot live safely in their own home alone, and because there is a lack of affordable housing. Respondents in Idaho offered a similar observation. The HCBS waiver allows applicants/participants to choose where they want to live.

Table 3: Participation in Medicaid and state general revenue programs

Measure	2009	2007[6]	2004	2002
Facilities				
—Medicaid	11,456	9,878	10,374	9,048
—State general revenue	62	50	325	247
—Total facilities	11,518	9,928	10,699	9,295
Participants				
—Medicaid	131,208	120,159	119,290	91,271
—State general revenue	3,317	1,003	2,678	2,108
—Total participants	134,525	121,162	121,968	93,379
Number of states	41	39	40	34

In California, the declining economy and decrease in private pay residents, especially in Los Angeles County, led to a surge in applications to be waiver providers. Consequently, waiver enrollment increased significantly in 2008. However, the state agency is not able to enroll additional providers due to declining state revenues.

Reimbursement rates for assisted living in Colorado increased more than the rates for other HCBS services in Colorado. However, staff at the Arizona Health Care Association indicated that rates may be reduced 2% in FY2009–10 because of lower state revenues.

The state respondent attributed Florida's program growth to its aging retiree population, many of whom do not have family members to provide support. The need for assistance and the preference to live as independently as possible make ALFs an attractive option for those who require limited assistance.

State officials in Indiana noted that an improved rate structure and better marketing and provider recruitment helped the program expand.

Several factors contributed to the steady increase in the assisted living waiver program in Illinois, including demand for services in residential settings, partnerships with other state agencies, and an emphasis on quality care. Just like other programs for the elderly, the demand for affordable assisted living continues to climb. The Department of Healthcare and Family Services also has good working relationships with other state agencies involved in serving older adults and persons with physical disabilities, including the Department on Aging, the Long Term Care Ombudsman, Department of Human Services, and the Illinois Housing Development Authority. These agencies and their contractors help promote the program by informing potential residents and their families of the services available in supportive living facilities.

Additionally, the Department emphasizes the quality of care required in supportive living facilities, and confers credibility on the program, its providers, and services. Quality is measured and monitored through a quality management plan. Patterns of poor quality can be identified by

[6] Based on data gathered for this report, the total number of facilities and participants for 2007 for Hawaii and Minnesota were revised from the figures that were reported in the Residential Care and Assisted Living Compendium: 2007.

region, specific provider group, or throughout the state. Findings are used to design provider training, clarify policy, or prepare written resources/tools to assist providers. Providers and Department staff receive biannual training, which is developed and sponsored by the Department and two provider associations.

Maryland respondents cited several factors for the growth of the program: the declining health status of older adults; an increase in beneficiaries who are transitioning from nursing homes and are in need of a source of housing; and the lack of family members to provide oversight and support.

Client spenddown to Medicaid was noted as a factor in Minnesota. Respondents said that clients need more counseling about available services that they could receive in their home before they move and lose their home. Decision-makers (case managers, family members, and other community organizations) need more education on what is available when a client needs long-term care services.

Enrollment increased in Ohio when state law was changed to allow current residents, previously excluded from the program, to enroll in the waiver. Factors that limit participation are the low personal needs allowance ($60 a month); copayments for prescription drugs under Part D; provider capacity; and a perception among individuals living in the community that ALFs are institutional. The state does not plan to expand the number of waiver slots, increase rates, or expand eligibility because of declining state revenues.

Rate methodology and payments

Payment methodologies can be grouped into five primary categories: flat, tiered, case mix, care plan, and negotiated. The groups are not mutually exclusive and the numbers in table 4 reflect that some states use one rate methodology for HCBS waiver payments and another for state personal care payments. See the state summaries for the actual rates.

A few states use combined approaches. Minnesota caps rates by case mix level, and the rate paid for a specific individual is negotiated based on the care plan developed from an assessment completed by a case manager. One state (Tennessee) sets rates based on each residence's usual and customary charge, but the amount is capped at $1,100 a month.

Arizona's Long-Term Care System (ALTCS) also combines approaches. The methodology established three rate levels based on resident needs, and the ALTCS program contractors and ALFs negotiate the actual payments within the tiers. The rate levels vary by type of setting: assisted living homes that serve 10 or fewer residents and assisted living centers that serve 11 or more residents.

Three states vary the rate by the area of the state. Hawaii sets one rate for Oahu and another rate for the neighbor islands. Illinois uses regional variations based on the average nursing home rate, and Washington uses rate schedules for King County, other metropolitan counties, and nonmetropolitan counties. Nebraska sets different rates for ALFs in rural and urban settings.

Flat rates

Flat rates pay providers the same amount per day without adjustments for variations in the amount of service and staff assistance required by each resident. Under a flat rate system, ALFs have an incentive to admit residents with lighter care needs and discharge residents when their needs exceed the payment amount. ALFs may also set their internal admission and retention policy to balance acuity so that the rate meets the needs of an average resident. Seventeen states use flat rate reimbursements. Rates range from $35.04 a day in Georgia to $69.75 in Utah. Florida's combined rate for waiver services ($32.20 a day) and assistive care services ($9.28 a day) totals $41.48 a day. The District of Columbia makes a flat monthly payment of $1,159 or $1,269 (depending on the size of the facility), and New Hampshire pays facilities $1,506 a month for services.

Flat rates may vary depending on the type of residential care setting. Texas pays a higher rate for apartment and other private occupancy settings, reflecting the state's preference for these settings.

New Jersey licenses assisted living services that are provided in a range of settings. The state developed rates for each setting. Newly constructed assisted living residences (ALRs) receive $70 a day to cover waiver services, and comprehensive personal care homes receive $60 a day. Assisted living programs (services provided in subsidized housing) receive $50 a day.

Varying rates by setting may reflect differences in the average level of resident service needs in each setting. For example, a state may reimburse for services in both traditional elderly housing buildings and purpose-built ALFs. Generally, tenants in elderly housing sites are less impaired than those in purpose-built ALFs. Unlike purpose-built ALFs, elderly housing sites typically do not have 24-hour staffing or the capacity to meet the unscheduled needs of tenants. Therefore, elderly housing facilities receive a lower rate than purpose-built ALFs with 24-hour staffing.

Rates in Illinois vary region of the state. Set as a percentage of the average nursing home rate, the daily rates range from $55.99 to $72.10 a day.

Tiered rates

Tiered rates pay providers based on the needs of individuals. These systems typically use three to five payment levels based on the type, number, and severity of ADL limitations and/or cognitive or behavioral impairments. Tiered rates create incentives for providers to serve residents with higher service needs. Nineteen states developed tiered rates to reimburse providers. Payment rates range from $20 to $60 a day in Nevada and from $90 to $103.67 a day in Vermont for services in ALRs. Vermont's payment combines services paid under the Medicaid state plan and the Choices for Care §1115 waiver.

Oregon, one of the first states to use the tiered approach, has five payment levels based on the type and degree of residents' impairments. ADLs assessed include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control, and behavior. The state limits the room and board payment for Medicaid beneficiaries to $523.70, and the

beneficiary retains a personal needs allowance of $141 a month. The service rate ranges from $1,002 to $2,355 a month.

Ohio developed three tiers and assigns participants to a tier based on four areas of need (cognitive impairments, physical impairments, nursing, and medication management) and the amount and type of service(s) the assisted living provider is responsible for delivering to the consumer. The areas of need are described below:

- The cognitive impairment category tier assignment is based on the frequency of intervention required to ensure the consumer's health and safety needs are met.
- The physical impairment category tier assignment is based on the amount of time required to assist the consumer with ADLs/IADLS as a result of a physical limitation(s).
- The nursing category tier assignment is based on the frequency of individualized, hands-on nursing care provided by the facility.
- The medication management category tier assignment is based on the type of intervention required by the consumer and provided by the facility.

Payments range from $49.98 to $69.98 a day. Ohio contracted with a consulting agency in 2008 to evaluate its rate methodologies for all waiver services including assisted living. The report concluded that the current acuity-based rate system could be improved by refining the description of the tiers and considering setting regional rates to reflect differences in direct care costs.

Arkansas uses four tiers that are based on a person's level of care and the amount of assistance needed. The tiers vary based on cumulative scores for specific tasks.

Montana elected to use a tiered system because a flat rate did not seem appropriate considering the range in level of care needs and variations in the level of services provided in facilities. Rates were set based on a comparison of equivalent in-home service utilization.

Montana's payment system has elements of a tiered system but without structure and number of payment levels of tiered approaches. Rates are based on a care plan that includes two components. Facilities receive a basic service payment of $717 a month, which covers meal service, homemaking, socialization and recreation, emergency response system, medical transportation, and 24-hour availability of staff for safety and supervision. Additional payments are calculated based on ADL and other impairments. Points are calculated for each impairment—bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, cognitive functioning, and other. Each function is rated as follows:

- with aids/difficulty: needs consistent availability of mechanical assistance or expenditure of undue effort;
- with help: requires consistent human assistance to complete the activity, but the individual participates actively in the completion of the activity; or
- unable: the individual cannot meaningfully contribute to the completion of the task.

Each point equals $34 a month. For example, a resident consistently needing help with toileting would be scored a two and would earn $68 a month for that impairment. The maximum payment is $65.05 per day in 2009.

Oklahoma did extensive research to develop a three-tiered rate structure services based on the type, the intensity and frequency of assistance with ADLs/IADLs, and health care needs. The levels and rates were established using information from multiple data sources: historical data from service plans and claims data for waiver participants and data from operating costs that were obtained from providers.

Utilization of personal care, advance supportive/restorative assistance, skilled nursing, and meal preparation were analyzed for a sample of waiver participants. Units of informal personal care activities recorded on the service plan were included in the analysis and were limited to a maximum of 4.5 hours per day. Units of informal care were allocated to an equivalent cost per waiver unit of personal care. Informal care was included in the analysis to recognize the role of of informal caregivers in providing care needed by participants.

The total cost of services that would be provided by an ALF was analyzed in relation to 23 assessment tool variables, primarily ADL and IADL scores, using step-wise regression analysis. Five variables predicted service use: assistance with dressing, mobility, medications, housekeeping, and meal preparation.

The sample group was ranked by total score of the five variables and the total per diem cost of authorized services. The total cost was adjusted to 90% of total authorized cost based historical ratio of authorized to delivered units of service. The sample was divided into three groups. Within each of these groupings, the average cost of services was used to set the per diem rate for each group.

The resulting rates are shown below:

Daily payment rate		
Total score	**Group**	**Daily rate**
0–6	A	$42.24
7–10	B	$57.00
11–15	C	$79.73

The methodology was used to set initial rates. Rates will be indexed to the current rate for Medicaid state plan personal care services. Modifications are determined for three rate levels:

- the lowest level is adjusted by 11.636;
- the midlevel per diem rate is adjusted by 15.702; and
- the highest level per diem rate is adjusted by 21.964.

Case mix rates

Several states have adopted payment systems based on their nursing home case mix methodology. Like tiered rate approaches, case mix approaches create incentives to serve more

impaired residents by linking reimbursement to the level of care needed. Case mix approaches typically have more categories than tiered rates. The case mix approach requires the collection of extensive functional and health data for residents.

Both tiered rates and case-mix rates are subject to "category creep" or "gaming," a tendency for facilities to interpret assessment data to support payment of the next higher rate or to request an adjustment because the resident has become more impaired and requires more staff support than upon admission. To address such gaming, states can use an assessment by an independent case management agency to determine the original payment level. Subsequent requests to adjust the payment level can be reviewed by either a case management agency or the state agency before being approved. Five states use case mix rates.

Over time, Washington has expanded from three to five tiers and currently uses a rate structure with 17 payment levels for services provided in residential care settings. Rates for licensed Boarding Homes are based on the CARE (Comprehensive Assessment Reporting Evaluation) classification levels, geographic areas, benchmarked costs, and cost of living increases approved by the legislature. The rates consist of daily wages (daily hours times hourly wage) plus a percentage for payroll taxes and fringe benefits plus daily rent plus daily expenses. The components of the rate are described below:

- *Daily hours:* In 2001 and 2002, the department conducted a time study to determine how much time is required to care for an individual at each of the classification levels.
- *Hourly wage:* The department collected wage data (2007) from the Employment Security Department's Occupational Employment statistics. Using the wage data and the time it took to care for individuals at the classification levels identified by CARE, the department developed the cost of care for each classification level.
- *Daily expenses/payroll taxes and fringe benefits based on 2007 nursing home cost reports:* The department selected benchmarks for fringe benefits, payroll taxes, and other administrative expenses (e.g., insurance, direct care supplies, office equipment, licenses).
- *Rent:* To determine a capital cost, the department uses the Marshall Valuation Service and the U.S. Treasury bond constant maturity average rate. The Marshall Valuation Service is basis for determining price-per-square-foot construction costs, i.e., the total value of the property. The interest rate represents an annual yield of U.S. Treasury 30-year maturity bonds as of a specific date. The interest rate is applied to the total value of property to determine the imputed annual rent.

Washington's rates range from $69.22 to $169.47 a day in King County. Rates are lower in other counties.

North Carolina covers personal care in adult care homes as a Medicaid state plan service and uses a payment system that has elements of a case mix system. The payment includes a flat rate for basic personal care with add-ons for residents with specific ADL impairments. Residents with extensive or total impairments in eating, toileting, or both eating and toileting qualify for a higher rate. In 2009, the basic payment is $17.50 for facilities with 30 or fewer beds and $19.17 for facilities with more than 30 beds. The additional daily rate for residents with extensive or

total impairments in eating is $10.80 and in toileting is $3.86. Additional payment for residents needing assistance with ambulation/locomotion is $2.76 a day. Eligibility for the additional payment is based on an assessment by the adult care home, which is verified by a county case manager.

Fee-for-service rates

Fee-for-service rates are determined by the number of units of service identified in a care plan or a point system based on an assessment. For example, Kansas treats ALFs as providers of home care services and reimburses for the services delivered. This approach may be cumbersome for some facilities to implement because they are used to receiving a regular monthly payment and providing resident services based on a plan of care. If services are reimbursed on a fee-for-service basis, facilities must track service delivery and prepare and submit bills to the payment agency.

Service delivery in ALFs also differs significantly from in-home service programs. Services for home care program participants are typically authorized in blocks (e.g., two hours of care, five days a week). Assisted living residents typically receive services in 15-minute increments at various times seven days a week including nights. Home care programs typically do not cover services at night and, of course, cannot meet unscheduled needs.

Tracking, aggregating service unit increments, and billing can become cumbersome and time consuming, especially for facilities used to charging a single, all-inclusive service fee. However, the pricing structure of many facilities includes a basic package of services with additional charges based on the increments of service used by residents. Facilities with such a policy for private-pay residents may be better able to participate in Medicaid programs that reimburse using a fee-for-service approach.

Six states use fee-for-service rates. Examples are described below.

Arkansas allows personal care services to be provided through the state plan in a person's home "or other setting" such as a residential care facility (RCF). RCFs are paid for up to 64 hours of personal care per month at a rate of $13.84 an hour.

In Missouri, personal care and advanced personal care services are reimbursed as a Medicaid state plan service in residential care facilities. Facilities receive a unit rate (15 minutes) for services that are authorized in the care plan. The unit rate is $4.10 for personal care aides, $4.61 for advanced personal care aide services, and $31.07 for nursing visits. The maximum payment is $2,646 a month, which is equal to the state's Medicaid cost for nursing home care. No more than one nursing visit a week can be authorized. Very few residents receive advanced personal care and nursing visits.

Missouri limits the room and board rate for Medicaid beneficiaries to the federal SSI payment plus the state supplement or "a supplemental nursing care grant" that varies depending on the type of facility. The amount of the grant is based on the difference between the facility's rate and the resident's income. In RCFs, the maximum grant is $156 a month for a total of $830 a month.

The maximum grant in ALFs is $292 a month for a total payment of $966. The personal needs allowance is $30 a month.

The figures in table 4 reflect the use of different rates used in states with multiple sources of coverage and rates with components of more than one methodology.

Table 4: State rate methodologies

Flat	Tiered	Case mix	Care plan	Negotiated
17	19	4	6	3*

* New Mexico will shift to negotiated rates under a new managed long-term care program.

Rate changes

The current fiscal climate affects rates paid to assisted living providers. Indiana expected to reduce rates by 5% in July 2009. Rates have not been increased since 2003 in Nevada, 2006 in Ohio, and 2007 in Connecticut. An increase was proposed in California but was not adopted. Montana staff said an increase is not likely this year. Utah reduced rates about $3 a day in May 2009.

In other states, rates are adjusted regularly. For example, Arkansas proposed a 3% increase. The Arizona Medicaid agency, AHCCCS, in some years has contract language that directs its managed care organizations to pass on the inflationary amount assumed for HCBS in the capitation rate adjustment. Arizona indicated that a 4.6% increase was assumed in 2009; however, according to the Arizona Health Care Association, rates may decrease by 5% in 2010. Rates are negotiated between managed care contractors and providers. Illinois links its rates to 60% of the average regional nursing home rate, which is adjusted every two years.

Idaho's statute ties payment for state plan personal care services to the prevailing hourly wage for similar nursing facility staff. The rates include a 55% supplement for travel, administration, training, and all payroll taxes and fringe benefits. Annual adjustments are typical in Missouri and Nebraska, whereas other states increase rates when funding is approved by the legislature.

Room and board policies

Federal regulations do not allow Medicaid reimbursement for room and board except in an institution and for respite care that is furnished in a state-approved facility. 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.

States consider several factors when dealing with room and board charges. Some policymakers contend that room and board should be capped to make these expenses affordable for SSI beneficiaries and to treat SSI beneficiaries and Medicaid beneficiaries with higher income

equally. Other policymakers believe that they should not set limits on room and board charges because Medicaid does not pay for room and board and, therefore, has no role in setting charges.

State policies on room and board charges vary considerably. 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 paid by the resident. Only five states—Arizona, Nebraska, New Hampshire, Rhode Island, and Washington—reported that they include room and board in the Medicaid rate.

Twenty-three states limit the amount that facilities can charge Medicaid beneficiaries for room and board. These states usually limit room and board to the state's SSI payment plus a state supplement, if any, and minus a personal needs allowance. This ensures that beneficiaries can pay for room and board in facilities that accept Medicaid. If the room and board payment is too low, providers will not admit Medicaid beneficiaries or retain private pay residents who exhaust their income and resources and qualify for Medicaid. The SSI payment is often well below the cost of room and board.

Seventeen states do not cap charges for room and board. This allows facilities to charge higher amounts to residents who qualify financially under the special income level (300% of the federal SSI payment) depending on the amount of income that participants may retain as a "maintenance allowance." The maintenance allowance is the amount participants keep in order to maintain their home or residence.

Only New Jersey has a statute that requires that facilities licensed after the effective date of the statute (September 2001) set aside a percentage of units for Medicaid residents within three years of licensing.

Arizona residents pay a share of cost that is their spend-down amount or 85% of the SSI benefit, whichever is greater. They never pay more than the per diem rate.

Montana ties room and board charges to the "medically needy" income standard, which is $645 a month. Oklahoma caps charges at 90% of the federal SSI payment.

Nearly all states allow residents to retain an allowance for personal needs. The personal needs allowance (PNA) varies from $25 to $178 a month. Income above the PNA and the room and board charges may be applied to the cost of waiver services. Introduction of the Medicare Part D prescription drug program in 2006 increased the burden on the PNA allowance for ALF residents who are dually eligible for Medicare and Medicaid. Part D shifted coverage of Medicaid prescription drug coverage to the new federal drug program. Under the Part D statute, dual eligibles living in nursing homes and other institutional settings have no cost sharing, but those receiving services in HCBS settings, including ALRs, must pay co-payments. Like nursing home residents, residents of ALFs use an average of eight to 10 prescription drugs a day. In 2009, Part D co-payments for dual eligibles range from $1.10 to $6.00, depending on income level and whether a medication is generic. The co-payments leave residents with little income for other personal needs. Legislation has been introduced in the U.S. House and Senate that would eliminate co-payments for dual eligibles in HCBS settings (S. 534, H.R. 1407).

SSI state supplements

To increase access for SSI beneficiaries in areas with high development costs, states can create a special SSI state supplement for people in residential care facilities and they can limit what providers may charge to the amount of the federal payment plus the state supplement. Twenty-four states reported that they supplement the federal SSI payment ($674 a month in 2009) in assisted living settings. SSI state supplement payment standards (including the federal payment) vary from $722 and $735 a month in Vermont and New Hampshire, respectively, to $1,275 a month in Hawaii and $1,350 in one area of Virginia.[7] A few states (e.g., Massachusetts, New York, Missouri) established supplemental payments specifically for SSI recipients in residential care settings to help pay for room and board and some services. These states typically set their payment standard before they were able to provide state plan personal care services in "other settings" in addition to a person's actual "home." Michigan and Missouri pay different amounts based on the licensing category. Virginia established different payment standards based on the region of the state.

The amount of the supplement is included in the state summaries. Some states use a specific term to refer to their supplement, and some use the term SSI to refer to both the federal payment and any state supplement. Others refer to the payment standard as an "optional state supplement."

Family supplementation

Residents, especially those who receive SSI, may not have enough income to cover the room and board costs or to cover the cost of a private unit. Family members may be able and willing to help with room and board costs when the beneficiary is unable to pay them. States set their own rules governing family supplementation.

Twenty-five states reported that they allow family supplementation, 14 states do not allow supplementation, and the remaining states either do not have a policy or did not respond (see table 5).

Table 5: Supplementation policy

	Number of states
Allow supplementation	25
Do not allow supplementation	14

Because Medicaid does not pay for room and board in residential care settings, rules regarding supplementation in nursing facilities do not apply (i.e., families of nursing home residents may not supplement any service or item that is covered by the Medicaid payment). Several states indicated that they permit supplementation to enable beneficiaries to upgrade to a better unit.

Payments that supplement the resident's income are considered in determining financial eligibility for SSI and Medicaid. Federal SSI regulations define how unearned income is treated.

[7] See http://www.ssa.gov/policy/docs/progdesc/ssi_st_asst/2008/ for information about state supplements for each state.

Family contributions made directly to an SSI beneficiary are counted as unearned income that reduces the federal SSI payment and, depending on the amount of the benefit, could result in a previously SSI-eligible applicant losing SSI and Medicaid.

Contributions paid directly to an ALF on behalf of the beneficiary are treated as in-kind payments and lower the monthly SSI payment dollar for dollar, after excluding the first $20 of income per month but not more by one-third of the federal payment.

Family supplementation also affects Medicaid financial eligibility. Because Medicaid income and resource rules follow SSI rules, payment to a residential care setting would be considered in-kind income to the beneficiary. If the individual still receives SSI and, therefore, remains a Medicaid beneficiary, there is no impact.[8] Beneficiaries who are eligible through the poverty-level eligibility category, medically needy spend-down, or the special income level category (300% of SSI) might be affected if the supplementation raises their income above the income thresholds.

Under §1902 (r)(2), states can exempt income or resources. This authority permits a state to exempt income that is needed to pay for room and board in ALFs.

Services

Services covered by the rate in each state are summarized in table 17. The labels represent common components of the services covered by state payments. States cover a range of services in assisted living settings. Services are listed individually or bundled. Personal care/attendant care is included in the rates by all states that cover services in residential settings. Assistance with medications is provided by 32 states. The level of assistance varies from administration of medications to assisting and reminding residents with self-administration. Twenty-nine states cover tasks that are described as housekeeping, laundry, or homemaker services, and 23 states include social and recreational activities. Eighteen of the responding states provide coverage for nursing services, and oversight/24 hour supervision and transportation were reported by 17 states. Other services were less frequently listed. Examples of the states' services covered in ALFs follow.

In Colorado, alternative care services are provided in ALFs. State regulations define alternative care services as a package of personal care and homemaker services provided in a state-certified alternative care facility. Such services include assistance with bathing; skin, hair, nail and mouth care; shaving; dressing; feeding; ambulation; transfers and positioning; bladder and bowel care; medication reminding/administration; housekeeping; meal preparation; 24-hour protective oversight; personal care; and homemaker, chore, and laundry services.

Florida's Assisted Living for the Elderly (ALE) waiver describes assisted living as:

> "...personal care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet resident needs and to provide supervision, safety, and security.

[8] Payments in 209 (b) states might affect Medicaid eligibility because it is not linked to SSI eligibility.

> Assisted Living is a service that is comprised of an array of components provided by or through the assisted living facility in which the beneficiary resides. These components will be provided only when the beneficiary is not capable of performing them."

The ALE waiver lists several components that may be included in the assisted living service: attendant call system, attendant care, behavior management, chore services, companion services, homemaker services, intermittent nursing, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services.

Services may overlap in some programs. Indiana's waiver covers assisted living service, defined as personal care, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under state law), and therapeutic social and recreational programming. Attendant care and personal care are similar services. Attendant care services primarily involve hands-on assistance for aging adults and persons with disabilities. These services are provided in order to allow older adults or persons with disabilities to remain in their own homes and to carry out functions of daily living, self-care, and mobility. Personal care is defined as assistance with eating, bathing, dressing, personal hygiene, and ADLs (460 IAC 8-1-2; 27), and attendant care means hands-on care of both a supportive and health-related nature, specific to the needs of a medically stable, functionally disabled individual (460 IAC 8-1-2; 7).

Unit requirements

The survey asked about the state's requirements for living units. Unit requirements are set by regulations by licensing agencies. The survey, however, was completed by state Medicaid staff or staff in other agencies that are not responsible for licensing; therefore, there may be differences between Medicaid and licensing requirements with regard to unit requirements. Twenty-three states responded that Medicaid requires apartment-style units, and 20 states indicated that apartment-style units were not required. The units may be shared only by choice of the residents in 24 states. The implications of the reported unit requirements and emerging federal regulations are discussed later in this report.

Table 6: Unit requirements

Option	Number of states
Apartment-style unit required	23
Allow shared units	40
Shared only by choice of residents	24

Responsibility for furnishing the unit may be determined by state policy or by facilities' practices. Sixteen states indicated that units are furnished by the facility, 10 states said the resident/family is responsible for furnishing the unit, and either or both the facility and the resident/family furnishes the unit in seven states.

Table 7: Furnishing the unit

Responsible for furnishing	Number of states
Provider	16
Resident/family	10
Provider/resident	7
Not addressed	9

Mental health screening

A growing number of residents with mental illness live in residential settings. The survey asked two questions about provisions for residents with mental illness. The first asked whether applicants were screened for mental illness by facility staff or case managers to determine the appropriateness of placement. Licensing rules typically require that facilities only admit residents whose needs can be met in the facility. This determination is based on a resident assessment and the ability to meet identified needs with trained staff or outside services. Eighteen states indicated that residents are screened by facilities, and 19 said that screening is not required. Case managers screen participants for mental health needs in 20 states. Nine states indicated that both a case manager and the facility staff complete the screening. (See table 8.)

Table 8: Screening for mental illness

Responsible for screening	Yes	No
	Number of states	Number of states
Case manager	20	19
Facility staff	18	19

In Kansas, case managers complete a brief mental health screen as part of their assessment process and if the customer scores over a 13, then they would recommend a referral for mental health services. ALFs are also responsible for arranging services from an outside provider.

The North Carolina legislature included an amendment in the 2007 appropriations that directed the Department of Health and Human Services to complete a Medicaid screening tool to determine the mental health needs of individuals admitted to adult care homes. However, the process has not been implemented due to continuing budget restrictions.

State licensing regulations may include specific requirements for facilities that serve individuals with mental health needs. Regulations usually require that facilities admit and retain residents whose needs can be met by the facility either directly or by an outside agency. Facilities need to assess prospective residents to understand their needs and to determine whether they have the staff and training to meet them. (Licensing agencies were not surveyed for this project.)

Missouri reported that residents referred by the Department of Mental Health (DMH) must have an individual treatment plan or individual habilitation plan prepared by DMH. Facilities that admit or retain residents who have mental illness or exhibit assaultive or disruptive behavior

must provide treatment and services either directly or through arrangements with outside agencies to address residents' needs and behavior as outlined in the individual service plan.

The second survey question regarding mental health services was, "Who is responsible for providing or arranging mental health services to residents with a mental illness?" Three states indicated that the assisted living provider was responsible for *providing* mental health services, 17 states said facility staff are responsible for arranging services from an outside provider, and 19 states said the case manager was responsible for arranging services. (See table 9.)

Washington reported that mental health screening is not used to determine the appropriateness of placement, but case managers use the information gathered by the automated assessment to arrange needed services.

In Arizona, some ALFs have staff that provide behavior management services. These ALFs may contract with a psychiatrist or psychologist for consultation/care plan development purposes. Iowa does not require screening for mental health needs to determine appropriateness of the placement and although state policy does not specify who is responsible for arranging for mental health services, they are provided though a behavioral health managed care program.

Table 9: Arranging mental health services

Responsibility for services	Number of states
ALF provides mental health services	3
ALF arranges services	16
HCBS case manager arranges	20
Not addressed	10

Discussion

Despite difficult budget times, states continue to support coverage of services in assisted living settings for low-income populations. All but two states—Alabama and Kentucky—cover, or plan to cover, services in ALFs. Section 1915 (c) waivers are the most common source of funding for services. The number of residents served grew 122% since 2002 and 11% between 2007 and 2009. Future participation levels may depend on the adequacy of payment for services and room and board and emerging federal policy on the definition of a community setting.

It is difficult to compare rates across state because of variations in the services covered, the rate methodology, level of care variations required for HCBS waiver enrollment and room and board payments. For the most part, rates were not reduced in 2009 due to state fiscal constraints. Only a few states indicated that the budget climate had an impact on coverage in ALFs and a handful of states reported that rates had or will be reduced. A few states reported that they plan to provide a modest rate increase. However, the data were obtained before states passed their budget for FY 2010. Rates may be affected as the economic recession continues to reduce state revenues.

States that view assisted living as a cost-effective alternative to nursing homes are likely to continue offering this option. Because waiver expenditures are small relative to other spending, policymakers may spare them from budget reductions. Assisted living is an option for low-income individuals who may be able to move out of nursing homes because assisted living provides access to housing and services that are available to meet unscheduled needs.

On the federal level, two dynamics affect coverage of services in assisted living settings for Medicaid beneficiaries. First, through a series of grant programs, CMS continues to support offering nursing home residents the option to move to a community setting. CMS awarded nursing home transition grants to 11 states and five centers for independent living (CILs) in 2001 and to 12 states and five CILs in 2002 to support the relocation of nursing home residents to community settings, including assisted living. The grants helped states build capacity to identify and assist nursing home residents interested in relocating to a community setting. A review of the programs by RTI International (RTI) found that 66% of the people who moved from a nursing home in Nebraska moved to assisted living.[9] A state official in Texas reported that 25% to 32% of the older adults who relocated from a nursing facility moved to assisted living. The RTI report found that people who did not receive a voucher either returned to their own home, moved in with family, or moved into a community residential care facility such as assisted living or adult family homes. These facilities provide a housing option and an easier transition process from the case manager's perspective.[10] Based on their experience with the transition process, many states have amended their HCBS waivers to cover transition coordination (case management) and transition services. Transition services provide one-time assistance to establish a residence in the community with items such as furnishings, utility deposits, and kitchen utensils.

In 2003, CMS awarded grants to nine states under the initial "Money Follows the Person" category to support people who want to move from an institution to the community.

A second dynamic is the ongoing debate over the institutional versus residential qualities of assisted living. Some contend that assisted living appears and functions like an institution in many states, and others contend it is very residential and homelike. Characteristics of residential, homelike settings include apartment-style units that offer sleeping and living areas, kitchenette or food preparation area, a bathroom, and a door to the unit that the resident can lock. Other features may include a philosophy that supports choice, independence, privacy, and dignity and allows residents to age-in-place or to receive more services as their needs increase. Apartment-style units may be required by state licensing regulations or Medicaid contracting requirements. Facilities may offer apartment-style units in states that do not require them in order to compete in the marketplace.

Federal policymakers have joined the debate about the character of assisted living. The DRA included authorization of the Money Follows the Person demonstration program (MFP). The program provides an enhanced federal reimbursement for 12 months for qualified services

[9] Janet O'Keeffe, Deborah Osber, Christine O'Keeffe, Kristin Siebenaler, and David Brown. FY 2002 NFT Grantees: Final Report. July 2007. Available at: http://www.hcbs.org/files/124/6166/NFTFY02FinalReport_Part_I.doc

[10] Janet O'Keeffe, Christine O'Keeffe, Kristin Siebenaler, David Brown, Wayne Anderson, Angela Greene and Deborah Osber. FY 2001 Nursing Facility Transition Grant Program: Final Report. Available at: http://www.hcbs.org/files/96/4792/NFTGrantee.htm#fy2001g.

provided to Medicaid beneficiaries who relocate from an institution to a "qualified residence." The DRA defines a qualified residence as:

- a home that is owned or leased by the individual or family member;
- an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has control or domain; or
- a residence in a community-based residential setting in which no more than four unrelated individuals reside.

Congress intended to limit the use of settings by the program. Under MFP, ALFs can only participate if they offer apartment-style units. To respect consumer choice, MFP also requires that residences have a lease that does not include admission and discharge provisions that may force a person to move when their needs increase.

Although the DRA did not describe such ALFs that serve five or more residents as institutions, CMS guidance to grantees states that under the second criterion, residences must have an individual lease, not a resident agreement ***and*** the resident must have a separate eating, sleeping, bathing, and cooking area over which he or she has control. Other factors such as policies that limit aging-in-place and choice also limit coverage under the MFP demonstration.

On August 3, 2009, CMS issued policy guidance to MFP grantees that clarifies that assisted living may be covered as a qualified residence under certain circumstances. The guidance (see Appendix A) provides that:

- The resident agreement must have the elements of a lease.
- If apartments are not required by the states' licensing regulations, MFP may only contract with ALRs that offer apartment units.
- ALRs that serve participants with cognitive impairments must include design features that maximize the participants' capacity to live as independently as possible. Conditions that limit a person's activities must be addressed in the plan of care, be related to risks to the individual's health and welfare, and be agreed to by the individual or caregiver in writing.
- Residents have a choice of providers for services that are not included in the service rate paid to the ALR.
- Notices of absences cannot be a condition of the agreement or contract but can be part of the operating practices of the ALR as long as the expectation is reasonable.
- ALRs must allow residents to age-in-place.
- Leases may not reserve the right to assign or change apartments.

As federal policy emerges, states continue to offer nursing home residents the option of moving to an ALF outside the demonstration program. States with active nursing facility transition programs report that 25% to 35% of the older adults who relocate from a nursing facility move to assisted living.

CMS regulations

In addition to the definition of a qualified residence for the MFP program, CMS intends to issue regulations that contain a process to determine whether assisted living is a community or institutional setting. The regulations will affect the Medicaid state plan home and community services options under §1915 (i) and the existing §1915 (c) HCBS waiver programs.

Proposed regulations implementing §1915 (i) were issued April 4, 2008.[11] The proposed regulations describe concerns that assisted living includes a range of settings and some might be considered institutional whereas others are clearly "community settings."

The proposed regulations state that:

> "We interpret the distinction between 'institutional services' and 'home or community-based services' in terms of opportunities for independence and community integration as well as the size of a residence. Applicable factors include the residents' ability to control access to private personal quarters and the option to furnish and decorate that area; if the personal quarters are not a private room, then unscheduled access to private areas for telephone and visitors and the option to choose with whom they share their personal living space; unscheduled access to food and food preparation facilities; assistance coordinating and arranging for the residents' choice of community pursuits outside the residence; and the right to assume risk. Services provided in settings lacking these characteristics, with scheduled daily routines that reduce personal choice and initiative, or without personal living spaces, cannot be considered services provided in the home or community."

CMS intends to establish minimum standards and a process to consider whether a facility will be considered "community," which will depend on whether "individuals in residential settings meeting the standards for community living facilities, that house four or more persons unrelated to the proprietor and provide one or more services or treatments to the residents, the person-centered assessment and plan of care must include a determination that the residence is a community setting appropriate to the individual's need for independence, choice and community integration." Adjustments will be made for participants with particular needs such as dementia.

A similar process will be developed for §1915 (c) waivers that cover services in residential settings. CMS published an advance notice of proposed rulemaking in the *Federal Register*[12] stating that it plans to describe expectations for waiver participants served in residential settings. The notice states that the planned changes will "include methods that states may follow to identify financing mechanisms for reducing the size of existing large residences, divesting themselves or helping their providers divest themselves of sizeable properties and assisting providers' transition to small, more individualized settings." The notice further states that "some individuals who receive HCBS in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a

[11] *Federal Register*, Friday, April 4, 2008. Available at: http://edocket.access.gpo.gov/2008/pdf/08-1084.pdf
[12] *Federal Register.* Monday, June 22, 2009. Pages 29453–29455. Available at: http://edocket.access.gpo.gov/2009/pdf/E9-14559.pdf.

person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting."

The notice also said that CMS intends to add two criteria for HCBS participants:

- They must reside in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services.
- Reside in a home or apartment that is owned, leased, or controlled by a provider of one or more health-related treatment or support services and that meets standards for community living as defined by the state and approved by the Secretary.

The second criterion allows the state to set standards for defining community living that will be reviewed and approved by CMS in the waiver application rather than requiring states to meet standards set by CMS.

If the ensuing federal regulations limit HCBS waiver coverage of assisted living, states in turn will either revise their provider participation requirements, use state general revenues to pay providers, or reduce coverage.

Section 2: State Summaries

This section includes summaries of state coverage of services in assisted living/residential settings. Each summary includes:

- a brief description of the activity;
- data for the number of facilities that contract with the state;
- the number of participants served;
- rate methodology and payment;
- room and board policy;
- services covered;
- waiver level of care criteria;
- unit requirements; and
- mental health service provisions.

Alabama and Kentucky are not included in the summaries because they do not cover services in assisted living settings under Medicaid or state general revenues.

Pennsylvania will prepare a §1915 (c) application when assisted living licensing regulations are implemented.

Kentucky offers a state SSI supplement for personal care home recipients who are ambulatory or mobile non-ambulatory and able to manage most ADLs. Facilities provide supervision, basic health and health-related services, personal care, and social or recreational activities. The total payment in 2009 is $1,194 a month.

Summaries for Mississippi, New Mexico, North Dakota, South Dakota, and Virginia are based on information from the *Residential Care and Assisted Living Compendium: 2007* and information available on state Web sites.

Alaska

Licensing category Assisted Living Homes

Coverage summary
Residential supported living services are covered in assisted living homes under a §1915 (c) waiver. The legislature approved a 4% increase in the base rate for assisted living homes and an additional one-year 2% increase in 2008. Homes receive a base rate. The base rate is lower for residents whose plan of care includes adult day care at least 3 days a week. The rates are "augmented" for residents whose needs require hiring or designating additional staff.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	277	235	174	126

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	650*	730	632	492

* The ID/DD waiver serves 1,004 participants in assisted living homes.

Rate methodology and payment
Rates vary by area of the state. A multiplier that ranges from 1.00 to 1.38 is applied to the rates, resulting in higher payments in rural and frontier areas (i.e., $100 service in one region may be reimbursed at $138 in another region). Providers receive a basic service rate that varies for adult foster care, adult residential I and adult residential II. An "augmented service rate cost factor" is available for clients whose needs warrant the hiring or designating of additional staff. The "augmented care" payment recognizes the added staffing needed by homes caring for residents needing incontinence care, skin care, added supervision, and help with medication. Some residents also attend adult day care (ADC). The service rate is lower for residents attending day care at least three days a week.

The Office of Rate Review is studying options for modifying the methodology. A study found that historical cost data was not sufficient to support differences in the rate. The study recommended aggregation to trend toward a weighted average rate with adjustments for regional locations. Aggregated rates would be phased in over four years.

Medicaid payment rates, July 2008				
Anchorage area	**ADC basic rate**	**Basic service rate**	**Augmented factor**	**Basic and augmented**
Adult foster care	$34.25	$46.30	$18.06	$73.36
Adult residential I	$46.30	$58.34	$18.06	$85.40
Adult residential II	$58.34	$70.39	$18.06	$97.45

Room and board policy
The rates do not include room and board. Charges for room and board are not capped, and supplementation is allowed. The SSI payment standard with the state supplement is $932 a month. The personal needs allowance is $100 a month.

Services covered
Residential supported living services include assistance with ADLs and other services that are necessary to prevent institutionalization, for example, laundry, cleaning, food preparation, writing letters, obtaining appointments, help with the telephone, and engaging in recreational activities.

Waiver level of care criteria
To qualify for waiver services, participants must

- receive a listed nursing service daily;
- receive a nursing service less than daily and require limited, extensive, or total assistance with two ADLs (bed mobility, transfer, locomotion, eating, toilet use, personal hygiene, walking, bathing);
- have impaired cognition and require limited, extensive, or total assistance with two ADLs; or
- have behaviors (wandering, verbal or physical abuse, socially inappropriate) and require limited, extensive, or total assistance with two ADLs.

Units
Apartment-style units are not required. Units may be shared. Providers are responsible for furnishing the unit.

Mental health services
Case managers screen for mental health needs during the assessment process and are responsible for arranging for services when needed.

Arizona

Licensing category Assisted Living Centers; Assisted Living Homes and Adult Foster Care

Coverage summary
Services in ALFs are covered through the Arizona Long-Term Care System (ALTCS) program which operates under an §1115 demonstration waiver. ALTCS managed care contractors contract with three types of assisted living settings: adult foster care (four or fewer residents in which the provider lives in the home), assisted living homes (10 or fewer, owner is not a resident), and assisted living centers that serve 11 or more residents.

ALTCS served 23,315 members in September 2008. Twenty percent of the members lived in residential settings compared to 13% in 2002. The percentage of members living in institutions declined from 47% in 2002 to 33% in 2008. Nearly half of the members who live in residential settings reside in assisted living centers that serve 11 or more residents; 41% live in assisted living homes that serve 10 or fewer residents; and 6% live in adult foster care settings. The remaining members live in behavioral health settings.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1115 demonstration waiver	1,084	866	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1115 demonstration waiver	4,989	4,034	3,076	2,300

Rate methodology and payment
ALTCS managed care contractors negotiate rates with licensed facility operators. Three classes of rates are negotiated based on the level of care: low, intermediate, and high skilled.

Annual inflation was reported as the primary reason for periodic updates to the rates. The Arizona Health Care Cost Containment System (AHCCCS) in some years has contract language that directs the managed care organization (MCO) to pass on the inflationary amount assumed for HCBS in the MCO capitation rate adjustment. For example, AHCCCS assumed a 4.6% increase to HCBS for calendar year 2009. Because of state revenue shortfalls, rates are not expected to increase in FY2010 and may decrease by 5% according to the Arizona Health Care Association.

Arizona ALF Rates – Calendar Year (CY) 2009 (October 2009–September 2010)

MCO	Level I			Level II			Level III		
	AFC	ALH	ALC	AFC	ALH	ALC	AFC	ALH	ALC
A	$52.41	$58.62	$64.44	$62.11	$68.01	$74.33	$72.53	$76.61	$92.40
B	$47.92	$47.50	$56.37	$55.49	$55.00	$71.96	$64.58	$59.00	$97.99
C	$60.47	$62.21	$75.52	$68.94	$70.93	$90.31	NA	$96.43	$92.38
D	NA	$55.30	$64.78	NA	$70.13	$73.88	NA	$85.57	$92.71
E	$56.00	$46.53	$59.19	$62.46	$53.87	$75.56	$78.15	NA	$92.39
F	$41.00	$51.00	$52.00	$45.00	$59.50	$66.00	$50.00	NA	$78.00
G	NA	$72.01	$77.56	NA	$82.77	$92.42	NA	NA	NA
H	$52.31	NA	$73.24	NA	$61.26	$94.17	NA	NA	$104.63

Note: The rates do not include any type of specialty care (e.g., behavioral management, wandering dementia, ventilator dependent).

Room and board policy
The reported rates include room and board. Residents pay a share of cost that is their spend-down amount or 85% of the SSI benefit, whichever is greater. They can never pay more than the per diem rate. Family members may supplement room and board charges to pay for upgrades to the room. The personal needs allowance is $101.10.

Services covered
Facilities are licensed by the level of care provided. ALFs licensed to provide personal care services provide assistance with ADLs that can be performed by persons without professional skills or professional training and the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse. ALFs licensed to provide directed care services offer programs and services, including personal care services, provided to persons who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions. Facilities licensed to offer supervisory care do not participate in ALTCS because the residents do not meet nursing home facility (NF) level of care criteria.

Waiver level of care criteria
Assessment information in scored in three areas: functional, emotional and cognitive, and medical. Functional areas include ADLs (bathing, dressing, grooming, eating, mobility, transferring, and toileting), communication and sensory skills, and continence. Emotional and cognitive information is obtained on orientation and behavior (wandering, self-injurious behavior, aggression, suicidal behavior, and disruptive behavior). Medical information is collected on conditions and their impact on ADLs, conditions requiring medical or nursing services and treatment, medication, special services and treatments needed and physical measurements, history and ventilator dependency.

Each score is weighted and totaled. The weighted functional score (ADLs and cognition) can range from 0–15 on each item and the maximum total is 141. Applicants are grouped into two medical groups based on their conditions. Applicants in either medical group with a total score of

60 or over and those in groups 1 and 2, whose total scores are less than 60 but exceed a specified numerical threshold in each component, are eligible.

Units
Apartment-style units are not required, and shared units are allowed by resident choice. Providers are responsible for furnishing the unit.

Mental health services
Care managers and facility staff screen residents for mental health needs. HCBS case managers may arrange for services. A few ALFs have staffing to provide behavior management programs. These ALFs may have a psychiatrist or psychologist on contract for consultation/care plan development purposes.

Arkansas

Licensing category Assisted Living Facilities; Residential Long Term Care Facilities

Coverage summary
The state covers services in ALFs under a single service §1915 (c) waiver and in residential care facilities under the Medicaid state plan personal care benefit. The Living Choices Assisted Living HCBS Waiver Program was implemented in January 2002. Waiver "assisted living services" providers must be licensed as a Level II Assisted Living Facility or a licensed Class A Home Health Agency that has a contract with a licensed Level II Assisted Living Facility to provide waiver services and pharmacy consultant services.

The assisted living waiver program serves clients who are age 65 and over, or who are 21 years of age or over and blind or disabled. A registered nurse from the Division of Medical Services, Office of Long Term Care, determines level of care eligibility for the waiver. A Division of Aging & Adult Services assisted living waiver registered nurse completes the comprehensive assessment and establishes the tier of need and completes the service plan upon admission to the program and annually or when there is a significant change.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
1915 (c) waiver	20	15	5	NA
State plan	NR	NR	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
1915 (c) waiver	350	211	50	NA
State plan	NR	NR	1,155	1,178

Rate methodology and payment
The state developed a four tiered rate methodology based on a person's level of care and the amount of assistance needed.

Medicaid payment rates (2007)		
Tier 1	0–5 total ADL points and 0–39 total other points	$57.64/day
Tier 2	0–5 total ADL points and 4–60 total other points or 6–10 total ADL points and 0–39 total other points	$61.37/day
Tier 3	0–5 total ADL points and 61 or more total other points or 6–10 total ADL points and 40–69 total other points	$66.58/day
Tier 4	6–10 total ADL points and 70 or more total other points	$69.40/day

Comparable rates in 2007 were $43.19/day for tier 1; $48.61 for tier 2; $51.87 for tier 3; and $54.61 for tier 4. A 3% annual rate adjustment was included in the waiver approved by CMS.

Points are assigned for the impairments as follows:

Tier calculation point scale	
Task	Points
Eating	2 points
Toileting	2 points
Ambulation	2 points
Bathing	2 points
Transfer	1 point
Body care	1 point
Medication reminding/monitoring	.5 times number of medications
Needs Rx assistance	.75 times number of medications
Dosage prep	1 times number of medications
Needs administration	2 times number of medications
Speech not understandable, unable to speak, unable to communicate	10 points
Sight: Legally blind with corrective lenses/blind	10 points
Hearing: Must be loud even with aids; unable to hear	10 points
Disorientation	12 points
Memory impairment	16 points
Impaired judgment	17 points
Wandering	15 points
Disruptive behavior	20 points

Room and board policy
The rates do not include room and board. SSI waiver recipients living in ALFs retain 9% of their SSI payment a month for personal needs, $61 in 2009, and the remaining funds cover room and board. The state does not supplement the federal SSI payment.

Services covered
Services provided under the waiver include attendant care (assistance with ADLs); therapeutic social and recreational activities; medication oversight to the extent permitted by law; medication administration; periodic nursing evaluations; limited nursing services; and non-medical transportation as specified in the plan of care.

Waiver level of care criteria
The waiver serves functionally disabled individuals who meet at least one of the following three criteria as determined by a licensed medical professional:

- The individual is unable to perform either of the following:
  - At least one of the three ADLs of transferring/locomotion, eating, or toileting without extensive assistance from or total dependence upon another person; or
  - At least two of the three ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or,

- The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
- The individual has a diagnosed medical condition that requires monitoring or assistance at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening.

Units
Medicaid waiver providers are required to offer apartment style units. Shared units are allowed by choice of the residents. Providers and family members are responsible for furnishing the unit.

Mental health services
Case managers and facilities are not required to screen prospective residents for mental health needs. Arranging for mental health services is not addressed by state policy.

California

Licensing category Residential Care Facilities for the Elderly

Coverage summary
An assisted living waiver pilot program was implemented in 2006 in three counties. The pilot covered services in two settings: licensed Residential Care Facilities for the Elderly (RCFEs) and elderly public housing settings. Services in elderly housing settings are delivered by home health agencies. The assisted living waiver was renewed in 2009 and will expand to two additional counties per year for five years. The approved waiver projects serving 1,300 the first year (2009) and increasing to 3,700 persons by the fifth year of the renewal. However, budget limitations do not allow the program to enroll new providers. One-third of new participants will relocate from nursing homes.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	53	20	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	1,000	205	NA	NA

Rate methodology and payment
The state developed a tiered rate based on the experience of similar waivers in Arkansas, Oregon, Vermont, and Washington. Residents are assigned to an assisted living service tier based on the ALWPP Assessment Tool administered by the Care Coordinators. The tool measures the need for assistance with ADLs and the need for assistance in seven functional categories: cognitive patterns, behavioral symptoms, continence, communications, medications, skin conditions, and other treatments. Based on the combined need for assistance in these areas, the tool calculates a level of care eligibility and tier of service for the client. A rate increase was proposed to keep the rates competitive. The proposed rates would be $250 a month for care coordination; $62 a day for Tier 1; $72 for Tier 2; $82 for Tier 3; and $92 for Tier 4. The rate changes were based on the number of persons in each tier and were compared to nursing home rates.

Payment rates	
Assisted living services	
Tier 1	$52 per day
Tier 2	$62 per day
Tier 3	$71 per day
Tier 4	$82 per day
Care coordination	$200 per month
Nursing home transition coordination	$1,000
Consumer education – up to 10 hours in first year	$22 an hour
Interpretation/translation – 4 hours per year	$59 an hour

Room and board policy
Room and board are not included in the rate. Family supplementation is not allowed. The state SSI payment is $1,075 a month in 2009, which includes the personal needs allowance of $125 a month. Room and board charges are capped at $950 a month in RCFEs. Providers and residents/family members are responsible for furnishing the unit.

Services covered
Services that are included in the rate are 24-hour awake staff to provide oversight and meet scheduled and unscheduled needs of residents; provision and oversight of personal and supportive services (assistance with ADLs and IADLs); assistance with self-administration of medications and/or administration by licensed nursing staff; social services; recreational activities; coordination of three meals per day plus snacks; housekeeping and laundry; and transportation to medically necessary appointments and other transportation included in the individual service plan.

Waiver level of care criteria
There are two levels of care described in the regulations. NF-A (Intermediate care) requires a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. NF-B (skilled care) requires the need for 24-hour skilled nursing care to render treatment for unpredictable, unscheduled, and/or unmet nursing needs. This level of care also includes bedridden patients, quadriplegics, and full-assist patients with excess ADL and IADL needs that exceed the capacity of the ICF and qualify for NF-B.

Units
Apartment-style units are required. Units may be shared by choice of the residents. The initial waiver included community transition services which provided one-time funding for residents relocating from a nursing home to purchase basic furnishings and supplies. The service was not used and was not included in the renewal application, which was approved in 2009.

Mental health services
Case managers and facility staff screen applicants for mental health needs. Responsibility for providing or arranging mental health services varies with the experience of the facility. Some RCFEs provide services for residents with cognitive impairments while others arrange for services from outside providers. Case managers may also arrange services based on the assessment.

Colorado

Licensing category Assisted Living Residences

Coverage summary
Services in "alternative care facilities," the Medicaid term for assisted living, have been covered since 1984 under a §1915 (c) waiver for older adults, adults with physical disabilities, individuals with mental retardation/developmental disabilities (MR/DD), and people with mental illness.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	283	281	273	266

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	4,007	3,773	3,804	3,800

Rate methodology and payment
The payment rate was $49.01 effective on 7/1/2008. The state is interested in exploring development of a tiered rate methodology. Rates are changed through legislative action in the annual state budget process. Typically, rate increases are appropriated annually; however, in state FY2009–2010, rates will be reduced 2% for all HCBS services, including assisted living, due to declining revenue.

Room and board policy
The rates do not include room and board. Room and board charges for Medicaid beneficiaries are capped at $618 a month effective 1/1/2009. Participants may retain up to $101 a month for personal needs. Supplementation is permitted for items that are not covered by the Medicaid rate.

Services covered
Alternative care services, as defined in 25.5-6-303 (4) C.R.S., means, but is not limited to, a package of personal care and homemaker services provided in a state-certified alternative care facility including assistance with bathing, skin, hair, nail and mouth care; shaving; dressing; feeding; ambulation; transfers; positioning; bladder and bowel care; medication reminding; accompanying; routine housecleaning; meal preparation; bed making; laundry and shopping; oversight; personal care; and homemaker, chore, and laundry services. A pilot program tested the impact of an enhanced rate to create incentives to retain people as their needs increased and to accept residents with greater needs from nursing homes and hospitals. An additional $400 per month was available for residents who have enhanced needs in three of four areas: personal care, mobility, incontinence, and behavior/confusion.

Waiver level of care criteria
Functional eligibility is determined by a local single-entry-point case management agency based on an assessment of the following ADL areas: mental cognition and the need for supervision and

observation; behavior(s); mobility; bathing; dressing; eating/feeding; bowel continence; and bladder continence. Clients must need help with at least two ADLs or have need for the supervision because of cognition/behavior(s).

Units
Apartment-style units are not required. Shared units are allowed by choice of the residents. Providers are responsible for furnishing the unit.

Mental health services
Facility staff and case managers screen applicants for mental health needs to assess the appropriateness of admission. ALFs are encouraged to help residents arrange access to mental health services.

Connecticut

Licensing category Assisted Living Service Agencies

Coverage summary
Services are provided by assisted living service agencies under a §1915 (c) waiver that covers an array of services. Connecticut has different models of assisted living. One model provides services in state-funded congregate housing sites and HUD housing units. Additionally, there are four affordable assisted living sites in the state that are funded through a combination of sources including tax credits. The state also pays for assisted living services in private ALFs for 75 people. Each unit has a private entrance and cooking facilities.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	43	25	34	NA
General revenues	NR	*	*	*

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	137	439	65	NA
General revenues	354	*	*	*

* Participants in 2007, 2004, and 2002 are included in the waiver figure.

Rate methodology and payment
The rate is based on the number of units of service, both home health aid and nursing, that a resident requires on a weekly basis. There is a separate rate of $8.57 per day for CORE services that includes housekeeping, maintenance, security and laundry.

Additional payments are made as follows:

- Occasional personal services: 1–3.75 hour per week, $26.78, plus nursing supervision as needed, $8.57, for a total of $33.35 per day.
- Limited personal services: 4–8.75 hours per week of personal services, $42.85, plus nursing visits as needed, $8.57, for a total of $51.41 per day.
- Moderate personal services: 9–14.75 hours per week, $58.92, plus nursing visits as needed, $8.57, for a total of $67.49 per day.
- Extensive personal services: 15–25 hours per week, $69.63, plus nursing visits as needed, $8.57, for a total of $78.20 per day.

Rates are normally adjusted annually, but they have not increased since July 2007. Rates for waiver service providers are normally set by the legislature and/or they may be proposed by the Department of Social Services. Policymakers considered adding another higher tier, but due to fiscal constraints this has not been pursued.

Room and board policy
The rates are not capped by state policy and do not include room and board. The state does not supplement SSI. The personal needs allowance is $164.10 per month.

Services covered
Core services are housekeeping, laundry, maintenance/chore, recreation, medical and nonmedical transportation, emergency response, and service coordination. There are four levels of personal care.

Waiver level of care criteria
State policy requires that residents require assistance with three or more critical needs. Critical needs include bathing, dressing, toileting, transferring, eating, medication administration, and meal preparation.

Units
Each unit has a private entrance, full bathroom, and cooking facilities. Units may be shared by choice of the residents. The provider and the resident/family are responsible for furnishing the unit.

Mental health services
Case managers and facilities screen applicants for mental needs and case managers and providers are responsible for arranging services from outside providers.

Delaware

Licensing category Assisted Living Facilities

Coverage summary
The state covers services under an assisted living only §1915 (c) waiver. Rates were increased in 2009. A new waiver for people with acquired brain injuries was implemented in 2007 and also covers assisted living. Twenty participants transferred to it from the assisted living waiver. ALFs may also provide respite services, which are covered under a broad HCBS waiver.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	12	15	29	11

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	179	217	14	NR

Rate methodology and payment
The state uses a tiered payment system. Rates for assisted living initially were established by a consulting firm by comparing what the nearby states were paying for the similar services. In addition, the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) of consults with the Medicaid agency to collaborate annually to establish rates. Per diem reimbursement for assisted living services comprises two prospectively determined rate components that reimburse providers for primary patient care and secondary patient care. The rate components are defined as:

- *Primary patient care:* The primary patient care component of the per diem rate is based on the nursing care costs related specifically to each patient's classification. In addition to assignment to case mix classifications, selected patients with dementia and other cognitive impairments may qualify for supplemental primary care reimbursement based on their special service needs. The primary care component reimbursement for each patient classification will be the same for all facilities. This cost center encompasses all costs that are involved in the provision of basic nursing care for assisted living patients. There is no cap for the primary care cost component of the per diem rate.
- *Secondary patient care:* This cost center encompasses other patient costs that directly affect patient health status and quality of care and is inclusive of clinical consultants, social services, dietitian services, and activities personnel. Payment for secondary patient care is unique to each facility. Provider costs are reported annually to DSAAPD and are used to establish rate ceilings for the secondary patient care.

Medicaid payment rates, 2009			
Component	Level I	Level II	Level III
Room and board	$692	$692	$692
Services	$1,045	$1,284	$1,558
Total	$1,737	$1,976	$2,240

Rates are reviewed annually. Factors that may lead to changes in the rates are staffing requirements due to new regulations, staff cost of living increases and increases in insurance costs.

Room and board policy
The Medicaid rate does not include room and board; charges are capped at $692 a month, but family members may supplement the charges. The SSI state supplement total payment is $814 a month. The monthly personal needs allowance is $122.

Services covered
The Medicaid Waiver for Assisted Living provides services and supports for eligible older persons and adults with physical disabilities who otherwise would require care in a nursing home. The goal of the program is to provide services that allow an individual to live as independently as possible in a homelike, residential setting. Support usually includes personal services and light medical or nursing care. The waiver also covers case management, which helps older persons, persons with disabilities and caregivers get connected with the services that they need. Case managers help in three ways:

- assessing (or evaluating) a person's situation and needs;
- working with individuals and their families to develop care plans to map out what kind of services an individual needs, how often they are needed, etc.; and
- providing ongoing coordination to see that an individual's care needs are being met.

Waiver level of care criteria
The State uses the long-term care assessment tool developed and used by the state's Medicaid agency to determine the level of care for the assisted living waiver program. This comprehensive assessment instrument identifies an individual's physical health, mental health, and social strengths and concerns. Additionally, medical verification is obtained from the client's physician to further support the assessment findings. This tool is used to determine whether the individual has at least one ADL deficit, which is the basis for the nursing facility level of care criteria. The tool provides a comprehensive data base that provides the basis for the nature and level of services provided in the AL setting.

Units
Apartment-style units are not required. Shared units are permitted. State policy does not address who is responsible for furnishing the unit.

Mental health services
Case managers are responsible for mental health screening. Responsibility for arranging for mental health services is not addressed.

District of Columbia

Licensing category Assisted Living Residence

Coverage summary
The District's §1915 (c) waiver amendment to add assisted living services was approved in March 2007.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	2	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	13	NA	NA	NA

Rate methodology and payment
The District pays a flat rate of $60 a day.

The service rate for assisted living services was based upon a geographic market analysis that included a technical assistance group (TAG). The TAG and Medical Assistance Administration examined the average daily rate for all inclusive costs among the small and medium sized group homes that might be interested in providing care for assisted living Medicaid residents because they were already serving SSI and SSA participants or were considering serving Medicaid participants. The TAG asked for a review of current costs among the small group home providers for services that they were providing or believed were needed. Information on reasonable and customary services was requested as well as how much they charged for those services and how often they were used or offered—daily and weekly. The average weekly costs were then multiplied by 52 weeks and then divided by number of persons receiving those services. The percentage of room and board costs were between 50% and 60% of total assisted living expenditures. This percentage was subtracted from the overall rate leaving costs that were on average $22,000 annually. This $22,000 cost was then divided by 365 days leaving an average cost of $60 a day. The $22,000 was compared to several facilities and was less than half as expensive as other ALFs in the region. There is no automatic inflation increase and there is no set methodology for determining rate increases. It is anticipated that assisted living rates will be adjusted periodically to ensure adequate provider supply.

Room and board policy
The flat rate does not include room and board. The current optional state supplement payment rate is $1,159 for single residents living in an ALF with 50 residents or less and $1,269 for single residents in an ALF with greater than 50 residents. The personal needs allowance is $100 a month. Supplementation is permitted.

Services covered
Assisted living services include any combination of the following: 24-hour supervision and oversight to ensure the well-being and safety of residents, assistance with ADLs and IADLs to

meet the scheduled and unscheduled services needs of the beneficiary, laundry and housekeeping services not provided by the resident, personal care aide or homemaker aides, facilitation of access for a resident to appropriate health and social services, and coordination of scheduled transportation to community-based activites.

Waiver level of care criteria
Participants must need category 2 or 3 assistance with at least two ADLs and one IADL is required to maintain health and welfare.

Units
Apartment-style units are not required. Shared units are allowed. Providers are responsible for furnishing the unit.

Mental health services
Facilities assess applicants for mental health needs to determine their appropriateness for admission. HCBS case managers and facilities are responsible for arranging services.

Florida

Licensing category Assisted Living Facilities

Coverage summary
Florida covers services under two §1915 (c) waivers—the assisted living for the elderly (ALE) waiver and the nursing home diversion waiver—and the Medicaid state plan. Waivers services are available in ALFs that also provide extended congregate care or limited nursing services. ALFs must be licensed to provide these levels of care.

Coverage of assistive care services (ACS) under the state plan was implemented in September 2001 in all ALFs and in adult family homes in January 2002. ACS includes health support, assistance with ADLs and IADLs and assistance with self-administration of medication. This Medicaid program is an optional state plan service for individuals in ALFs, adult family care homes (AFCH), and residential treatment facilities (RTFs).

ALE waiver services are available in ALFs licensed for extended congregate care and/or limited nursing services.

The state respondent attributed growth in the program to Florida's aging retiree population, many of whom do not have family members to provide support. The need for assistance and the need for independence make ALFs an attractive option especially when the need for assistance is minimal and the care required is not at the nursing facility level of care.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver*	546	478	581	299
State plan	NR	NR	1,527	1,565

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver*	2,513	3,623	4,167	2,681
State plan	12,250	7,766	14,188	9,990

* Data include the ALE waiver only. Contractors for the nursing home diversion waiver will begin reporting the living arrangements of waiver participants in September 2009.

Rate methodology and payment
Facilities may receive payment for both waiver services and assistive care services. ALE waiver providers receive $32.20 a day for services. The payment for case managements is $100 a month and incontinence supplies are reimbursed $125 a month. The ACS payment rate is $9.28 a day for each day the recipient receives services in the facility.

Recipients eligible for both ACS and ALE waiver assistance must have a service plan in which services that are considered ACS are shown and identified separately from those provided under the waiver.

The rates change when the Department of Elder Affairs or the policy analyst for the Medicaid agency, the Agency for Health Care Administration, determine that changes are needed. Several factors are considered including input from ALF providers that the rate no longer meets their expenditures in the market place; when the number of providers declines drastically and cannot meet the needs of waiver participants; or the legislature recommends/provides increased general revenue funding for the program to increase rates.

Room and board policy
The Medicaid rate does not include payment for room and board, which is not capped. Family supplementation is allowed, but the state caps the amount of supplemental income that may be received. The state SSI supplement payment standard is $752.40 a month.

Services covered
The ALE waiver includes three services: case management, assisted living services, and incontinence supplies if needed. Assisted living is a bundled service that may provide attendant call system; attendant care; behavior management; personal care services; chore and homemaker services; medication administration; intermittent nursing care services; occupational therapy; physical therapy; speech therapy; therapeutic social and recreational services; and specialized medical equipment.

Services covered by the diversion waiver include personal care services, homemaker services, chore services, attendent care, companion services, medication oversight, therapeutic, social and recretional programming, and may include physical therapy, occupational therapy, speech therapy, medication administration, and peridoc nursing evaluations.

Assistive care services, a Medicaid state plan service, includes health support; assistance with activities of daily living; assistance with instrumental activities of daily living; and assistance with self-administration of medication.

Waiver level of care criteria
Eligibility for the ALE waiver is based on the Institutional Care Program income requirements and level of care. The level of care must be the same as nursing facility level of care. Eligibility for the Diversion waiver is higher than the nursing home criteria.

ALE waiver	Diversion waiver
Requires assistance with four or more ADLs or three ADLs plus assistance with administration of medication	Require assistance with five or more ADLs or four ADLs plus supervision or administration of medication
Requires total help with one or more ADLs; or	Require total assistance with two or more ADLs
Has a diagnosis of Alzheimer's disease or another type of dementia and requires assistance with two or more ADLs	Has a diagnosis of Alzheimer's disease or another type of dementia and requires assistance or supervision with three or more ADLs
Has a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard licensed ALF but are available for an ALF that is licensed to provide limited nursing	Has a diagnosed degenerative or chronic medical condition requiring daily nursing services

ALE waiver	Diversion waiver
services (LNS) or extended congregate care services (ECC)	
Is a Medicaid-eligible resident awaiting discharge from a nursing home who cannot return to a private residence because of the need for supervision, personal care services, periodic nursing services, or a combination of the three; and is receiving case management and is in need of assisted living services	

Units

Facilities participating in the ALE waiver must offer a private room or apartment or a unit that is shared with the approval of the beneficiary. Apartment-style units are not required by the Diversion waiver or ALFs that provide ACS.

Mental health services

Mental health screening is not used to determine the appropriateness of admission; however, mental health needs are addressed during the level of care assessment. Providers and case managers are responsible for arranging for mental health services when needed.

Georgia

Licensing category Personal Care Homes; Community Living Arrangements

Coverage summary
The HCBS Community Care Services Program is a §1915 (c) waiver that reimburses alternative living services in two models of personal care homes—group homes that serve seven to 24 people and family model agencies serving two to six people. State officials plan to review amendments to the waiver that would respond to the needs of beneficiaries with severe physical disabilities. The current daily rate is not sufficient to allow providers to serve individuals with challenging physical or behavioral needs.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	754	375	465	444

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	2,705	2,300	2,851	2,759

Rate methodology and payment
Providers receive a flat rate of $35.04 a day. The state plans to review alternative rates methodologies. An amendment to the waiver may be submitted that will add a residential service for participants with severe physical disabilities. Rates for all HCBS providers are typically adjusted by the legislature every 4 to 5 years.

Room and board policy
The rate does not include room and board. Rates are capped at $571 a month in 2009. The personal needs allowance is $95 a month. Supplementation is permitted.

Services covered
The rate covers assistance with ADLs and IADLs, assistance with medications and 24-hour supervision.

Waiver level of care criteria

Intermediate level of care		
Medical condition	**Mental status**	**Functional status**
One of the following: Nutrition management; Maintenance and preventive skin care; Catheter care; Therapy services; Restorative nursing services; Monitoring of vital signs; or Management and administration of medications	One of the following: Documented short- or long-term memory deficits; Moderate or severely impaired cognitive skills; Problem behavior; or Undetermined cognitive patterns which cannot be assessed by a mental status exam, e.g., aphasia.	Require one of the following: Limited/extensive assistance with transfer and locomotion; Assistance with feeding (continuing stand-by supervision, encouragement or cuing required and set-up help); Direct assistance to maintain continence; Documented communication deficits; Direct stand-by supervision or cuing with one person's assistance to complete dressing and personal hygiene (must be combined with one of the above).

Units

Apartment-style units are not required. Units may be shared. Providers are responsible for furnishing the unit. The nursing home transition grant provides funds to furnish a unit for residents relocating from a nursing home.

Mental health services

Mental health screening to determine the appropriateness of placement is not required. Case managers are responsible for arranging mental health services when such needs are identified during the assessment process.

Hawaii

Licensing category Assisted Living Facilities; Expanded Adult Residential Care Homes; Community Care Foster Family Home

Coverage summary

Assisted living was added as a Medicaid waiver service in 2000 for elders and people with disabilities living in ALFs and extended adult residential care homes (E-ARCH). In 2009, aged, blind, and disabled Medicaid beneficiaries were enrolled in the state's §1115 demonstration program called the QUEST Expanded Access (QExA) program. The goals and objectives of QExA are to create a managed care delivery system that will ensure coordination of care and decrease care fragmentation across the benefit continuum including primary, acute, behavioral health, and long-term care benefits; provide access to high-quality, cost-effective care that is provided, whenever possible, in a member's own home and/or community, if the member so chooses; encourage development of more community services and supports; support choice of services for members; and develop a program design that is fiscally predictable, stable, and sustainable over time. QExA covers residential living services in ALFs, E-ARCH, and continuing care foster family homes.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1115 waiver	1,075	NA	NA	NA
§1915 (c) waiver	NA	81	NA	NA
State plan	NA	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1115 waiver	1,200	NA	NA	NA
§1915 (c) waiver	NA	1,405	0	NA
State plan	NA	NA	NA	NA

Rate methodology and payment

The State of Hawaii has a two-tiered rate system. On February 1, 2009, the state converted from fee-for-service to managed care plans to provide services. The health plans are using rates from the previous fee for service system but will modify the rate payment over time.

Medicaid payments for assisted living and E-ARCH residents vary based on the individual's Medicaid eligibility group and level of care. Level II clients have higher skilled nursing needs and/or behaviors that require more service and supervision than Level I clients. Rates vary by Islands. On Oahu, the Medicaid payment for E-ARCH's is $24.98 a day for Level I and $41.06 for Level II. Beneficiaries who qualify for Medicaid under the medically needy category retain $418 a month for room and board. The Medicaid payment is $52.65 a day for Level I and $68.73 a day for Level II.

Daily rates		
Oahu	Level 1	Level 2
Cost share/spousal/non-eligible SSI	$24.98	$68.73
SSI	$52.65	$41.06
Neighbor Island		
Cost share/spousal/non-eligible SSI	$57.65	$73.73
SSI	$29.98	$46.06

Room and board policy
Room and board is not included in the service rate. Charges are capped based on the SSI state supplement. Medically needy beneficiaries pay $418 a month for room and board. The SSI/SSP payment is $1,275.90. Residents retain $50 a month for personal needs.

Services covered
The rate includes assistance with ADLs, meals, housekeeping, laundry, medication administration, and delegated procedures.

Waiver level of care criteria
To qualify for an ICF level, beneficiaries must need intermittent skilled nursing, daily skilled nursing assessment, and 24-hour supervision provided by RNs or LPNs. They may also require unskilled nursing services such as administration of medications, eye drops, and ointments, general maintenance care of colostomies or ileostomies, and other services and significant assistance with ADLs.

Units
Apartment-style units are not required in E-ARCH. Shared units are permitted. Providers are responsible for furnishing the unit. The ALF licensing regulations require apartment units with a bathroom, refrigerator, and cooking capacity, including a sink and a minimum of 220 square feet, not including the bathroom (sink, shower, and toilet).

Mental health services
Case managers screen applicants for mental health needs and are responsible for arranging for services when needed.

Idaho

Licensing category Residential Assisted Living Facilities

Coverage summary
Services are covered under a §1915 (c) waiver that covers multiple services and the Medicaid state plan personal service. Policymakers stated that the HCBS waiver gives applicants the options to choose where they would like to live. ALFs are options for participants who no longer can safely reside in their own home but do not wish to live in a nursing home. The Department of Health and Welfare requested funds to increase the rate to support Medicaid participants who reside in ALFs.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915(c) waiver	292	279	265	35
State plan	NR	NR	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915(c) waiver	2,899	2,231	1,870	720
State plan	NR	NR	NR	NR

Rate methodology and payment
Payments under the HCBS waiver are based on a care plan that is capped at the average per capita cost of nursing home care. In 2009, the rates for attendant care are $15.56 an hour and $13.60 an hour for homemaker services. The payments do not include room and board.

State plan personal assistance services payments are based on care levels. Payment rates range from $125.30 to $225.54 a month. Each level converts to a specific number of hours of personal care services.

- Reimbursement Level I: 8.75 hours of personal care services per week.
- Reimbursement Level II: 10.5 hours of personal care services per week.
- Reimbursement Level III: 15.75 hours of personal cae services per week.
- Reimbursement Level IV: 12.5 hours of personal care services per week.

Idaho's statute (Title 39, Chapter 56-5606) states that the department will establish annually uniform reimbursement rates for providers based on the prevailing hourly rate paid for comparable positions in the state for nursing home industry employees. Providers shall also receive a 55% supplemental component to cover travel, administration, training, and all payroll taxes and fringe benefits.

Room and board policy

Room and board charges are not capped by state policy. The suggested amount in 2009 is $584 a month. Residents retain $90 a month for personal needs. The policy on supplementation was not stated.

Services covered
The HCBS waiver covers nursing services; nonmedical transportation; medication management; assistance with ADLs; meal preparation; housekeeping; laundry; opportunities for socialization; recreation; and assistance with personal finances. Administrative oversight must be provided for all services provided or available in this setting. The rate for state plan services covers medication management; assistance with ADLs; meal preparation; incidential housekeeping services; and shopping.

Waiver level of care criteria
The assessment areas are divided into critical, high, and medium indicators. To qualify for nursing home admission, applicants must have one or more critical indicators; two or more high indicators; one high and two medium indicators; or four or more medium indicators.

Criteria for determining nursing home need	
Indicators	**Level of need**
Critical–12 points each	Total assistance preparing meals Total assistance in toileting Total or extensive assistance with medication which requir decision making prior to taking or assessment of efficacy after taking
High–6 points each	Extensive assistance preparing or eating meals Total or extensive assistance with routine medications Total, extensive, or moderate assistance with transferring Total or extensive assistance with mobility Total or extensive assistance with personal hygiene Total assistance with supervision for a section of the uniform assessment instrument
Medium–3 points each	Moderate assistance with personal hygiene, preparing or eating meals, mobility, medications, toileting Total, extensive, or moderate assistance with dressing Total, extensive, or moderate assistance with bathing Frequent or continual supervision in one or more of the following: orientation, memory, judgment, wandering, disruptive/socially inappropriate behavior, assaultive/destructive behavior, self preservation, or danger to self or others

Units
Apartment-style units are not required. Units may be shared, and providers are responsible for furnishing the unit.

Mental health services
Screening to determine the appropriateness of placement for individuals with mental health service needs is not required. ALFs are responsible for arranging mental health services from outside providers.

Illinois

Licensing category Supported Living Facilities

Coverage summary
Services are covered through a §1915 (c) supported living facilities (SLF) waiver. Policymakers reported that the legislature has been very supportive of the ALF HCBS waiver program. Each year the funds appropriated reflect the continued growth of the program. State leaders see the waiver program as a cost savings to the state because it delays or prevents more costly care in nursing facilities. Decreased state revenue has led to some payment delays. The average payment cycle during state fiscal year 2008 for the Supportive Living Program was 53 days. Additionally, SLFs with a required minimum percentage of Medicaid eligible residents can apply to be placed on an expedited payment schedule. The Department of Healthcare and Family Services (DHFS) plans to continue to work with the legislature to ensure that adequate funding is appropriated for SLFs.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	108	81	41	13

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	5,204	4,681	1,602	293

Rate methodology and payment
The service payment is based on 60% of the average nursing facility rate paid in the region. The 60% was chosen initially to test the ability of the provider community to support a financially viable model at this level of reimbursement. The DHFS also wanted to ensure that the demonstration would meet the CMS waiver requirement that the program be cost neutral when compared to nursing facilities. Rates change biannually based on changes in the nursing facility rates.

Illinois described several factors that contributed to the continuous increase in the ALF waiver program including demand, partnerships with other state agencies, and an emphasis on high-quality care. As the older population ages, so does the demand for choices in care, especially those that are affordable. DHFS has good working relationships with other state agencies involved with services for the elderly and persons with physical disabilities, including the Department on Aging, the Long Term Care Ombudsman, Department of Human Services, and the Illinois Housing Development Authority. These agencies and their contractors help promote the program by informing potential residents and their families of the services available in supportive living.

Additionally, the Department emphasizes the quality of care required in supportive living facilities, which builds the program's favorable reputation, its providers, and services. Quality is measured and monitored through a quality management plan that identifies patterns by region, specific provider group, or throughout the state. The Department designs training for providers,

issues written policy clarifications, and develops written resources/tools to assist providers depending on the scope and nature of the issue. Providers and Department staff receive biannual training developed through a cooperative effort between of the Department and two provider associations.

Medicaid payment rates by geographic area (2009)				
Region	**Daily**	**Room & Board**	**Medicaid**	**Total**
Chicago	$72.10	$584	$2,192	$2,882
South Suburb	$68.18	$584	$2,073	$2,763
Northwest	$63.94	$584	$1,944	$2,634
Central	$62.29	$584	$1,894	$2,584
West Central	$57.43	$584	$1,746	$2,436
St. Louis	$60.98	$584	$1,854	$2,544
South	$55.99	$584	$1,702	$2,392

Room and board policy
Rates do not include room and board; however, charges are capped at $584 a month for single occupancy and $416 for shared occupancy. Family supplementation is permitted. The monthly personal needs allowance is $90 a month.

Services covered
Temporary nursing care; social/recreational programming; health promotion and exercise programs; medication oversight; ancillary services; 24 hour response/security; personal care; laundry; housekeeping and maintenance are covered. Providers also regularly assess health status and consult with the resident on an ongoing service plan that promotes health and wellness.

Waiver level of care criteria
Waiver eligibility is based on a determination-of-need (DON) score. The score is derived from the Mini-Mental State Examination (MMSE), six ADLs, nine IADLs (including ability to perform routine health and special health tasks, and ability to recognize and respond to danger when left alone). Each ADL, IADL, and special factors are rated by level of impairment (0–3) and unmet need for care (0–3). Scores for each area are summed and applicants with a DON score of 29 or more are eligible. The MMSE component is weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports and people with lower levels of impairment without informal supports.

Units
Apartment-style units are required and units may be shared by choice of the residents. Residents or their family members are responsible for furnishing the unit.

Mental health services
The assessment completed by the case manager includes mental health screening. Supported living facility providers are responsible for arranging services from outside providers.

Indiana

Licensing category Residential Care Facilities

Coverage summary
The state covers assisted living services in residential care facilities under a broad §1915 (c) waiver. The state respondent cited the improved rate structure and better provider marketing and recruitment efforts for the growth in the program.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
1915 (c) waiver	50	43	14	8

Participants				
Source	**2009**	**2007**	**2004**	**2002**
1915 (c) waiver	400	NR	71	22

Rate methodology and payment
The state uses a three-tiered payment system based on assessment information that is scored. Residents with a score of less than 36 points are paid at the Level 1 rate of $66.55 a day; 36–60 points at Level 2 rate of $73.33 and 61–75 points at the level 3 rate of $80.93 per day. Legislation passed in 2008 (SB 315) requires biennial review of the rates. Rates are reviewed through collaboration between the Division of Aging and the Office of Medicaid Policy and Planning. Staff reviewed rates charged by facilities to private pay residents and revised the Medicaid rates to narrow the difference while remaining within the agency's budget for waiver services. The agencies will continue to collaborate to determine whether further revisions are needed to provide access to ALFs for waiver participants that are interested in this option. However, budget contracts may trigger a 5% reduction in July 2009. However, the Division of Aging considers assisted living services to be cost effective and it is expected to continue receiving support from policymakers.

Medicaid payment rates 2009	
Level	**Daily rate**
Level 1: (<36 points)	$66.55
Level 2: (36–60 points)	$73.33
Level 3: (61–75 points)	$80.93

Room and board policy
The Medicaid rates do not include room and board which is capped at the SSI payment less a $52 per month personal needs allowance. The state has not set a policy on supplementation by family members or other third parties. There is no state supplement to the federal SSI payment.

Services covered
The assisted living payment covers a bundle of services that includes attendant care, chore services, companion services, homemaker, medication oversight (to the extent permitted under state law, personal care and services, and therapeutic social and recreational programming.

Waiver level of care criteria
Individuals are eligible if they have three or more of 14 substantial medical conditions or ADL impairments. The list includes supervision and direct assistance on a daily basis to ensure that prescribed medication is taken correctly; 24-hour supervision and/or direct assistance due to confusion; disorientation not related to a mental illness; inability to eat, transfer from bed or chair, change clothes, bathe, manage bladder and/or bowel functions, or ambulate or use a wheelchair without direct assistance. The criteria allow a person with three ADLs or two ADLs and the need for medication assistance to receive waiver services.

Units
By regulation, providers of assisted living waiver services must offer individual residential units that include that include a bedroom, private bath, a substantial living area and a kitchenette that contact a refrigerator, food preparation area, a microwave, and access to a stove top or oven. Facilities licensed prior to the unit requirements must offer 220 square feet of living space, excluding the bathroom. Shared units are allowed if residents agree to do so.

Mental health services
The waiver case manager and the facility screen applicants for mental health needs. The facility is responsible for arranging services from an outside provider.

Iowa

Licensing category Assisted Living Programs

Coverage summary
Services are covered under a §1915 (c) waiver that covers an array of services. Certified or accredited assisted living programs may be providers of Medicaid home and community-based waiver services. Services are also covered under a state-funded State Supplementary Assistance program that covers in-home health related services that are not covered under other programs or for HCBS assisted living residents who need more care than is available under the waiver service cap. Rate increases requested by providers in 2009 may not be approved because of revenue limitations.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	155	73	54
State supplementary assistance	NR	NR	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	677	497	126	129
State supplementary assistance	1,757	NR	NR	NR

Rate methodology and payment
The HCBS waiver payment is based on a care plan. The maximum cap is $1,117 a month in 2009. The rates do not include room and board.

Facilities may receive up to $26.50 a day under the state supplementary assistance program for in-home health related services not covered under HCBS or for residents who need more care than is available under the service cap.

Room and board policy
Room and board charges are set by the facility. The personal needs allowance is $90 a month. The state did not indicate a policy on supplementation.

Services covered
ALPs are providers of assistive devices, chore, consumer directed attendant care, emergency response, home delivered meals, home health aide, homemaker, nursing, nutritional counseling, respite, senior companions, and transportation.

Home delivered meals are only provided after the interdisciplinary team makes an assessment that the consumer could not provide the meal for him or herself. Participants must meet the assessment criteria to receive waiver payment for home delivered meals in a residential setting. The HCBS waiver can pay for two meals per day, seven days per week, for a maximum of 14 meals per week.

Waiver level of care criteria
Intermediate level of care can be approved if the individual requires daily supervision with dressing and personal hygiene in conjunction with one of the following: cognitive functions, mobility, skin, pulmonary status, continence, physical functioning–eating, medications, communication/hearing/vision patterns, or prior living circumstances–psychosocial. Intermediate level of care can also be approved if the individual requires physical assistance by one or more persons to perform dressing and personal hygiene.

Units
Apartment-style units are required. Assisted living programs may have private dwelling units with lockable doors and individual cooking facilities. Single occupancy dwelling units in buildings built after July 2001 must have at least 240 square feet of floor area, excluding bathrooms. Units used for double occupancy must have at least 340 square feet, excluding bathrooms. Units may be shared by choice of the residents. The rules do not address who is responsible for furnishing the unit.

Mental health services
Screening for mental health needs to determine appropriateness of the placement is not required and state policy does not specify who is responsible for arranging for mental health services which are provided though a behavioral health managed care program.

Kansas

Licensing category Assisted Living Facilities; Residential Health Care Facilities; Home Plus and Board Care Homes

Coverage summary
Services in ALFs are covered by a §1915 (c) waiver that also covers other services. The state reports a continual rise in the number of ALF settings enrolling as providers of HCBS/Frail Elderly services. The HCBS/Frail Elderly budget is extremely tight, but ALFs are not affected any more than other housing options chosen by the customer.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	178	155	155	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	1,819	769	659	NR

Note: Numbers of facilities and participants are estimates.

Rate methodology and payment
Services are reimbursed based on a plan of care for each participant. The plans of care are individual to the customer's own needs so that if a customer needs three hours per week for bathing that is what would be authorized while someone else might only need one hour.

The rates for individual services were determined when the "frail elderly" waiver was established in 1997 and are updated periodically. The rates for services increase when the Kansas legislature approves the additional funding to implement rate increases. The rates increased July 1, 2006, and July 1, 2008. In 2009, the attendant care services rate is $3.38 per unit (15 minutes) for attendant care Level I tasks and $3.73 per unit for attendant care Level II tasks.

Room and board policy
The rates do not include room and board which is negotiated with the facility. Supplementation is allowed. The amount retained by the resident for personal needs allowance is part of the negotiation of room and board charges. State policy does not specify the personal needs allowance.

Services covered
In addition to attendant care services, the waiver covers assistive technology, nurse evaluation visit, personal emergency repsonse system, comprehensive support, and wellness monitoring for customers in ALF settings. Attendant care services provide supervision or assistance with ADLs and IADLs for individuals who are unable to perform one or more activities independently. These services are limited to 12 hours a day.

There are two levels of attendant care. Level I activities include assistance with ADLs and IADLs (bathing, grooming, toileting, transferring, feeding, mobility, accompanying to obtain

necessary medical services, shopping, house cleaning, meal preparation, laundry, and life management). Level II activities are health maintenance activities and include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, medication administration/assistance, wound care, range of motion, and reporting changes in function or condition. These services must be authorized by a physician or a nurse.

Waiver level of care criteria
To be eligible for the HCBS/FE waiver the customer must meet the Medicaid long-term care threshold criteria, which are based on the results of the Long-Term Care Threshold Guide of the Uniform Assessment Instrument. Customers must have an impairment in a minimum of two ADLs with minimum combined weight of six; and impairment in a minimum of three IADLs with a minimum combined weight of nine; and a total minimum level of care score of 26; or the customer has a minimum score of 26, with at least 12 of the 26 points being IADL and the remaining 14 being any combination of IADL, ADL, and/or risk factor points (incontinence, cognition, falls, abuse/neglect, and amount of informal supports).

Units
Apartment-style units are required and customers and family members furnish the unit. Units may be shared only by choice of the customers.

Mental health services
Screening for mental health needs to determine appropriateness of placement is not required. Case managers complete a brief mental health screen as part of their assessment process and if the customer scores over a 13 then they would recommend a referral for mental health services. ALFs are also responsible for arranging services from an outside provider.

Louisiana

Licensing category Adult Residential Care

Coverage summary
The state submitted a §1915 (c) waiver application to cover services in assisted living centers in two regions of the state. The waiver proposal was submitted in January 2009 and is the source of information for the summary below. The waiver would serve 230 individuals each year for three years. Medicaid provider participation standards were issued in December 2008.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) submitted	NA	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) submitted	NA	NA	NA	NA

Rate methodology and payment
The per diem rates will be grouped into three or more tiers.

Adult residential care services will be provided to waiver participants based on a comprehensive assessment of need. Assessments will be performed by service coordinators using the Minimum Data Set for Home Care (MDS-HC). The RUG-III/HC system has been derived from the RUG-III payment system now used by Louisiana to reimburse nursing facilities and will support the integration of a common payment methodology into a new service setting.

The per diem payment to Medicaid eligible individuals will be determined as follows. The rate paid for ARC services shall be based on a percentage of the July 1 statewide average nursing facility case-mix rate after removing the provider fee component and the patient liability amount. This rate shall remain in effect until it is updated each year following the July 1 nursing facility case mix rate update. The individual components of the assisted living rate calculation are further detailed as follows:

- The nursing facility provider fee component is removed from the statewide average nursing facility case mix rate.
- The statewide average nursing facility case mix rate is further reduced for the patient liability amount. The patient liability amount recognizes that portion of the nursing facility rate that is for room and board (items of comfort or convenience, or the costs of center maintenance, upkeep and improvement, cost of rent, the purchase of food, or the cost of furnishing units with kitchenettes) after considering the personal needs allowance for an adult residential care (ARC) waiver participant. The patient liability amount will be based on Louisiana Medicaid statewide nursing facility claims data for the calendar year immediately

preceding the ARC rate effective date. The average per day patient liability amount will be adjusted for the difference between the ARC personal needs allowance (PNA) and the nursing facility PNA in effect at the rate effective date.

After establishing the July 1 statewide average nursing facility case mix rate, minus the provider fee and patient liability, the result will be multiplied by an ARC percentage associated with the nursing services for each tier provided for ARC waiver participants for services within the care plan.

Room and board policy
The rates will not include room and board which will be capped at the SSI rate minus a personal needs allowance, which has not been determined.

Services covered
The proposed waiver includes the following services: medication administration, intermittent nursing services, assistance with personal hygiene, assistance with transfers and ambulation, assistance with dressing, housekeeping, meals, transportation, and laundry. ARC services are equivalent to services provided in assisted living centers.

Waiver level of care criteria
The state has criteria for skilled nursing care and two levels of intermediate care. The minimum criteria for admission to a nursing home include the following: requiring supervision or assistance with personal care needs, assistance in eating, administration of medications, injections less than daily, skin care, protection from hazards, mild confusion or withdrawal, medications for stable conditions, or those requiring monitoring once a day and stable blood pressure requiring daily monitoring. The determination is made by a physician based on his or her professional judgment of the above factors**.**

Units
ARC providers must meet Louisiana Department of Health and Hospital's licensure standards and waiver rules. The licensure standards require single occupancy units that include a kitchenette and bathroom. Waiver participants must have adequate space for personal furnishings or ARC-provided furnishings that create a home-like living environment. Units may be shared with individuals unrelated to the waiver participant but only when the waiver participant initiates the request. The state's intent is to dissuade sharing of units; however, there will be instances where sharing is appropriate (for example for married couples, siblings, or in some instances long-time friends). Support coordinators shall authorize such requests only for the purpose of assuring that the ARC provider applied no undue pressure to share the unit.

All units shall have a private full bathroom and kitchenettes equipped with a refrigerator, cooking appliance (a microwave is acceptable) and adequate storage space for utensils and supplies.

Mental health services
Not reported.

Maine

Licensing category Residential Care Facilities (Private Nonmedical Institutions)

Coverage summary
Services are covered in residential care facilities that contract with Medicaid as private non-Medicaid Institutions and ALFs. Services are reimbursed as rehabilitation services under the Medicaid state plan. State policymakers are exploring options to cover services under a §1915 (c) waiver or to use the personal care state plan option rather than the rehabilitation services option.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
State plan (PNMI)	138	211	150	151
State plan (assisted living)	7	NR	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
State plan (PNMI)	3,445	4,571	3,762	3,096
State plan (assisted living)	155	NR	NA	NA

Rate methodology and payment
The rate for MaineCare beneficiaries receiving PNMI services in an "Appendix C" RCF consists of the sum of: a peer group PNMI Direct Care price adjusted by a case mix index determined by the Minimum Date Set-Residential Care Assessment (MDS-RCA) assessment tool; PNMI Personal Care Services (PCS) costs; and room and board costs. The PNMI RCF rate components are based on a combination of audited FYE 12/31/98 costs, peer group upper limits and pass-through fixed costs. (Appendix C refers to the MaineCare (Medicaid) manual.)

The rate for MaineCare beneficiaries receiving assisted living services (ALS) in an ALF is a base price adjusted by a case mix index determined by the Minimum Data Set-Assisted Living Services (MDS-ALS) assessment tool. The ALS rate is a $42 base price adjusted by the case mix resource group. The ALS rate is based on time studies.

Rates for both settings are adjusted semi-annually through the rule-making process.

Room and board policy
Room and board charges for MaineCare beneficiaries in the seven ALFs are subject to the HUD limits. Room and board charges for MaineCare beneficiaries in the PNMI Appendix C RCFs are subject to the limit in the MaineCare rate. The ALS SSI state supplement is $10; the PNMI Appendix C RCF State supplement is "up to $234."

Services covered
PNMIs are reimbursed for personal care, housekeeping, laundry, dietary, and other services. The case mix adjusted price includes services provided by the direct care services staff such as

clinical consultant services; interpreter services; licensed practical nurse services; licensed social workers or other social worker services; practical nurses; registered nurse consultant services, and other qualified medical and remedial staff.

Assisted living services means the provision of assistance with ADLs and IADLs, personal supervision, protection from environmental hazards, diet care, care management, diversional or motivational activities, medication administration, and nursing services within an ALF.

Waiver level of care criteria
NA

Units
Reasonable and necessary funishing, fixtures and equipment are an allowable cost in a PNMI Appendix C RCF.

Mental health services
Not addressed.

Maryland

Licensing category Assisted Living Programs

Coverage summary
The state administers an HCBS waiver and a state-funded program that serves beneficiaries age 50 and older in residential settings. A waiver amendment included assisted living services as part of a broad package of services available to people 50 years of age or older in their own or in residential settings.

The state-funded Senior Assisted Living Group Home Subsidy program provides access to assisted living in small group homes that are licensed by the Department of Health and Mental Hygiene for 4 to 16 residents. The subsidy supports the cost of services provided in assisted living, including meals, personal care, and 24-hour supervision for elderly residents who are frail and unable to live independently. Participants with incomes no greater than 60% of the statewide median income and assets no greater than $11,000 for a single person and $14,000 for a couple apply their income (less a $68 needs allowance) toward the cost of care.

State law directs the Office of Aging to develop assisted living programs in conjunction with public or private, profit or nonprofit entities, maximizing the use of rent and other subsidies available from federal and state sources. These activities can include finding sponsors; assisting developers formulating design concepts and meeting program needs; providing subsidies for congregate meals, housekeeping and personal services; developing eligibility requirements in connection with the subsidies; adopting regulations governing eligibility; and reviewing compliance with relevant regulations.

Several factors were cited for the growth of the program. The declining health status of older adults over time; an increase in participants who are transitioning from nursing homes; and the lack of family members to provide oversight and support lead to increased use of assisted living programs.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	997	975	763	362
State general revenue	349	300	NR	259

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1015 (c) waiver	1,314*	1,810*	1,793*	730
State general revenue	716	754	350	520

* The figures reported for 2007 and 2004 represent unduplicated counts; the 2009 figure represents current enrolled waiver participants.

Rate methodology and payment
The state uses a two-tiered payment methodology for Medicaid waiver services. Under the general revenue program, the Department of Aging pays the difference between the resident's income, after deducting $68 a month for personal needs and $650 a month.

State regulations require that Medicaid waiver rates be reviewed annually. Automatic adjustments are made July 1 of each year by the lesser of: a percentage increase based on the program's budget for the fiscal year or the change from March to March in the medical component of the Consumer Price Index for all urban consumers for the Washington-Baltimore area. The regulations specify that rates may increase 2.5% a year. However, the regulations are amended each year depending on the funds available in the program's budget and cost containment priorities. Approval of rate increases or the amount of the increase in 2009 may depend on the status of state revenues.

Medicaid payment rates (daily)		
	Level II	**Level III**
Services	$56.86	$71.72
Services if also receiving medical day care	$42.65	$53.78
Assistive equipment add on	Up to $1,000	up to $1,000

Room and board policy
The Medicaid rates do not include room and board which is capped at $420 per month. Residents retain a personal needs allowance of $68 a month. Family supplementation is not permitted. Non-SSI beneficiaries are allowed a personal needs allowance of $64 a month and all additional income is applied to the cost of care. SSI beneficiaries retain SSI benefits above the amount paid for rent and do not pay toward the cost of services. The SSI payment standard is $858 a month.

Services covered
Assisted living program are responsible for providing three meals per day and snacks including provision of or arrangement for special diets; daily monitoring of resident and resident's assisted living service plan; personal care and chore services; medication management including administration of medications or regular assessment of participants ability to self-medicate and regular oversight by the facilities delegating nurse; facilitating access to health care and social services, including but not limited to social work services, rehabilitation services (occupational, physical, speech and therapies), home health services, hospice services, skilled nursing services, physician services, oral health care, dietary consultation and services, counseling, psychiatric, other specialty health and social work services; providing or arranging for socialization opportunities, leisure activities, and access to religious and spiritual activities including providing/arranging transportation; nursing supervision and delegation of nursing tasks by registered nurse; basic personal hygiene supplies; and assistance with transportation to Medicaid and other needed services.

Waiver level of care criteria
Nursing home care is covered when an individual requires health related services provided on a daily basis by or under the supervision of a nurse due to medical, cognitive or physical disability.

The need for intermittent, part-time services does not qualify (for example home health nursing), nor does the need for unlicensed care (e.g., personal care) even if care is needed full time. There is some overlap in how the term intermittent nursing care is applied under the licensing and Medicaid level of care policies.

Units
Apartment-style units are not required. Shared bedrooms are allowed. Residents are responsible for furnishing their unit.

Mental health services
Mental health screening is not required as part of the process for determining appropriateness for placement. However, case managers and assisted living programs are responsible for arranging for mental services when they are needed.

Massachusetts

Licensing category Assisted Living Residences (ALRs are certified)

Coverage summary
Services for eligible low income tenants in residences that contract with Medicaid are subsidized through the Group Adult Foster Care (GAFC) program. GAFC is a service available under the Medicaid state plan rather than a Medicaid waiver. The program serves adults over age 22 that have a physician's authorization confirming they are at risk of entering an institution. Participants must have at least one ADL impairment. GAFC is available in ALRs and conventional elderly housing.

Although figures were not available, the fastest-growing group of GAFC participants live in other community settings (non-assisted living residences). Masshealth (Medicaid) members living in ALRs and receiving GAFC services grow at a slower rate due many factors including the high cost of the room and board in ALR settings. The majority of ALRs in Masachusetts are for-profit entities and charge fair market rates for rental units. The majority of ALRs only reserve a few number of units for lower income residents who are eligible for GAFC.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
State plan	NR	NR	101	44

Participants				
Source	**2009**	**2007**	**2004**	**2002**
State plan	NR	NR	1,120	922

Rate methodology and payment
The rate is $40.33 a day effective April 1, 2008. The rate was set by the Division of Health Care Finance and Policy based on 2006 direct care cost data submitted by providers. The payment includes two components—one for administrative costs and another for direct care. The service rate is based on the provision of two hours of personal care per day, case management, and nursing oversight (0.5 hours per day). The methodology includes a component for administration, calculated as 20% of the direct care costs. A cost adjustment factor is applied to account for differences between the base cost year and the rate years. MassHealth is beginning to collect cost data that will be used to revise the current rate setting methodologies.

Room and board policy
The state created a special living arrangement for residents in assisted living residences that participate in the GAFC program. The SSI payment rate in 2009 is $1,128 a month. The state does not have a policy on supplementation. The personal needs allowance was not reported.

Services covered
Participants receive assistance with personal care including ADLs and IADLs; nursing oversight and care management. In addition to GAFC services, participants may also receive other

MassHealth covered services including but not limited to two days of adult day health services, therapy, private duty nursing, and so forth.

Waiver level of care criteria
Individuals must need one skilled service daily from a specified list or have a medical or mental condition requiring a combination of at least three services including at least one nursing service. The nursing services that must be performed at least three days a week include: specified physician ordered skilled services; positioning while in bed or chair; measurement of intake or output based on medical necessity; administration of oral or injectable medications that require a RN to monitor the dosage, frequency, or adverse reactions; staff intervention requirements for selected types of behavior considered dependent or disruptive, unable to avoid simple dangers, wandering; physician ordered occupational, speech, or physical therapy; nursing observation and/or vital signs monitoring; or treatment involving prescription medication for uninfected post-operative or chronic conditions or routine dressing changes that require nursing care and monitoring. Two services may be required for assistance with bathing (i.e., direct care, attendance, or constant supervision), dressing (i.e., direct care, attendance, or constant supervision), toileting, bladder or bowel control for incontinence, scheduled assistance, or routine catheter/ostomy care, transfers, mobility/ambulation or eating.

Units
Licensed ALRs must offer apartment-style units. Shared units are allowed. State policy does not address who is responsible for furnishing the unit.

Mental health services
Mental health screening for participation in GAFC is not required. Responsibility for arranging for mental health services is not addressed; however, participants are assessed by a multidisciplinary team and the process would identify such needs.

Michigan

Licensing category Homes for the Aged; Adult Foster Care

Coverage summary
Medicaid personal care coverage under the state plan is available to beneficiaries in adult foster care and homes for the aged. Waiver services are available to beneficiaries living in housing that may be operated as an unlicensed facility, that is, a facility or building that does not provide personal care services and, therefore, is not required to be licensed. Because these unlicensed settings are considered a person's home, services can be received from providers of one's choice.

The Medical Services Administration submitted a waiver amendment in April 2009 to add services in residential settings to the MI Choice HCBS waiver. The waiver application estimates that 150 people will be served in year 2; 600 in year 3; 670 in year 4; and 690 in year 5.

The waiver amendment also adds funds for 25 waiver slots to support an affordable assisted living option. This housing and service option will not be licensed and adds services to convention elderly housing. One provider began operating in May 2009, and additional funds will be added to the waiver as more developments are ready to admit tenants.

Michigan licenses five types of adult foster care (AFC) homes that will be available in the MI Choice Waiver. Family homes serve 1–6 residents; small group homes serve 1–12 residents; medium group homes serve 7–12 residents; large group homes serve 13–20 residents; and congregate homes service 21 or more residents. Michigan is phasing out the licensing of congregate homes, but existing homes continue to operate. Homes for the aged (HFA) are licensed separately and generally house 21 residents or more.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
State plan	NR	NR	NR	NR
§1915 (c) waiver	NA	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
State plan	6,498*	10,300	14,138	13,000
§1915 (c) waiver	NA	NA	NA	NA

* Fiscal 2008 data.

Rate methodology and payment
The 2008 appropriations act passed by the legislature raised the rate paid to licensed facilities for personal care state plan services by $8 a month to $192.38 a month effective October 1, 2008. The Department of Community Health is reviewing options to replace a per diem rate in residential settings. State and CMS officials are reviewing rate options to unbundle the rate including a tiered rate.

Under the waiver amendment, services will be reimbursed based on the assessment and plan of care prepared by the waiver case manager. Waiver agents (case management agencies) will receive $40 a day in year 2; $41.60 in year 3; $43.26 in year 4 and $44.99 in year 5 for each participant. However, the amount received by the service provider will vary based on the needs of each participant determined by an assessment and a care plan prepared by the case manager. Participants will have the option to receive services from the AFC/HFA staff or another community service provider.

Room and board policy
Room and board is not included in the rate. The state SSI payment standard is $831.50 a month in adult foster care and $853.30 a month in homes for the aged. The personal needs allowance is $44 a month.

Under the waiver amendment, payment excludes room and board, items of comfort and convenience, costs of facility maintenance, upkeep and improvement, or other costs that are required under the terms of licensure.

Services covered
The personal care supplement (state plan) covers assistance with eating/feeding, toileting, bathing, grooming, dressing, transferring, ambulation, and assistance with self-administered medication. Assistance in adult foster care homes includes verbal prompts.

The waiver proposes to add residential services in licensed adult foster care and homes for the agend. Residential services include enhanced assistance with ADLs and supportive services. MI Choice participants who receive this service must reside in a licensed homelike, non-institutional setting. As a stipulation of the licensure standards, such settings provide continuous on-site response capability to meet scheduled or unpredicted resident needs and provide supervision, safety, and security.

Waiver level of care criteria
See table below.

Units
Apartment-style units are not required in AFC/HFAs. Facilities are responsible for furnishing the unit. Units may be shared.

Mental health services
Case managers do screen applicants for mental health needs to determine appropriateness of admission and are responsible for arranging for services.

Michigan level of care criteria		
Door	**Areas scored**	**Threshold**
1: ADLs	(A) Bed mobility, transfers, toilet use, and (B) eating.	Score of 6: (A) independent or supervision, 1; limited assistance, 3; extensive or total, 4; did not occur, 8. (B) independent/supervision, 1; limited assistance, 2; extensive or total, 3; did not occur, 8.
2: Cognitive performance	Short-term memory, cognitive skills for daily decision making, communication.	Must have severely impaired decision making, memory problems and moderate or severely impaired decision making, or memory problem and sometimes or rarely understood.
3: Physician involvement	Under care for an unstable medical condition.	Based on frequency of physician visits and orders.
4: Treatments and conditions	Stage 3–4 pressure sores; intravenous or parenteral feedings; intravenous medications; end-stage care; daily tracheotomy care, respiratory care, or suctioning; pneumonia; daily oxygen therapy; daily insulin with two order changes in past 14 days; peritoneal or hemodialysis.	At least one of nine conditions.
5: Skilled rehabilitation therapies	Speech, occupational, or physical therapy.	Requires at least 45 minutes of active therapy in last seven days and continues to require therapy.
6: Behavior	Wandering, physical/verbal abuse, socially inappropriate/disruptive, resists care, delusions/hallucinations.	Either has delusions/hallucinations or exhibits other behaviors at least four of last seven days.
7: Service dependency	Currently receiving services in a NF or waiver program.	Must be a participant for one year.

Minnesota

Licensing category Class A and Class F Home Care Providers

Coverage summary
Services for low-income residents have been covered through the Medicaid HCBS waiver program since 1993. Coverage through the state-funded Alternate Care Program was dropped in September 2005. Coverage of services in residential settings was changed July 1, 2007, based on legislation passed in 2006 and 2007. Services in residential settings are now called "customized living services" and "24-hour customized living services." Rates are negotiated within caps based on the case mix classification system (see table) and are based on the service to be delivered rather than a base rate.

The current budget climate and growth of the program, driven in part by residents spending down their assets to Medicaid eligibility levels, focused attention of options for containing costs. Anecdotal information suggests that some providers may be increasing room and board charges to offset lower rates.

In FY2006, the state implemented changes to the service delivery systems for elderly waiver recipients resulting in the statewide expansion of capitated payments to managed care providers required to provide the elderly waiver benefits. Delivery programs include MSHO, an integrated Medicaid/Medicare health care/long-term care option; and Minnesota Senior Care Plus, a Medicaid health care/long-term care option. In FY2006, many waiver participants transitioned from fee for service to the managed care options. In FY2007, state law mandated that all seniors be enrolled in managed care. Minnesota Senior Care Plus operated in 80 counties. At the end of FY2008, 71% of elderly waiver clients received services through a managed care organization.

Facilities*				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	615	588	396	281

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	8,795	7,369	4,114	2,895

* The number of "facilities" is the number of housing with service establishments that contract to serve Medicaid beneficiaries. Of the 1,400 housing with service establishments, about 63% are considered assisted living. Class A and Class F home care providers are not included.

Note: 2009 participant data include fee-for-service and managed care participants living in residential care and AFC who were not included in previous reports. 2007 data represent the unduplicated number of people receiving customized living services and 24-hour customized living services for the calendar year.

Rate methodology and payment
The rate was developed within the case mix framework already used to establish individual service packages and has evolved over time to provide more accountability and consistency in

developing an individual service package based on assessed needs that drive an authorized service package. Rates for individuals change when a new assessment justifies a change in services. Payment rate parameters and service limits may change annually based on legislative actions that effect all provider rates.

State officials are developing a rate tool designed to improve consistency across purchasers and standardize how inputs to the rate are used to establish and bundle any individual's total service package. The tool will be finalized in the summer of 2009.[13]

Minnesota case mix categories and maximum statewide rate limits for assisted living and all other waiver services—effective 10/1/08			
Case mix	**Customized living payment[a]**	**24-hour customized living rate limits[b]**	**Description**
A	$1,149	$2,298	Up to 3 ADL dependencies
B	$1,307	$2,615	3 ADLs + behavior
C	$1,534	$3,067	3 ADLs + special nursing care
D	$1,682	$3,169	4–6 ADLs
E	$1,747	$3,495	4–6 ADLs + behavior
F	$1,800	$3,601	4–6 ADLs + special nursing care
G	$1,858	$3,716	7–8 ADLs
H	$2,095	$4,193	7–8 ADLs + behavior
I	$2,161	$4,303	7–8 ADLs + needs total or partial help eating (observation for choking, tube, or intravenous feeding, and inappropriate behavior)
J	$2,292	$4,587	7–8 ADLs + total help eating (as above) or severe neuromuscular diagnosis or behavior problems
K	$2,673	$5,346	7–8 ADLs + special nursing

[a] Statewide average customized living monthly payment by case-mix classification.

[b] See EW Customized Living Workbook – Steps 2 & 3 an Excel workbook available at http://www.dhs.state.mn.us/dhs16_143983.

Room and board policy

The rates do not include room and board. Room and board charges are not capped. Family members may supplement the resident's payment. The group residential housing payment is a state SSI supplement for individuals who are risk of institutional placement. The SSI payment standard for 2009 is $776 a month. A Minnesota supplemental aid payment is also available.

[13] See Bulletin #09-25-08. DHS Issues Elderly Waiver (EW) Customized Living (CL) Planning and Rate-Setting Tool. Available at http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_145868.pdf

Services covered
Customized living service is a package of component services individually designed to meet the assessed needs of a waiver participant living in a qualified setting. [14] The components can include supervision and oversight, home management tasks including laundry and meal preparation, home care aide tasks, home health aide-like tasks, central storage of medications, incidental nursing services and supervision, medication assistance, and emergency response.

24-Hour Customized Living/Assisted Living Plus services include individualized supports that are chosen and designed specifically for each recipient's needs and can only be provided in a registered housing with services establishment. The services include 24-hour supervision and oversight; home care aide tasks; home management tasks; meal preparation; arranging for or providing transportation; assisting with setting up meetings or appointments; socialization; and assisted with personal fund management. 24-hour on-site supervision covers ongoing awareness of the person's needs and activities; a method for the person to summon assistance; and an employee is available to respond to a resident's request within a reasonable amount of time. Residential care services are also provided in residential settings and include up to 24-hour supervision, meal preparation, home management tasks, socialization, setting up meetings and appointments, arranging medical and social services, assistance with management of personal funds, and coordinating or providing transportation.

Waiver level of care criteria
Nursing facility level of care determinations may be based on a variety of conditions or needs, including complex medical needs, unstable health, need for assistance with ADLs or IADLs, or dementia or other cognitive impairments, and subsequent need for supervision or assistance.

The determination includes evaluating whether the applicant is able to:

- meet their personal care needs;
- perform household management tasks;
- communicate basic wants and needs and ensure their own safety; and
- access community resources.

The nursing facility level of care criteria applies to individuals who have the need for at least one of the following:

- physical assistance to perform activities of daily living or someone to complete ADLs for the individual;
- physical assistance to perform IADLs or someone to complete IADLs for the individual;
- assistance with ADLs or IADLs resulting from a sensory impairment;
- extended state plan home care services to prevent or delay nursing facility admission secondary to a complex or unstable medical need;
- home modifications or equipment that will maximize independence and contribute to meeting health and safety needs;

[14] Bulletin #08-25-07. Comprehensive Policy on Elderly Waiver customized (formerly Assisted) Living. Available at http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_142555.pdf

- services or supports to access community resources or maintain social networks and relationships;
- caregiver supports to supplement and extend supports provided by informal caregivers;
- supervision, direction, cueing, or hands-on assistance to perform activities or IADLS due to cognitive limitations.

Units
Apartment-style units are not required. Units may be shared by choice of the residents. State policy does not address who is responsible for furnishing the units. Residents may receive assistance from a supplemental aid program and the HCBS waiver's transitional supports service to furnish a unit.

Mental health services
Case managers and facility staff screen for mental health needs to determine appropriateness of placement. HCBS case managers arrange mental health services when necessary.

Mississippi

Licensing category Personal Care Homes

Coverage summary
The information is based on data provided in 2007. A Medicaid waiver was implemented as a pilot program in seven counties in 2001 to serve older adults, people with disabilities, and people with dementia. In 2006, coverage was expanded statewide.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	14	6	1

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	200	68	15

Rate methodology and payment
In 2007, the per diem rate was $33.18. The rate was developed based on case mix adjusted rates paid to nursing homes for less impaired residents (PA1 and PA2). Average rates were computed for four nursing home rate components: direct standard care, care related rate, administrative costs, and operating costs. The payment rate consists of 40% of the direct care standard, 10% of the care-related rate, and 50% of the administrative and operating rates.

Room and board policy
Room and board is not included in the Medicaid rate.

Services covered
Services included in the payment are personal care; homemaker services; chore services; attendant care services; medication oversight; therapeutic, social, and recreational programs; intermittent skilled nursing services; transportation; and attendant call systems.

Waiver level of care criteria
Beneficiaries qualify for the waiver if they need assistance in three ADLs (eating, toileting, bathing, personal hygiene, ambulation, transferring, and/or dressing) or two ADLs plus a diagnosis of dementia. The assessment form is completed by a physician.

Units
Not reported.

Mental health services
Not reported.

Missouri

Licensing category Assisted Living Facilities; Residential Care Facilities

Coverage summary
Missouri received approval from CMS for a §1915 (c) HCBS waiver for assisted living services that will serve up to 5,000 participants. The waiver will be implemented when funding is approved by the legislature.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
Medicaid state plan	794	614	494	569

Participants				
Source	**2009**	**2007**	**2004**	**2002**
Medicaid state plan	7,401	6,000	8,125	7,300

Note: 2004 participants represent an unduplicated count from 2003; 2007 and 2009 figures represent the number of participants in July 2007 and March 2009.

Rate methodology and payment
When the HCBS waiver is implemented, AFLs will receive $37, $45, or $53 a day depending upon the individual's needs. The proposed waiver rates were based on average costs for participants in the state plan personal care program and "aged and disabled" waiver and the number of ADLs in which a participant requires assistance.

State plan personal care services are reimbursed in 15-minute increments. Effective July 1, 2008, the rate is $4.10 for personal care aide services and $4.61 for advanced personal care aide services. Nursing visits are paid at $31.07 per visit. The maximum payment is $2,646 per month. The payment varies by resident based on an assessment and a plan of care completed by a case manager from the Division of Health and Senior Services. Rates usually increase annually when funding is approved by the state legislature.

Room and board policy
Facilities set the charges for room and board. Family supplementation is allowed. Missouri provides a "supplemental nursing grant" of up to $156 for RCF Level I and $292 for ALFs and former RCF IIs that choose not to become licensed as an ALF for total payments of $830 and $966 per month respectively. The personal needs allowance is $30 a month.

Services covered
Personal care covers hands-on assistance in dietary needs, dressing and grooming, bathing and personal hygiene, toileting and continence, mobility and transfer; and asistance with the self-administration of medications including applying nonprescription topical ointment or lotion

Waiver level of care criteria
Eligibility for nursing home and personal care services is determined by a scoring system. Applicants with an assessed level of 21 or more points qualify for intermediate care and higher point levels qualify for skilled nursing care. Residents are assessed in nine areas: mobility; dietary (eating); restorative services; monitoring; medication; behavior; personal care (hygiene, personal grooming including dressing, bathing, oral hygiene, hair and nail care, and shaving) and bowel and bladder functions; and rehabilitation. Each area receives points based on the level of need: 0 points for no or very limited care; 3 points for minimal care; 6 points for moderate assistance; and 9 points for maximum assistance. Regulations defines what qualifies as minimal, moderate, and maximum assistance. The assisted living waiver also requires daily assistance in one ADL.

Units
Apartment-style units are not required. Shared units are permitted. Providers are responsible for furnishing each unit.

Mental health services
Facilities are responsible for screening residents for mental health needs. State regulations require that residents referred by the Department of Mental Health (DMH) shall have an individual treatment plan or individual habilitation plan on file prepared by DMH. Facilities that admit or retain residents with mental illness and residents with assaultive or disruptive behavior shall provide treatment and services to address the residents' needs and behavior as stated in their individual service plans. If specialized rehabilitative services for mental illness are required, the facillity must ensure the required services are provided.

Mental health screening is not completed to specifically address the appropriateness of residents for placement. Providers complete the pre-admission screening to ensure the facility is able to care for their needs and an individualized service plan to address any care needs they have. Facilities that accept residents with a mental health need must ensure they provide appropriate care and services to the resident. There is also a requirement that facilities cannot continue to care for residents whose needs cannot be met.

Montana

Licensing category Assisted Living Facilities

Coverage summary
An HCBS waiver program provides adult residential care services to elders, people with disabilities, and people with mental illness in ALFs and adult foster homes. Growth in the number of participants is driven by an increase in the population needing long-term care services and the annual expansion of waiver slots. However, more facilities are expressing reluctance to accept Medicaid participants and a few either no longer accept Medicaid or require that waiver participants share rooms.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	167	133	165	111

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	858	614	475	400

Rate methodology and payment
Rates are based on a care plan that includes two components. Facilities receive a basic service payment of $717 a month, which covers meal service, homemaking, socialization and recreation, emergency response system, medical transportation, and 24-hour availability of staff for safety and supervision. Additional payments are calculated based on ADL and other impairments. Points are calculated for each impairment—bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, cognitive functioning and other. Each function is rated as follows:

- With aids/difficulty: needs consistent availability of mechanical assistance or expenditure of undue effort;
- With help: requires consistent human assistance to complete the activity, but the individual participates actively in the completion of the activity; or
- Unable: the individual cannot meaningfully contribute to the completion of the task.

Each point equals $34 a month. For example, a resident consistently needing help with toileting would be scored a 2 and would earn $68 a month for that impairment.

The maximum payment is $65.05 per day in 2009 compared to $63.35 per day in 2007. The state agency requests annual provider rate increases each biennium from the legislature to respond to increased in provider costs. However, increases in the next budget are not likely due to the current budget climate.

The state is not considering changes to the rate methodology. The methodology was developed to reflect differences in the range of service needs of participants and differences in the level of service available from facilities. The rates were developed based on equivalent payments for participants living in their own home.

Room and board policy
The Medicaid rates do not include room and board. Charges for room and board are set at the medically needy income standard, which is $645 a month. The SSI state supplement payment standard is $768 a month and includes a personal needs allowance of $100. Family supplementation is not permitted.

Services covered
Adult residential care is a bundled service which includes personal care, homemaker services, nutritional meals and snacks, medication oversight (to the extent permitted under state law), social and recreational activities, and 24-hour on-site response to ensure the care, well being, health and safety needs of the residents are met at all times.

Waiver level of care criteria
Applicants can meet criteria in either of two areas to be eligible. The first area includes one of the following: comatose; ventilator dependency; respiratory problems requiring constant treatments, observation or monitoring under direction of registered nurse; unstable medical conditions requiring 24-hour availability of services; nasopharyngeal aspiration; cognitive impairment requiring a structured, professionally staffed environment; tube feedings; or maintenance of a tracheostomy, gastrostomy, colostomy, ileostomy, or other indwelling tubes. The second area requires two of the following: constant supervision to total human assistance in two ADLs; administration of daily medications; physical, mental, or medical needs that are deteriorating or will continue to deteriorate in the absence of monitoring or supervision; restorative nursing or therapy treatments; care of extensive decubitus ulcers or other widespread skin diseases; or requires regular intervention by a case manager.

Units
Apartment-style living units are not required. Rooms may be shared, and providers are responsible for furnishing each unit.

Mental health services
Waiver case managers screen applicants for mental health needs and arrange services from community providers as needed.

Nebraska

Licensing category Assisted Living Facilities

Coverage summary
A Medicaid HCBS waiver was implemented in July 1998. Waiver assisted living services are available to elders and people with disabilities. The state uses a flat rate system that varies for urban/rural facilities, trust fund facilities, and single/double occupancy.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	220	217	187	130

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	1,776	1,693	1,500	605

Rate methodology and payment
Rates are set for single and multiple occupancy and rural and urban areas of the state. Rates are adjusted annually as directed by the legislature. Payments to ALFs that received funding from a trust fund to convert from nursing home to ALF receive 95% of the service rate. The total rate, including room and board and the client's share of cost (if any), is $2,155 a month for single occupancy units in rural areas and $2,432 a month in urban areas. Rates for multiple occupancy units are $1,649 a month per person in rural areas and $1,858 in urban areas. The rates below were effective January 1, 2009.

	Room and board	**Rural single occupancy Total payment**	**Rural multiple occupancy Total payment**	**Urban* single occupancy Total payment**	**Urban* multiple occupancy Total payment**
Standard	$614.00/mo	$2,155.00	$1,736.00	$2,432.00	$1,956.00
Trust fund	$614.00/mo	$2,047.00	$1,649.00	$2,310.00	$1,858.00
Admission & discharge months					
Daily standard rate for all days client is physically present	$614.00 Prorated	$50.66	$36.89	$59.77	$44.12
Daily trust fund rate for all days client is physically present	$614.00 Prorated	$47.11	$34.03	$55.76	$40.90

*Urban Counties—Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward, and Washington Counties

Room and board policy
The rates include room and board. Charges for room and board are capped at $614 a month in 2009. The personal needs allowance is $60 a month. Family supplementation is not allowed.

Services covered
Adult day care/socialization activities; escort services; essential shopping; health maintenance activities; housekeeping activities; laundry service; medication assistance; personal care services; and transportation services.

Waiver level of care criteria
Participants must have one of the following:

- limitations in three or more ADLs and require medical treatment or observation; or
- limitations in three or more ADLs and one or more risk factors; or
- limitations in three or more ADLs and one or more cognition factors; or
- limitations in one or more ADLs and one or more cognition factors and one or more risk factors.

ADLs include bathing, continence, dressing/grooming, eating, mobility, toileting, and transferring. Risk factors include behavior (the ability to act on one's own behalf, including the interest or motivation to eat, take medications, care for one's self, safeguard personal safety, participate in social situations, and relate to others in a socially appropriate manner); frailty (the ability to function independently without the presence of a support person, including good judgment about abilities and combinations of health factors to safeguard well-being and avoid inappropriate safety risk); and safety (the availability of adequate housing, including the need for home modification or adaptive equipment to ensure safety and accessibility; the existence of a formal and/or informal support system; and/or freedom from abuse or neglect).

Medical treatment or observation means: a medical condition is present that requires observation and assessment to ensure evaluation of the individual's need for treatment modification or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe and/or evaluate the need to contact skilled medical professionals; or due to the complexity created by multiple, interrelated medical conditions, the potential for the individual's medical instability is high or exists; or the individual requires at least one ongoing medical/nursing service. The regulation includes a non-inclusive list of such services which may indicate need for medical or nursing supervision or care.

Cognition addresses memory (the ability to remember past and present events; does not need cueing); orientation (fully oriented to person, place, and time); communication (the ability to communicate information in an intelligible manner and the ability to understand information conveyed); and judgment (the ability to solve problems well and make appropriate decisions).

Units
Apartment-style units are not required. Units may be shared only by choice of the residents. The payment for single occupancy units is higher than the rate for double occupancy units. ALFs are responsible for providing essential furniture and the resident or family may furnish the unit.

Mental health services
Case managers include mental health as part of the screening process. The provision of mental health services is not specified; however, they are accessed as a Medicaid state plan service.

Nevada

Licensing category Residential Facilities for Groups

Coverage summary

The states has two §1915 (c) waivers that cover services in residential settings: the waiver for the elderly in adult residential care (WEARC) and the assisted living (AL) waiver. The AL waiver serves a maximum of 45 participants due to limited funding.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver – WEARC	87	73	52	66
§1915 (c) waiver – AL	1	1	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver – WEARC	330	333	222	121
§1915 (c) waiver – AL	45	50	NA	NA

Rate methodology and payment

The state uses a tiered methodology. Rates for WEARC waiver have been in effect since 2003 and the state's experience indicates that the rates attract enough providers to make services available consistent with efficiency, economy and quality of service. The rates are established by a unit of the Division of Health Care Financing and Policy based on federal regulations and fee studies prior to billed charges. Rates are the same for WEARC and AL providers.

Adult Residential Care Levels of Service				Daily Rates
Assisted Living Level 1	Supervision to minimal assistance with an ADL and a score a 3 on the Total Level of Care Score line.	Personal Care Level 1	Supervision to minimal assistance with an ADL and a score a 3 on the Total Level of Care (LOC) Score line.	$20.00
Assisted Living Level 2	Moderate assistance with both critical ADLs* or moderate assistance with any 4 ADLs or dependent with 1-2 ADLs or score of 2 in at least 1 critical behavior.**	Personal Care Level 2	Moderate assistance with both critical ADLs* or moderate assistance with any 4 ADLs or dependent with 1-2 ADLs or score of 2 in at least 1 critical behavior.** Minimal physical assistance with ADLs, with some tasks requiring moderate assistance.	$45.00
Assisted Living Level 3	Maximum assistance to dependent with both critical ADLs or maximum assistance with any 4 ADLs or dependent for 3 or more ADLs or score of 3 in at least one critical behavior area.	Personal Care Level 3	Maximum assistance to dependent with both critical ADLs or maximum assist with any 4 ADLs or dependent for 3 or more ADLs or score of 3 in at least one critical behavior area. Moderate physical assistance with ADLs, with some self care tasks requiring maximal assistance.	$60.00

*Critical ADLs include eating/feeding, bladder and bowel continence

**Critical behaviors include wandering, resists care, self-abusive behavior, abusive to others, and memory/cognition

Room and board policy
The rates do not include room and board and are not capped. Family members may supplement the room and board charges. The state supplements the federal SSI payment. The total payment is $1,065 a month in 2009 and the personal needs allowance is $110 a month.

Services covered
Assisted living supportive services, including augmented personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, and services that will ensure that the residents of the facility are safe, secure and adequately supervised. This care is over and above the mandatory service provision required by regulation for residential facilities for groups. There are three levels of augmented personal care based on the recipient's functional status.

Waiver level of care criteria
The waiver application describes the level of care as follows:

The assessment includes medical history pertinent to nursing facility placement, ability to safely self administer medications; special needs such as durable medical equipment or frequency and duration of any treatments; the level of assistance (self care, supervision, assistance, dependent) needed with activities of daily living (mobility, transfers, locomotion, dressing, eating, feeding, hygiene, bathing, bowel and bladder); need for supervision; ability to perform instrumental activities of daily living (meal preparation and homemaking services related to personal care). Additional consideration given to social history and current living environment, family (or other) support systems available, discharge planning information, potential risk of injury or danger to self or others. The assessment determines if the condition requires the level of services offered in a nursing facility with at least three functional deficits identified in sections 1-5 of the screening tool or a more integrated service which may be community based. The applicant/recipient would require imminent placement in a nursing facility (within 30 days) if HCBS waiver services or other supports were not available.

Units
Apartment-style units are required by the assisted living waiver and units may be shared by choice of the residents. Apartment-style units are not required by the WEARC waiver and units may be shared. Responsibility for furnishing the units is not addressed.

Mental health services
Case managers and facility staff screen applicants to determine the appropriateness of admission for people with mental health needs. Responsibility for arranging or providing mental health services is not addressed.

New Hampshire

Licensing category Assisted Living Facilities

Coverage summary
A Medicaid waiver was approved in 2000 that includes assisted living. Respondents attributed slow growth in participation to the preference of individuals to remain independent as long as possible and receive services in their own homes rather than move into a residential setting. Residential settings are more acceptable to individuals who are transitioning from a long-term stay in nursing homes. The participants are afforded more independence with assistance when necessary.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	71	75	42	37

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	356	243	176	178

Rate methodology and payment
The flat rate in 2009 is $2,185 a month. The rate methodology is based on state statutes which states that every two years, the department of health and human services must review Medicaid reimbursement rates based on: Medicare rates; Medicaid rates in other New England states; reimbursement rates of managed care companies and other commercial payers; and actual provider costs. Rates are also based on information and testimony gathered from a public hearing, held as part of the biennial rate setting process, at which time providers, beneficiaries and their representatives and other concerned residents are given a reasonable opportunity to review and comment on the rates, rate setting methodologies and justifications.

Room and board policy
Room and board is included in the payment rate. The SSI payment is $735 a month and the personal needs allowance is $56 which leaves $679 a month for room and board. Room and board charges are not capped. Supplementation is allowed on a case by case basis.

Services covered
Services covered in the rate are listed in the licensing rules that allow ALFs to provide health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided 24 hours a day regarding the residents' functioning, safety and whereabouts; and the residents' health status, including the provision of intervention as necessary or required; emergency response and crisis intervention; medication services; food services; housekeeping, laundry and maintenance services; on-site activities designed to sustain and promote physical, intellectual, social and spiritual well-being of all residents; assistance in arranging medical and dental appointments, including transportation to and from such appointments and reminding the residents of the appointments; and personal supervision of residents when required to offset cognitive deficits that may pose a risk to self or others if the resident is not supervised.

The licensee shall provide access to nursing services, rehabilitation services, including documentation of the licensed practitioner's order for the service, such as physical therapy, occupational therapy and speech therapy; and behavioral health care services.

Waiver level of care criteria
A person is Medicaid eligible for nursing facility services if they require 24-hour care for one or more of the following purposes, as determined by the Department of Health and Human Services:

- medical monitoring and nursing care;
- restorative nursing or rehabilitative care;
- medication administration (or instruction and supervision of self-medication for discharge purposes only); or
- assistance with two or more ADLs involving eating, toileting, transferring, bathing, dressing, and continence.

Units
Apartment-style units are not required. Units may be shared by choice of the residents. Providers are responsible for furnishing the unit.

Mental health services
Screening for mental health needs to determine appropriateness of admission is not required. ALFs and case managers are responsible for arranging for services when needed.

New Jersey

Licensing category Assisted Living Residences; Assisted Living Programs and Comprehensive Personal Care Homes

Coverage summary
The state covers services in three settings: assisted living residences, assisted living programs, and comprehensive personal care homes. A law passed in 2001 requires that facilities licensed after September 2001 must set aside 10% of their units to serve Medicaid residents within three years of licensing. The requirement is waived if there is a waiting list for Medicaid waiver services.

The Department of Health and Senior Services consolidated several waivers into a single "global options" waiver. The consolidation changed the method of reporting and participants are no longer coded as assisted living waiver participants. Participants in residential settings are now identified by tracking the provider's billing code.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	229	162	159	118

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	2,730	2,966	2,195	1,500

Rate methodology and payment
The state uses a flat daily payment that varies by the licensing category. The rates are $70 a day for assisted living residences; $60 a day for comprehensive personal care homes; and $50 a day for assisted living programs. Rates are typically adjusted every 3 to 4 years.

Room and board policy
The rates do not include room and board. Room and board is capped at $724.05. The SSI state supplement payment is $824.05 and includes a $100 personal needs allowance. Family supplementation is permitted for an upgraded living unit.

Services covered
The rates covers meals, personal care, chore services, attendant care, laundry, medication administration, social activities, skilled nursing, ongoing assessment, health monitoring, and provision of or arrangements for transportation to and from medical appointments. The waiver application describes assisted living as a coordinated array of supportive personal and health services, chore, medication administration, and intermittent skilled nursing services that are available 24 hours per day.

Waiver level of care criteria
Nursing home level of care means care, treatment, and services that may be provided to individuals who have chronic or unstable medical, emotional, behavioral, psychological, or social conditions resulting in the inability to care for themselves independently and/or safely.

Clinical eligibility for level of care is determined when the individual requires limited assistance in three ADLs: bathing, dressing, toileting, transferring, locomotion, bed mobility and eating; OR because of a cognitive deficit that affects short-term memory, procedural memory and/or decision-making and judgment, requires supervision/cueing or a combination of limited assistance and supervision/cueing to complete three ADLs**.**

Units
Apartment-style units are required in assisted living residences and assisted living programs. Units may be shared. State policy does not address responsibility for furnishing the unit.

Mental health services
Screening for mental health needs is not required; however, the Department is considering using the PASRR process to address this area.

New Mexico

Licensing category Adult Residential Care Facilities

Coverage summary
The HCBS disabled and elderly waiver for elders and people with disabilities covers assisted living services in licensed adult residential care facilities. New Mexico converted from a fee for services program to a managed term care model in 2008. The program, Coordination of Long-Term Services (CoLTS), covers Medicaid acute care services, institutional long-term care, and HCBS. Services are provided by two managed care organizations (MCOs)—Amerigroup and Evercare.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	40	19	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	180	254	189	76

Rate methodology and payment
The flat rate was $49.99 per day in 2007. These rates will continue until the MCOs negotiate rates with providers.

Room and board policy
Room and board are not included in the Medicaid rate. Charges are negotiated between the facility and the participant. Income supplementation is allowed but the state does not have an official policy. Providers obtain an informed consent form signed by the consumer that identifies the room and board charge. The personal needs allowance is included in the informed consent.

Services covered
The CoLTS provider contract states that assisted living services include personal supports services, companion services and assistance with medication administration.

Standards issued in 2006 describe assisted living as a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by the Interdisciplinary team and incorporated in the Individualized Service Plan. Assisted living services include ADLs (i.e., ability to perform tasks that are essential for self care, such as bathing, feeding oneself, dressing, toileting, and transferring) and IADLs (i.e., ability to care for household and social tasks to meet individual needs within the community). Core services provide assistance to the recipient in meeting a broad range of ADLs. Specific services may include the following; personal hygiene; dressing; eating; socialization; opportunities for individual and group interaction; housekeeping; laundry; transportation; meal preparation and dining; 24-hour, on-site response capability to meet scheduled or unpredictable participant needs; capacity to provide ongoing supervision of the

waiver recipient within a 24 hour period; and coordination of access to services not provided directly.

Waiver level of care criteria
Medical eligibility is based on nursing facility level of care general criteria and one or more clinical status factors. The general criteria require that two or more ADLs cannot be accomplished without consistent, ongoing, daily provision of some or all of the following levels of service: skilled, intermediate, and/or assistance. The functional limitations are secondary to a condition for which general treatment plan oversight of a physician is medically necessary. The clinical factors are medications, respiratory therapy and supplemental oxygen, ventilator care, ostomy care, management of decubitus ulcers, dressings, specialized rehabilitative or restorative care by qualified therapists and "other" services such as organic brain damage, dementia, and spinal cord injury.

Units
Apartment-style units are not required. Shared units are permitted. Responsibility for furnishing the units is not addressed.

Mental health services
Case managers and facility staff screen applicants for mental health needs. HCBS case managers are responsible for arranging for services.

New York

Licensing category Adult Homes; Enriched Housing Programs

Coverage summary
The state covers services in assisted living programs (ALPs) under the Medicaid state plan. To participate in the program, providers must be a certified adult care facility (adult home or enriched housing program) and hold a license as a home care services agency (licensed home care services agency, certified home health agency, or long-term home health care program). In 2008, the Department of Health issued a request for applications to add slots to the existing 4,000. The state's policy is to increase ALP beds in an effort to decrease the number of nursing home beds and reduce overall Medicaid expenditures in the future. In 2008, the Department awarded 1,854 slots that are still being processed. Slots were allocated by county and proposals received priority that:

- target services to people who otherwise may be inappropriately placed in a nursing home and whose residential and healthcare needs can be met by the ALP;
- demonstrate commitment to admit and retain individuals in receipt of SSI, Safety Net benefits, or medical assistance (MA);
- increase the supply of new ALP beds rather than convert existing AH and/or Enriched Housing Program (EHP) beds to ALP beds; and
- are able to commence services most quickly by demonstrating completion or near completion of financial arrangements and site control, and those who meet architectural compliance without any new construction or renovations, ideally operational within 22 months of contingent approval.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
State plan	70	62	57	53

Participants				
Source	**2009**	**2007**	**2004**	**2002**
State plan	3,701	3,335	3,315	3,034

Rate methodology and payment
The state sets the rate for assisted living programs at 50% of the comparable RUG payment for services in a nursing home.

Room and board policy
Room and board is not part of the service rate. The SSI payment standard for individuals in ALPs is $1,368 and includes room, board, and personal care. The personal needs allowance is $178 a month. Family supplementation is not permitted.

Services covered
The Medicaid rate covers home care, therapies, nursing, medical equipment (no prior authorization), and adult day health care. Personal care is covered by the SSI state supplement payment.

Waiver level of care criteria
NA

Units
Apartment units are not required and units may be shared. The ALP is responsible for furnishing the unit.

Mental health services
ALP staffs are responsible for screening application for mental needs and also arranging services from an outside provider.

North Carolina

Licensing category Adult Care Homes

Coverage summary
Personal care services are covered under the Medicaid state plan. The state is developing a §1915 (c) waiver.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
Medicaid state plan	1,242	1,497	2,200	2,389

Participants				
Source	**2009**	**2007**	**2004**	**2002**
Medicaid state plan	21,078	20,442	24,000	18,533

Rate methodology and payment
The payment includes a basic amount for personal care which varies between small and large faciltiles and an enhanced payment for residents with heavy care needs. Heavy care means a resident needs extensive assistance or is totallly dependent in eating or toileting, or both, and/or ambulation/location. Eligibility for the additional payment is based on the adult care home's assessment, which is verified by a county case manager.

Payment rates (per day)		
	1–30 beds	31+ beds
Basic personal care	$17.50	$19.17
Enhanced factors		
Eating	$10.80	$10.80
Toileting	$3.86	$3.86
Ambulation/locomotion	$2.76	$2.76
Transportation	$.60	$.60
Special care unit rate	$46.79	$51.25

Room and board policy
The rates do not include room and board. Family supplementation is permitted when the resident or family members request a private room. Room and board charges are covered by a Special Assistance Adult Care Home payment (an SSI state supplement). The nonfederal cost is split between the state and counties. The maximum payment is $1,253 a month, which includes a $46 personal needs allowance. The maximum payment in special care units is $1,515 a month.

Services covered
The payment cover basic and enhanced personal care and transportation services.

Waiver level of care criteria
NA

Units
Apartment-style units are not required. Units may be shared by choice of the residents. The provider is responsible for furnishing the unit; however, residents may bring their own furnishings.

Mental health services
In 2007, the legislature passed an amendment to the appropriations act that directed the Department of Health and Human Services to complete a Medicaid screening tool to determine the mental health of individuals admitted to adult care homes. Facilities are responsible for arranging mental health services from an outside provider.

North Dakota

Licensing category Basic Care Facilities; Assisted Living Residences

Coverage summary
The summary is based on information obtained in 2007. Residential care is covered in licensed settings serving five or more residents under a §1915 (c) waiver. Funding is also available through two state-funded programs—Service Payments for the Elderly and Disabled (SPED) and the expanded SPED. The expanded SPED program is a companion program to the basic care program and serves eligible persons living in their own home. Participants must be Medicaid-eligible and are moderately impaired, typically requiring some assistance with ADLs, supervision, or a structured environment. Participants served by the expanded SPED program are not as impaired as participants in the SPED program or in nursing facilities.

The SPED program serves participants who are frailer than individuals in the expanded SPED program, but not nursing home eligible. Participants must meet program financial eligibility requirements including a $50,000 liquid asset test, but do not have to be Medicaid eligible. Participants may be required to pay a portion of the costs of care. Contributions are based upon income levels and a sliding fee scale.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	56	42	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	NR	31	NR

Rate methodology and payment
The waiver payment was based on a plan of care with a cap of $80 a day in 2007.

The reimbursement rates and covered services are the same for Expanded Service Payments for the Elderly and Disabled (EXSPED) and SPED. Rates are based upon the tenant's plan of care. A point system is used to convert unmet service functional needs to a rate. The maximum rate for services was $49.23 a day in 2007 for both the SPED and expanded SPED programs.

Room and board policy
The waiver rate does not include room and board. Supplementation is allowed.

Services covered
Residential care under the HCBS waiver covers services provided in a facility in which at least five unrelated adults reside and in which personal care, therapeutic, social, and recreational programming are provided in conjunction with shelter. The service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security.

SPED and ESPED services are provided in a range of settings and include personal care, homemaker and other services provided in a person's home (chore, emergency response, environmental modifictions, and respite care), and adult family foster care.

Waiver level of care criteria
In addition to criteria related to rehabilitative and medical needs, individuals are eligible for admission to a nursing facility if they need constant help 60% of the time with at least two ADLs (toileting, eating, transferring, and locomotion). Constant help means continual presence or help without which the activity would not be completed; the individual has dementia that requires a structured, professionally staffed environment; or the individual needs help with two or more of the following: administration of medications, constant help 60% of the time with one of the above ADLs, feeding tubes, decubitus care, one or more unstable medical conditions requiring specific, individual services on a regular or continuing basis under the care of a registered nurse, or the person has restorative potential.

To be eligible for SPED, applicants must have impairments in four ADLs or five IADLs. Eligibility for ESPED is impairment in three of four IADLs (meal preparation, housework, laundry, or taking medications) or has health, welfare, or safety needs, including supervision or structured environment.

Units
Not reported.

Mental health services
Not reported.

Ohio

Licensing category Residential Care Facilities

Coverage summary
Assisted living services are available under a §1915 (c) waiver that only covers assisted living services. Enrollment is capped at 1,800. The waiver is affected by factors that contribute to increased participation and others that decrease participation. The state statute was amended to allow current residents of an ALF to enroll in the waiver. According to respondents, several factors may reduce participation: the limited personal needs allowance; prescription drug co-pays; provider capacity; and the perception by individuals in the community that the settings are institutions. However, an evaluation of the assisted living waiver by the Scripps Gerontology Center, the Benjamin Rose center, and the Jessie Richardson Foundation found satisfaction was very high. More than 90% rated employee relations (courteous, respectful, and friendly), facility environment (attractive, clear), resident environment (privacy, safety), and choice (choose bedtime, rules reasonable) as high. The lowest rating was for meals and dining (food tasty, food you like - 81% favorable) and care and services (snacks available, medications timely - 84%). Twenty-eight percent of waiver residents did not think the food was tasty and 22% did not think employees explained the care and services very well.[15] The same study reported that focus groups with consumers and caregivers identified three important factors affecting use of assisted living: consumer and family awareness of the option, readiness to make the transition decision, and access to an ALF of choice. Case managers expressed widespread support for the waiver.

The Department of Aging Web site (http://aging.ohio.gov/services/assistedliving/) includes information on conditions of participation; the statutory definition of assisted living services; transition services that may be covered for beneficiaries moving from to assisted living; and questions and answers about provider certification.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	169	60	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	1,115	235	NA	NA

Rate methodology and payment
Payments vary by tiers that are assigned based on three levels of service and four categories (cognitive impairments, physical impairments, nursing and medication management) and the amount and type of service(s) the assisted living provider is responsible for delivering to the consumer:

- The cognitive impairment category tier assignment is based on the frequency of intervention required to ensure the consumer's health and safety needs are met.

[15] http://aging.ohio.gov/resources/publications/ALevaluation2009.pdf

- The physical impairment category tier assignment is based on the amount of time required to assist the consumer with ADLs/IADLs as a result of a physical limitation(s). Examples of a condition/diagnosis that may result in the need for assistance with ADLs/IADLs include: Parkinson's disease, chronic obstructive pulmonary disease, amputee secondary to diabetes, cerebral vascular accident.
- The nursing category tier assignment is based on the frequency of individualized, hands-on nursing care provided by the facility.
- The medication management category tier assignment is based on the type of intervention required by the consumer provided by the facility.

The waiver evaluation found that 90% of the participants were assigned to Tier 3 and only one participant was assigned to Tier 1.

The state contracted with a consulting agency to evaluate the current rate methodologies for all waiver services including assisted living. The report concluded that the current acuity-based rate system could be improved by refining the description of the tiers and considering setting regional rates to reflect differences in direct care costs.

The rates are specified in the waiver application and are subject to change during the next waiver cycle. Rates are also subject to the biennial state budget process. Rates have not changed since the waiver was implemented in 2006. The decision to propose changes to the rates is a joint discussion between the Medicaid agency, the Office of Budget Management and the Department of Aging. If a rate change is approved by the legislature, rules governing the waiver must be issued for comment and approved by the Joint Committee on Agency Rule Review. In addition, a waiver amendment must be approved by CMS.

Medicaid Payment Rates			
Category	**Tier 1**	**Tier 2**	**Tier 3**
Rate	$49.98 per day	$60.00 per day	$69.98 per day
Cognitive Impairments	Occasional prompts	Daily cuing and prompts	Ongoing cueing, prompts and redirection
Medication Administration	Independent with Medications (Requires no staff involvement)	Supervision/assistance with medication management (staff involvement with procurement, storage and reminders)	Medication administration by qualified staff
Nursing	No individualized, scheduled, hands-on care provided by a licensed nurse	Weekly and/or monthly individualized, hands-on care provided by a licensed nurse.	Daily nursing care due to an unstable medical condition or intermittent skilled nursing care provided by the facility
Physical Impairments	Individuals who require up to 2.75 hours of service per day	Individuals who require more than 2.75 hours and less than 3.35 hours of service per day	Individuals who require more than 3.35 hours of service per day

Note: The category with the highest tier assignment determines the tier that will be assigned. Example: if a client meets Tier 2 for cognitive impairments and Tier 3 for Medication Management, tier 3 is assigned.

Room and board policy
The rates do not include room and board. Charges are capped at $624 a month in 2009, and the personal needs allowance is $50 a month. Family supplementation is not permitted.

Services covered
Services include 24-hour on-site response; personal care; homemaking, including personal laundry; coordination of three meals a day; social and recreational programming, nonmedical, scheduled transportation; and nursing services that include health assessment/monitoring and medication administration.

Waiver level of care criteria
Waiver participants must have an intermediate or skilled level of care. If the individual requires skilled nursing care beyond supervision of special diets, application of dressings, or administration of medication, it must only be required on a part-time, intermittent basis for not more than a total of 120 days in any 12-month period. A part-time, intermittent basis means that skilled nursing care is needed for less than eight hours a day or less than 40 hours a week.

For the skilled level of care, individuals must require at least one skilled nursing service at least seven days a week or a skilled rehabilitation service at least five days a week. For intermediate care, an individual must need hands-on assistance with at least two ADLs; or assistance with one ADL and be unable to perform self-administration of medications and require assistance with administration; or requires one or more skilled services at less than a skilled care level (seven days per week); or require the supervision of another person 24 hours a day due to dementia.

Units
Apartment-style units are required and shared units are allowed by choice of the residents. State policy does not specify who is responsible for furnishing the unit. The residential care facility licensing rules incude a list of furnishings that must be available. The provider may offer the items at no cost. The resident may also rent or purchase the items, or the resident may furnish the unit. The HCBS waiver provides up to $1,500 for community transition services that can be used to furnish a unit by individuals who relocate from a nursing facility.

Mental health services
Mental health screening to determine appropriateness of the placement is conducted by waiver case managers. Case managers also arrange mental health services when needed.

Oklahoma

Licensing category Assisted Living Centers

Coverage summary
The state is submitting an amendment to CMS to add assisted living cover services to a broad §1915 (c) waiver. State policymakers expect that, when implemented, provider participation will depend on the adequacy of rates and the inability of in-home services to meet client needs on weekends and late at night.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	8*	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	90*	NA	NA	NA

* Projections for 2009

Rate methodology and payment
A three-tiered rate structure for ADvantage assisted living services has three per diem rate levels based upon individual consumer need for services: type, intensity, and frequency to address consumer ADL/IADL and health care needs. The determination of levels and the setting of rates within each level were informed by the following sets of data: historical data from service plans and claims data for individuals served to date by ADvantage with comparisons of service type, amount and frequency with ADL/IADL and health care needs and data from Oklahoma Assisted Living providers on cost of operation obtained by National Cooperative Bank Development Corporation (NCBDC) survey funded by a CMS grant.

Daily payment rate		
Total score	**Group**	**Daily rate**
0–6	A	$42.24
7–10	B	$57.00
11–15	C	$79.73

Room and board policy
Room and board charges are limited to 90% of the federal SSI payment, $606.60 a month in 2009. There is a $46 state supplement for personal needs.

Services covered
Services covered within the assisted living services package are assistance with housekeeping, meal preparation and serving, laundry, personal care (including assistance with transfer or ambulation), nurse supervision, intermittent skilled nursing care, medication administration, cognitive orientation, and programs for socialization, activity, and exercise.

Waiver level of care criteria
Level of care is based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment. The minimum level of care criteria are:

1. Documented need for assistance to sustain health and safety as demonstrated by either the ADLs or Mental Status Questionnaire score is in the high risk range; or any combination of two or more of the following:
    - ADLs score is at the high end of moderate risk range; or,
    - MSQ score is at the high end of moderate risk range; or,
    - IADLs score is in the high risk range; or,
    - Nutrition score is in the high risk range; or,
    - Health assessment is in the moderate risk range
    - and, in addition –

2. The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:
    - Client Support is moderate risk; or,
    - Environment is high risk; or,
    - Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met.

3. The UCAT documents that:
    - The client has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:35-17-2(2)(A) criteria if untreated; and
    - The client previously has required hospital or nursing facility level of care services for treatment related to the condition; and
    - A medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
    - Only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

Units
Apartment-style units are required. Units may be shared by choice of the residents. Residents and family members are responsible for furnishing the units.

Mental health services
Facility staff and case managers are responsible for screening for mental health needs to determine appropriateness of placement. Case managers are responsible for arranging services.

Oregon

Licensing category Assisted Living Facilities; Residential Care Facilities

Coverage summary
Medicaid covers services in residential settings under an HCBS waiver that covers multiple services. Respondents reported that participation by providers has been stable since 2002 while the number of waiver participants served grew modestly in ALFs but doubled in residential care facilities (RCFs) between 2004 and 2009. In March 2009, Medicaid beneficiaries accounted for 39% of all occupied ALF units and 34% of RCF units. Medicaid ALF occupancy rates fluctuated in the 35%–39% range between March 2005 and March 2009, and in the 32%–34% range in RCFs.

About 14% of all HCBS participants lived in ALFs in December 2008. Oregon ranks beneficiaries according to service priority levels (SPLs) which are based on combinations of activities of daily living. ALFs served just over 10% of all participants in SPLs 1–4; 8.8% of participants in SPLs 5–8 and nearly 42% of the people in SPLs 9–13.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver: Assisted Living Facilities	178	172	170	172
Residential Care Facilities	174	156	165	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver: Assisted Living Facilities	3,921	3,870	3,731	3,600
Residential Care Facilities	2,260	2,113	1,127	NR

Rate methodology and payment
ALF rates are set based on the acuity of residents. There are five levels of payment. The levels are assigned based on a service priority score determined through an assessment. (See table below.) ADLs include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control, and behavior. Critical ADLs are toileting, eating, and behavior.

Medicaid also pays for services for persons living in level 2 RCFs who meet the nursing home level of care criteria. In 2009, the RCF base service rate for all clients was $1,249 per month. Depending on impairment level, there are three add-on payments. The base payment plus one add-on is $1,491; base plus two add-ons is $1,733; base plus three add-ons is $1,975. The add-on is based primarily on how dependent a person is with ADLs.

Medicaid service priority categories & payment rates: assisted living (1/1/09)				
Impairment Level	**Service Priority**	**Services**	**Room & board**	**Total rate**
Level 5	Dependent in three to six ADLs OR dependent in behavior and one to two other ADLs	$2,355	$523.70	$2,878.70
Level 4	Dependent in one to two ADLs OR assistance in four to six ADLs plus assistance in behavior	$1,957	$523.70	$2,480.70
Level 3	Assistance in four to six ADLs OR assistance in toileting, eating and behavior	$1,558	$523.70	$2,081.70
Level 2	Assistance in toileting, eating, and behavior or behavior AND eating or toileting	$1,242	$523.70	$1,566.70
Level 1	Assistance in two critical ADLs or assistance in any three ADLs or assistance in one critical ADL and one other ADL	$1,002	$523.70	$1,525.70

A new payment methodology is being developed that would set rates at a percentage of the private market rate. Factors that affect participation in Medicaid include the strength of private pay market and a moratorium on licensing new facilities which inhibits development.

Room and board policy
Room and board charges are capped at $523.70 in 2009. The personal needs allowance retained by residents is $141 a month. Family supplementation is not allowed.

Services covered
The Medicaid rate pays for the bundle of services provided by AFLs under the licensing requirements. Required services include three nutritional meals and snacks a day; personal and other laundry services; a program of social and recreational activities; services to assist with ADLs; medication administration and household services. Facilities must provide or arrange for social and medical transportation and ancillary services for related medical care (physicians, pharmacy, therapy, podiatry).

Waiver level of care criteria
Medicaid regulations set priorities for services based on the amount of assistance needed with a specified ADL or combination of specified ADLs and cognition. Due to budget constraints, the priority thresholds have been changed. Eligibility is currently limited to levels 1 to 13 effective July 1, 2004. The SPLs are:

- dependent in mobility, eating, toileting, eating, and cognition;
- dependent in mobility, eating, and cognition;
- dependent in mobility or cognition or eating;
- dependent in toileting;
- substantial assistance with mobility, assistance with toileting and eating;

- substantial assistance with mobility and assistance with eating;
- substantial assistance with mobility and assistance with toileting;
- minimal assistance with mobility and assistance with eating and toileting;
- assistance with eating and toileting;
- substantial assistance with mobility;
- minimal assistance with mobility and assistance with toileting;
- minimal assistance with mobility and assistance with eating;
- assistance with toileting;
- assistance with eating;
- minimal assistance with mobility;
- full assistance with bathing or dressing;
- assistance with bathing or dressing; and
- independent in the above levels but requires structured living for supervision for complex medical programs or a complex medication regimen.

Units
ALFs must offer apartment-style units with lockable door, private bathroom, and kitchenette. Units must provide 220 square feet of space, not including a private bathroom. Shared units are allowed by resident choice.

RCFs may have individual or shared living units that provide a minimum of 80 square feet per resident and serve not more than two residents per unit. Shared units are allowed.

Providers are responsible for furnishing units in both settings.

Mental health services
Facilities are responsible for screening for mental health needs but responsibility for providing or arranging for mental health services is not addressed by state policy.

Pennsylvania

Licensing category Personal Care Homes; Assisted Living Residences

Coverage summary
SB 704, passed by the legislature in 2007, creates an assisted living residence (ALR) licensing category and authorizes coverage of services in ALRs through a §1915 (c) waiver with priority for prospective or current residents facing imminent admission to a nursing facility. Licensing regulations are expected to be effective January 1, 2010, and the state plans to implement a §1915 (c) waiver by June 2010.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NA	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NA	NA	NA	NA

Rate methodology and payment
Not determined.

Room and board policy
SB 704 specifies that the actual rent and other charges may not exceed the SSI resident's actual current monthly income less a personal needs allowance of not less than $25 a month.
The SSI/State Supplement payment in Personal Care Homes is $1,113.30 in 2009 and includes a personal needs allowance of $60 a month.

Services covered
Not determined.

Waiver level of care criteria
Not reported.

Units
SB 704 requires apartment-style units in assisted living residences that may be shared by choice of the resident. The regulations must require that each living contain a private bathroom, living and bedroom space, kitchen capacity, closets, adequate space for storage, and a door with a lock.

Mental health services
Not determined.

Rhode Island

Licensing category Assisted Living Residence

Coverage summary
In 2009, services in assisted living residences are covered under two §1915 (c) waivers. The community assisted living waiver (CALW) covers a broad range of services, including assisted living, for residents who are relocating from nursing homes. The RI housing and mortgage finance assisted living (RIHMF) waiver covers case management and assisted living services for elderly and adults with physical disabilities in a demonstration program involving the Department of Elderly Affairs and the Rhode Island Housing Mortgage and Finance Agency to develop affordable projects.

In 2009, the state received approval from CMS for a §1115 waiver called the Global Community Choice Compact demonstration which consolidates all Medicaid services, including waiver services, into one program. The state is planning to transition to the new waiver during 2009.

The RIHMF waiver contracts with 16 sites, but only three serve residents. In June, 22 sites participated in the CALW waiver and additional facilities are interested in contracting to provide services. The CALW waiver has 243 participants. The number of participants in the RIHMF waiver is an estimate. The waiver has a cap of 200 slots.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	38	37	35	35

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	433	411	230	220

Rate methodology and payment
Both waivers use a flat rate for services. The rate is $36.32 a day. Under the Global Community Choice Compact, the rate methodology is expected to change.

Room and board policy
The rates do not include room and board charges. Room and board charges are capped at $700 a month for the CALW waiver and $1,132 for the RIHMF waiver. The SSI state supplement is $1,232 a month which includes a personal needs allowance of $100 a month. Supplementation is not permitted.

Services covered
The waivers cover personal care, minor assistive devices, meal preparation, housekeeping, case management, and 24-hour staffing.

Waiver level of care criteria
Nursing home residents must require the services of professional and/or qualified technical health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, audiologists, or require assistance with activities of daily living including walking, bathing, dressing, feeding, and toileting. The level of care criteria will be revised under the Global Community Choice program.

Units
Apartment-style units are required for both waivers. Furnishings are provided by the facility but residents are able to bring their own furnishings. The CALW allows units to be shared.

Mental health services
Facilities screen applicants to determine the appropriateness of placement and are responsible for arranging mental health services from outside agencies.

South Carolina

Licensing category Assisted Living/Community Residential Care Facilities

Coverage summary
In 2002, South Carolina added the integrated personal care program to the Medicaid state plan. The program covers personal care in residential settings and serves elders, adults with disabilities, people with mental retardation/developmental disabilities, and individuals with mental illness. To be eligible for coverage, beneficiaries must already receive the optional state supplement to the SSI program, which is available to persons residing in community residential care facilities and require assistance with two ADLs, or need assistance with one ADL and have a cognitive impairment, be unable to live alone due to inadequate support, and need assistance to sustain maximum functional level. Facilities must contract with a licensed nurse at least one day a week who is responsible for providing personal care training to staff and developing and monitoring care plans of individuals served by the integrated personal care program.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
State plan	60	52	35	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
State plan	820	829	600	NA

Rate methodology and payment
The payment covers one unit (one hour) of personal care services per participant day. The rate was increased from $14.80 a unit in 2007 to $16.00 a unit.

Room and board policy
Rates do not include room and board. Room and board charges are capped at $1,100 for optional state supplement recipients. Family supplementation is not permitted. The personal needs allowance is $57 a month.

Services covered
In addition to personal care services and incontinence supplies, facilities must be able to provide medical monitoring, medication administration and also be ADA compliant.

Waiver level of care criteria
NA

Units
Apartment-style units are not required. Information about sharing of units was not reported.

Mental health services
Facilities screen applicants for mental health service needs and arrange for services that are provided by physicians or local mental health providers.

South Dakota

Licensing category Assisted Living Centers

Coverage summary
Information in this summary was obtained in 2007. Services for elders are covered by a state optional supplement program and a limited HCBS waiver. The state supplement program is not a state supplement to the SSI payment. It serves Medicaid eligible adult and elderly beneficiaries who meet assisted living level of care criteria. The Medicaid HCBS waiver covers a single service, medication administration, in assisted living centers.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	109	140	110
General revenues	NR	101	90	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	160	227	NR
General revenues	NR	938	500	250

Rate methodology and payment
Under the waiver, centers received a total service payment of $30.64 per day in 2007. The payment rate for room and services under the general revenue program was $1,212 a month in 2007.

Room and board policy
The general revenue program payment includes room and board. Family supplementation is not allowed for either the state general revenue program or the Medicaid HCBS waiver program.

Services covered
Medication administration.

Waiver level of care criteria
The medical review team may assign an individual to a nursing facility level of care classification if the individual requires any of the following services:

- Continuing direct care services that have been ordered by a physician and can only be provided by or under the supervision of a professional nurse. These services include daily management, direct observation, monitoring, or performance of complex nursing procedures. For purposes of this rule, continuing care is repeated application of the procedures or services at least once every 24 hours, frequent monitoring, and documentation of the individual's condition and response to the procedures or services.

- The assistance or presence of another person for the performance of any ADL according to an assessment of the individual's needs completed according to §44:04:06:15.
- In need of skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week.

Units
Not reported.

Mental health services
Not reported.

Tennessee

Licensing category Assisted Care Living Facilities

Coverage summary
The state amended its §1915 (c) waiver to add assisted care living facility (ACLF) services in 2006. Legislation was needed to amend the licensing statute to allow ACLFs to serve waiver eligible residents as long as the services are consistent with the enrollee's plan of care and admission/retention is not otherwise prohibited under the law. The Department of Health completed a legal analysis of the language and confirmed that persons enrolled in HCBS waivers may be served in ACLFs so long as such persons otherwise qualify as "ACLF residents." The regulations require that residents are "ambulatory." The regulations further specify that, except under certain circumstances, an ACLF cannot admit or retain residents who require listed nursing services.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	31	NA	NA	NA

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	177	NA	NA	NA

Rate methodology and payment
Rates are based on each facility's usual and customary charges. ACLFs provide separate usual and customary charges for covered services and room and board. Examples of costs that are considered part of the service package include: salaries of personal care support employees, homemaker employees, other support staff and supervisors who provide oversight; the cost of preparing, serving and cleaning up after meals ("raw" food costs are excluded); FICA, staff health insurance costs or other benefits, worker's compensation, unemployment compensation (as apportioned to support and supervision); staff travel; resident travel (including vehicle depreciation); administrative overhead costs of doing business, including: office supplies and furnishings, percentage of administrative staff salaries, office telephone, recruitment, audit fees, operating fees/permits/licenses, percentage of office space costs, data processing costs, legal fees; staff liability insurance/agency liability insurance; and staff training/development/education.

The service payment is capped $1,100 a month. State officials are considering a tiered rate system to accommodate individuals who may need more intensive hands-on care than is typically provided in ACLF settings, or in allowing individuals with certain levels of need to receive personal care or other services in addition to the basic level of assistance that is typically provided under the ACLF services benefit.

Room and board policy
Room and board rates must be based on documented costs and are capped at 80% of the maintenance allowance, which is set at 200% of the federal SSI benefit ($1,348 in 2009.

Examples of costs that are considered room and board include: 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 as a service); household supplies and equipment necessary for the room and board of the individual; and furnishings used by the individual (does not include office furnishings).

Family members may supplement room and board up to the maximum payment.

Services covered
Assisted care living facility services are personal care services, homemaker services and medication oversight (to the extent permitted under state law) provided in a home-like environment in a licensed ACLF.

Waiver level of care criteria
Care must be expected to improve or ameliorate the individual's physical or mental condition, prevent deterioration in health status, or delay progression of a disease or disability. Individuals must have a condition that requires daily in-patient nursing care and need help with one or more of the following: transfer to and from bed, chair or toilet; mobility; eating; toileting (including use of toilet or incontinence care); expressive or receptive communication; orientation; medication administration; behavior; or skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than can practically be provided through a daily home health visit. Assistance with ADLs must be daily or multiple times per week. Nursing care includes observation and assessment, administration of legend drugs, supervision of nurse aides, and other skilled nursing therapies performed by LPNs or RNs.

Units
Information about apartment-style unit requirements was not reported. Shared units are not allowed. Residents/family members are responsible for furnishing the unit.

Mental health services
Mental screening to determine the appropriateness of admission is not required, and state policy does not address who is responsible for arranging or providing mental health services.

Texas

Licensing category Assisted Living Facilities

Coverage summary
Services in ALFs are covered under a broad §1915 (c) waiver. Provider payment level, well-organized nursing home relocation activities, and the complexity of medical and functional conditions of the resident affect the level of participation and the number of people served in the waiver.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	230	220	300	309

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c)	2,359	2,393	2,851	2,263

Rate methodology and payment
Texas uses a case mix system with uniform, statewide payment rates. Providers are required to submit an annual report of all costs associated with delivering services. The cost data are used to develop payment rates. The legislature directed the Department of Disability and Aging Services to establish a rate enhancement program designed to increase compensation and benefits to attendant staff. Participation in the rate enhancement program is optional. Providers who choose to participate in rate enhancement receive a higher rate based on a case mix of consumer level of care and the level of provider participation. Participating providers must complete an annual report verifying the provider has met the attendant compensation spending levels required for participation in rate enhancement.

Medicaid payment rates effective January 1, 2009 (daily)			
Group	**Single occupancy apartment**	**Double occupancy apartment**	**Non-apartment**
Nonparticipant rates	$40.96	$31.91	$22.66
Participant rates			
AL 1	$66.18	$59.18	$40.63
AL 2	$61.22	$54.23	$35.67
AL 3	$54.46	$47.47	$28.92
AL 4	$57.05	$50.06	$31.50
AL 5	$50.82	$43.84	$25.28
AL 6	$49.10	$42.11	$23.55

Room and board policy
The rates do not include room and board. Room and board charges are capped at SSI less an $85 a month for personal needs. Family supplementation is not allowed.

Services covered
Assisted living/residential care services means a 24-hour living arrangement in licensed assisted living in which personal care; home management; escort; social and recreational activities; 24-hour supervision; supervision of; assistance with and direct administration of medications; and the provision or arrangement of transportation are provided.

Waiver level of care criteria
Medical conditions and health care needs are, at a minimum, such that they require institutional care under the supervision of a physician. Waiver applicants and participants must meet the level-of-care/medical necessity criteria for nursing facility admission as specified in 40 TAC Part 1 Chapter 19 Subchapter Y and must need services for which a licensed nurse's supervision is required on a daily and/or routine basis. Factors assessed include: diagnoses; medications and dosage; physician’s evaluation; rehabilitative services; ADLs; sensory/perception status; behavioral status; restraints/safety devices; and therapeutic interventions.

The level of care is determined by combining an ADL score with assessments of the medical condition, rehabilitation, nursing care and confusion or behavioral problems. The ADL score is calculated by combining scores for transferring, eating, and toileting. A low ADL score indicates greater independence.

40 TAC Part 1 Chapter 19 Subchapter Y specifies that the individual must demonstrate a medical condition that: is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person and he/she requires licensed nurses' supervision, assessment, planning and intervention that are available only in an institution. The individual must require medical or nursing services that are ordered by a physician; are dependent upon the individual's documented medical conditions; require the skills of a registered or licensed vocational nurse; are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and are required on a regular basis.

Units
Apartment units are required. Units may be shared by choice of the residents. Providers are responsible for furnishing the unit.

Mental health services
Residents are screened for mental health needs by the facility to determine appropriateness of admission. Case managers are responsible for arranging services.

Utah

Licensing category Assisted Living Facilities

Coverage summary
In 2007, the state converted coverage in assisted living from a §1915 (a) state plan amendment to a §1915 (c) waiver. The New Choices Waiver covers adult residential services in ALFs and other residential settings. It serves individuals with disabilities over age 21 and adults age 65 and older who have been covered by Medicaid in a nursing home for at least 90 days and want to relocate to the community or who receive services in another waiver and are at immediate or near immediate need of admission to a nursing home.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	125	NR	77	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	642	548	380	400

Rate methodology and payment
The daily rate was reduced to $69.75 a day from $72.57 in May 2009. In setting the initial rate in 2007, state officials noted that ALFs provided a broad range of services and utilization varies depending on participant needs. The rate was set to compensate for the variation in services provided. ALFs submitted cost reports that assisted in setting the rate and ensuring that the service rate does include room and board costs. Many ALFs set a base rate with additional charges for services that are not included in the base rate. The Medicaid rate is sometimes higher than the base rate but includes services that would be covered by additional charges.

Room and board policy
The rate does not include room and board, which is negotiated between the facility and the resident. Supplementation is allowed.

Services covered
Personal care and supportive services (homemaker, chore, attendant services, meal preparation), including companion services, medication oversight (to the extent permitted under state law), including 24-hour on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety, and security in conjunction with residing in a homelike, non-institutional setting. Services include social and recreational programming and medication assistance (to the extent permitted by state law). Services provided by third parties must be coordinated with the residential services provider. Service and support include 24-hour on-site response capability or other alternative emergency response arrangements determined appropriate to meet scheduled or predictable participant needs and to provide supervision, safety, and security in conjunction with residing in a homelike, non-institutional setting. Nursing and skilled therapy services are incidental, rather than integral to, the provision of adult residential services.

Waiver level of care criteria
Two of the following must be documented:

- Due to diagnosed medical conditions, the applicant requires at least substantial physical assistance with ADLs above the level of verbal prompting, supervision, or setting up; or
- The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health care delivery program; or
- The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting or without the services and support of an alternative Medicaid health care delivery program.

Units
Apartment-style units are required. Units may be shared by choice of the residents. The resident or family is responsible for furnishing the unit.

Mental health services
Case managers and facility staff are not required to assess applicants for mental health needs. Responsibility for arranging mental health services is not addressed.

Vermont

Licensing category Assisted Living Residences; Residential Care Homes

Coverage summary
The Department of Disabilities, Aging and Independent Living (DAIL) supports individuals in Level III residential care homes and assisted living residences through the Choices for Care (CFC) demonstration and the Medicaid state plan. Choices for Care Program, a §1115 demonstration program, replaced the existing home and community based and enhanced residential care waivers on October 1, 2005. Participants are assigned to three groups based on an assessment—highest needs, high needs, and moderate needs.

The Medicaid State plan payment covers assistive community care services (ACCS) for individuals who are below the nursing level of care. The CFC program serves people in residential settings who qualify for admission to a nursing facility.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NA	NA	43	39
§1115 waiver	57	57	NA	NA
State Plan	NR	84	85	73

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NA	NA	157	152
§1115 waiver	317	298	NA	NA
State Plan	890	1,186	487	468

Rates
Payments to Choices for Care providers are based on a three-tiered system that was developed using the Enhanced Residential Care assessment tool, review of other state reimbursement systems and assessment data. Residents receive scores in five areas: ADLs, bladder and bowel control, cognitive and behavior status, medication administration, and special programs (behavior management, skin treatment, or rehabilitation/ restorative care). Residents are assigned to a level (1 or 2) based on the extent of ADL impairments. Individuals with scores of 6 to 18 are assigned to Level 1 and individuals with scores between 19 and 29 are assigned to Level 2. The four remaining areas are rated, and additional points are assigned.

The DAIL's Choices for Care quarterly report for July 2008 states that in the past three years of Choices for Care, the number of people served in Tier 3 has increased dramatically—from about 30 people to about 110 people. The number of people in Tier 2 increased for the first year and remained fairly stable since then. The number of people in Tier 1 slowly decreased in the first 18 months and has slowly increased since then.

The ACCS rate was initially established taking into consideration many factors including the average volume and scope of services to be provided, a survey of services provided by the

residential care homes, average amount of ADL and RN assistance as well as the cost of such services.

No changes in the rate methodology are planned. Rates are increased or reduced by the legislature depending on available revenues. The governor proposed a 4% reduction in the rates for FY2010.

Medicaid payment rates								
	Needs below nursing home level		Tier I		Tier II		Tier III	
	RCH	ALR	RCH	ALR	RCH	ALR	RCH	ALR
ACCS	$36.25	$36.25	$36.25	$36.25	$36.25	$36.25	$36.25	$36.25
1115 waiver	$0.00	$0.00	$48.76	$53.95	$55.51	$60.69	$62.25	$67.44
Total	$36.25	$36.25	$85.01	$90.20	$91.76	$96.94	$98.50	$103.69

RCH: Residential Care Home; ALR: Assisted Living Residence; ACCS: Assistive Community Care Services (Medicaid State Plan Program); ERC: Enhanced Residential Care (a service option within the Choices for Care waiver for approved RCHs and ALRs).

Special rates can be approved for participants with extraordinary needs.

Room and board policy
The rates do not include room and board, which is limited to $674 per month for SSI beneficiaries. The SSI payment standard is $722.38 in Level III RCHs. There is a $60 a month state supplement for personal needs. Residents who are not eligible for SSI may be charged 85% of their income for room and board.

Family supplementation is not allowed.

Services covered
Assistive community care services under the state plan include: assistance with ADLs; medication assistance, monitoring and administration; 24-hour on-site assistive therapy; restorative nursing; nursing assessment; health monitoring; case management; and routine nursing tasks.

Choices for Care covers enhanced residential services in assisted living residences and residential care homes. The services include nursing overview (assessment, health monitoring and routine nursing care up to one hour per week as needed); personal care services; medication management; recreation activities; 24-hour on-site supervision; laundry services; household services. Case management services from area agencies on aging or home health agencies are provided and billed separately.

Units
Apartment-style units are required in assisted living residences but not residential care homes. Units may be shared by choice of the residents. However, residents make the “choice” when they

agree to move in and will receive either a private or semi-private room or unit. Providers are responsible for furnishing the unit.

Mental health services
Assisted living residences and residential care homes determine whether they can meet the person's needs. Individuals whose primary need for services is because of a mental health diagnosis are not eligible for the Choice for Care demonstration.

Virginia

Licensing category Assisted Living Facilities

Coverage summary
Information for this summary was obtained in 2007. An HCBS waiver to serve 200 people with Alzheimer's disease was approved in 2005. Participants must reside in a licensed ALF, be in a safe and secure environment, meet Virginia's criteria for nursing facility placement, and be receiving an auxiliary grant. Individuals eligible to be placed on this waiver either live at home where an adult child is typically serving as primary caregiver; reside in an ALF without the benefit of specialized services, which are not provided in the base $50 per day rate; or reside in a more expensive institutionalized nursing facility setting.

The state provides an auxiliary grant, which is an SSI state supplement, and pays for additional services using state funds. The auxiliary grant program is a state and locally funded assistance program to supplement the income of recipients of the federal SSI program and certain other aged, blind, and disabled individuals residing in an ALF.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	NR	NA	NA
Auxiliary grant	NR	NR	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	9	NA	NA
Auxiliary grant	NR	NR	NR	NR

Rate methodology and payment
The waiver payment is $50 a day.

The auxiliary grant payment was $1,048 in 2007, and the personal needs allowance was $75 a month. The auxiliary grant rate covers room, board, basic supportive services, and supervision.

Room and board policy
Not reported.

Services covered
Services under the waiver include assistance with ADLs, housekeeping and supervision; administration; medication administered by a licensed professional; nursing evaluations; evaluation by a registered nurse; and therapeutic and recreational programming (weekly activity program based on needs and interests).

Auxiliary grant services include minimal assistance with personal hygiene, including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails

and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence; medication administration as required by licensing regulations, including insulin injections; provision of generic personal toiletries, including soap and toilet paper; minimal assistance with the following: care of personal possessions; care of personal funds if requested by the recipient and residence policy allows it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; and correspondence; securing health care and transportation when needed for medical treatment; providing social and recreational activities as required by licensing regulations; and general supervision for safety.

Waiver level of care criteria

Residents must meet functional and medical criteria. Functional criteria include:

- dependent in two to four ADLs and semi-dependent or dependent in behavior pattern and orientation and semi-dependent in joint motion or dependent in medication administration; or
- dependent in five to seven ADLs and dependent in mobility; or
- semi-dependent in two to seven ADLs and dependent in mobility and behavior pattern and orientation.

Medical or nursing supervision means:

- a condition that requires observation and assessment; or
- potential for instability is high or exists; or
- ongoing nursing services are required.

Units

Not reported.

Mental health services

Not reported.

Washington

Licensing category Boarding Homes

Coverage summary
The state reimburses services in residential settings under an HCBS waiver and the Medicaid state plan. All three levels of services are provided by licensed boarding homes that contract with Medicaid. Enhanced adult residential care and assisted living services are provided to HCBS waiver participants. Adult residential care services are provided under the Medicaid state plan.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) & state plan	577	584	526	539

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) & state plan	5,682	6,193	5,735	3,762*

Note: The figures combine services provided through the HCBS waiver and the state plan personal care service. 2002 data excludes expanded adult residential care and adult residential care participants.

Rate methodology and payment
Medicaid payment rates for licensed boarding homes are based on the CARE (Comprehensive Assessment Reporting Evaluation) classification levels, geographic areas, benchmarked costs, and cost of living increases provided by the legislature. The rates are individual specific. Each Medicaid client is assessed using CARE. CARE determines the level of need for services. There are 17 classifications from A (low) to E (high). The Aging and Disability Services Administration (ADSA) has assigned payment rates for the 17 classification levels. The rates consist of daily wages (daily hours times hourly wage) plus a percentage for payroll taxes and fringe benefits plus daily rent plus daily expenses to come up with the daily rate. The components of the rate are described below:

- *Daily hours:* The department conducted a time study in 2001–2002 to determine how long it took to care for an individual at each of the classification levels.
- *Hourly wage:* The department collected wage data (2007) from the Employment Security Department's Occupational Employment Statistics. Using the wage data and the time it took to care for individuals at the classification levels indentified by CARE, the department developed the cost of care for each classification level.
- *Daily expenses/payroll taxes and fringe benefits:* The department selected benchmarks for fringe benefits, payroll taxes and other administrative expenses (e.g., insurance, direct care supplies, office equipment and licenses) from the 2007 nursing home cost reports.
- *Rent:* To determine a capital cost, the department uses the Marshall Valuation Service and Treasury bond constant maturity average rate. The Marshall Valuation Service is used in determining a price per square foot construction costs (i.e., the total value of the property). The interest rate represents an annual yield of U.S. Treasury 30-year maturity

bonds as of a specific date. The interest rate is applied to the total value of property to determine the imputed annual rent.

Room and board policy
The payment rates include room and board charges paid by the resident and are capped by state policy. Family supplementation is allowed for items or services that are not covered by Medicaid. The personal need allowance is $60.78, and the state does not supplement the federal SSI payment.

Services covered
Assisted living services and enhanced adult residential care services are a package of services, including personal care, intermittent nursing services, medication administration, and supportive services that promote independence and self-sufficiency and make available and offer at no additional cost to the resident generic personal care items needed by the resident such as soap, shampoo, toilet paper, toothbrush, toothpaste, deodorant, sanitary napkins, and disposable razors. Adult residential care is a package of services, including personal care services, which the department contracts with a licensed boarding home to provide. A negotiated service agreement is developed for each resident that supports the principles of dignity, privacy, choice in decision making, individuality, and independence.

Waiver level of care criteria
Individuals eligible for admission to a nursing home and Community Options Program Entry System (COPES) waiver services must meet one of four criteria:

- require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;
- have an unmet need requiring substantial or total assistance with at least two or more of the following ADLs: eating, toileting, ambulation, transfer, positioning, bathing, and self-medication;
- have an unmet need requiring minimal, substantial, or total assistance in three or more of the above ADLs; or
- have a cognitive impairment and require supervision due to one or more of the following: disorientation, memory impairment, impaired judgment, or wandering, and have an unmet or partially met need with at least one or more of the ADLs.

Units
Assisted living services include housing for the resident in a private apartment-like unit that includes a separate private bathroom, which includes a sink, toilet, and a shower or bathtub, a lockable entry door; a kitchen area equipped with a refrigerator, a microwave oven or stovetop; and a counter or table for food preparation; and a living area wired for telephone and, where available in the geographic location, wired for television service. In a new boarding home, the kitchen area must also be equipped with a storage space for utensils and supplies. Shared units are not permitted in boarding homes that contract to provide assisted living services.

Apartment units are not required in boarding homes that contract to provide enhanced adult residential care and adult residential care and units may be shared but not more than two people may share a unit. Providers and residents are responsible for furnishing the unit.

Mental health services
Mental health screening is not used to determine the appropriateness of placement but information included in the CARE assessment is used by the case manager who is responsible for arranging for services as needed.

Note: See next two pages for tables of rates.

JULY 1, 2008 ADSA community residential daily rates					
King County					
	AL	**AL w Cap Add-On**	**ARC**	**EARC**	**AFH**
Classification	**Daily Rate**	**Daily Rate**	**Daily Rate**	**Daily Rate**	**Daily Rate**
A Low (1)	$69.22	$74.64	$48.95	$48.95	$48.32
A Med (2)	$74.95	$80.37	$55.54	$55.54	$54.83
A High (3)	$84.10	$89.52	$61.00	$61.00	$61.35
B Low (4)	$69.22	$74.64	$48.95	$48.95	$48.56
B Med (5)	$77.24	$82.66	$62.14	$62.14	$61.66
B Med H (6)	$87.48	$92.90	$66.07	$66.07	$66.06
B High (7)	$92.09	$97.51	$75.53	$75.53	$75.53
C Low (8)	$74.95	$80.37	$55.54	$55.54	$54.83
C Med (9)	$84.10	$89.52	$69.72	$69.72	$70.02
C Med H (10)	$104.70	$110.12	$92.94	$92.94	$91.73
C High (11)	$105.74	$111.16	$93.82	$93.82	$93.01
D Low (12)	$77.24	$82.66	$75.07	$75.07	$71.38
D Med (13)	$85.82	$91.24	$86.98	$86.98	$87.36
D Med H (14)	$110.98	$116.40	$110.61	$110.61	$105.12
D High (15)	$119.59	$125.01	$119.59	$119.59	$119.69
E Med (16)	$144.53	$149.95	$144.53	$144.53	$144.63
E High (17)	$169.47	$174.89	$169.47	$169.47	$169.57
Metropolitan Counties					
	AL	**AL w Cap Add-On**	**ARC**	**EARC**	**AFH**
Classification	**Daily Rate**	**Daily Rate**	**Daily Rate**	**Daily Rate**	**Daily Rate**
A Low (1)	$63.49	$68.41	$48.95	$48.95	$48.32
A Med (2)	$66.94	$71.86	$53.34	$53.34	$52.66
A High (3)	$81.81	$86.73	$58.17	$58.17	$58.08
B Low (4)	$63.49	$68.41	$48.95	$48.95	$48.56
B Med (5)	$72.65	$77.57	$58.84	$58.84	$58.37
B Med H (6)	$82.29	$87.21	$62.57	$62.57	$62.60
B High (7)	$89.81	$94.73	$73.40	$73.40	$73.40
C Low (8)	$66.94	$71.86	$53.56	$53.56	$53.05
C Med (9)	$81.81	$86.73	$68.82	$68.82	$68.31
C Med H (10)	$101.25	$106.17	$86.34	$86.34	$85.23
C High (11)	$102.26	$107.18	$91.84	$91.84	$90.43
D Low (12)	$72.65	$77.57	$74.04	$74.04	$69.80
D Med (13)	$83.48	$88.40	$85.24	$85.24	$85.01
D Med H (14)	$107.33	$112.25	$107.87	$107.87	$101.92
D High (15)	$116.30	$121.22	$116.30	$116.30	$115.79
E Med (16)	$140.04	$144.96	$140.04	$140.04	$139.53
E High (17)	$163.78	$168.70	$163.78	$163.78	$163.27

Non-Metropolitan Counties					
	AL	**AL with Cap Add-On**	**ARC**	**EARC**	**AFH**
Classification	**Daily Rate**	**Daily Rate**	**Daily Rate**	**Daily Rate**	**Daily Rate**
A Low (1)	$62.36	$67.60	$48.95	$48.95	$48.32
A Med (2)	$66.94	$72.18	$52.25	$52.25	$51.58
A High (3)	$81.81	$87.05	$57.23	$57.23	$57.01
B Low (4)	$62.36	$67.60	$48.95	$48.95	$48.56
B Med (5)	$72.65	$77.89	$57.75	$57.75	$57.29
B Med H (6)	$82.29	$87.53	$61.40	$61.40	$61.38
B High (7)	$89.81	$95.05	$69.42	$69.42	$69.42
C Low (8)	$66.94	$72.18	$52.25	$52.25	$51.58
C Med (9)	$81.81	$87.05	$65.05	$65.05	$65.70
C Med H (10)	$101.25	$106.49	$83.04	$83.04	$81.98
C High (11)	$102.26	$107.50	$86.81	$86.81	$85.52
D Low (12)	$72.65	$77.89	$69.99	$69.99	$66.01
D Med (13)	$83.48	$88.72	$80.57	$80.57	$80.39
D Med H (14)	$107.33	$112.57	$101.96	$101.96	$96.37
D High (15)	$109.93	$115.17	$109.93	$109.93	$109.48
E Med (16)	$132.36	$137.60	$132.36	$132.36	$131.92
E High (17)	$154.80	$160.04	$154.80	$154.80	$154.36

West Virginia

Licensing category Assisted Living Residences

Coverage summary
The state uses general revenues to pay assisted living residences the difference between the resident's income (minus a personal needs allowance of $96) and $1,122.23 a month for room, board, and personal care services. Residents must be assessed by a physician and determined to need personal care services. A small HCBS waiver pilot in public housing sites was withdrawn.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
General revenues	62	50	NR	NR

Participants				
Source	**2009**	**2007**	**2004**	**2002**
General revenues	490	475	NR	NR

Rate methodology and payment
The state payment supplements resident income and is capped at $1,122.23 a month in 2009. The individual's income is subtracted from the maximum payment to determine the amount of the payment. The cap is adjusted annually based on the social security/SSI cost of living adjustment. In addition to the monthly payment for care, providers may be eligible for incentive payments for participation in ongoing training and for their efforts in assisting adults in returning to independent living.

Room and board policy
The payment covers room and board and personal care services. Family members may supplement the payment. The personal needs allowance is $96 a month.

Services covered
The payment covers personal care services and room and board for persons who are evaluated by a physician to need personal care and supervised care.

Waiver level of care criteria
NA

Units
Apartment-style units are not required. Units may be shared. Providers are responsible for furnishing the unit. Residents and family members may also bring their own belongings.

Mental health services
Applicants must receive an evaluation from a psychiatrist or psychologist. Facilities that admit persons with mental health needs are responsible for arranging services from outside providers.

Wisconsin

Licensing category Residential Care Apartment Complexes; Community-Based Residential Facilities

Coverage summary
Services are covered for Medicaid beneficiaries who meet the nursing home level of care criteria through the Medicaid Community Options Program Waiver (COP-W), the Community Integration Program (CIP II), the Wisconsin Partnership Program (an integrated Medicaid/Medicare program), and the Family Care Demonstration program (a managed long-term care program). CIP II funding is only available when nursing home beds are closed and funding is transferred to provide community care to replace the closed capacity. Medicaid state plan personal care services are covered for beneficiaries in residential care apartment complexes (RCACs) and community-based residential facilities (CBRFs) with 20 or fewer beds.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	NR	NR	NR	125

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	12,782	8,542	3,822	2,605

Rate methodology and payment
Supportive, personal, and nursing services provided to Medicaid waiver recipients residing in a certified RCAC continue to qualify for reimbursement under the COP-W and CIP II programs, at an amount not to exceed 85% of the statewide average daily cost of Medical Assistance reimbursement for nursing home care. (s.46.27 (11) (c) 7 and S.46.277 (5) (e), Wis. Stats.) The maximum funding limit that can be reimbursed for services in a RCAC has changed from $88.22 per day to $88.31 per day effective January 1, 2009. This statutorily established reimbursement imposes a ceiling on the total cost of supportive, personal, and nursing services that can be paid for by the waiver for RCAC services for a person residing in a certified RCAC. This maximum funding limit does not include the amounts counties can report for case management or the 7% administrative costs.

The maximum RCAC funding limit should not be considered a facility rate. The amount of reimbursement the RCAC receives is the payment amount negotiated and contracted by a county with a particular facility for a particular individual according to the individual's service needs.

Medicaid reimbursement is limited to 85% of the average statewide Medicaid nursing home rate excluding room and board. Rates are negotiated between facilities and the county. The maximum spending for the resident's *total* service plan is $88.02 per day. (An adjustment based on average nursing facility payments is made each year in July). This payment includes assisted living services provided by the facility and other waiver costs such as county care management, transportation, and therapies not covered by the Medicaid state plan. Despite the high maximum service payment, counties must ensure that the average cost for all waiver participants (all

settings) does not exceed $41.86 per day. For every RCAC resident, counties must make sure there are sufficient participants in other settings who receive a lower cost service plan in order to bring down the average. Room and board costs are not included in this ceiling.

Room and board policy
The negotiated rates include room and board, which is not capped by state policy. The SSI state supplement benefit is $853.77 a month in 2009. Beneficiaries living in RCACs or CBRFs of 20 beds or less receive an additional SSI supplement (SSI-E) of $95.99 a month. The personal needs allowance is $65 a month.

The state agency allows income supplementation by families to cover room and board, a private room, or for service enhancements that are not covered by the Medicaid payment. However, each county can set its own policy on family supplementation.

Services covered
RCACs may provide to residents not more than 28 hours per week of supportive, personal, and nursing services. Supportive services means assistance with meals, housekeeping, laundry, and arranging access to transportation and medical services. RCAC services means services provided to meet the needs identified in a tenant's service agreement, to meet unscheduled care needs or to provide emergency services 24 hours a day. In addition to supportive, personal, and nursing services provided directly by the RCAC, other persons or agencies may also provide services directly or under arrangement with the RCAC that supplement but do not supplant those provided by the facility.

The Medicaid payment covers "care and supervision," which includes 24-hour available staff and assistance with ADLs and IADLs when needed by the resident. Services may include, but are not limited to supervision, dietary, and counseling/psychotherapy.

Waiver level of care criteria
Individuals qualify if they have severe medical conditions or substantial medical and social/behavioral needs. If the latter, an individual must meet all of the following eligibility criteria:

- a long-term or irreversible illness or disability;
- an unstable or stable medical or psychiatric condition requiring long-term maintenance and prevention;
- need for help with two or more IADLs;
- need for assistance with two or more ADLs (i.e., feeding oneself, dressing, bathing, using the toilet, getting out of bed or up from a chair, ambulation), or requires daily supervision to ensure safety or wanders, is combative or abusive, incompetent or seriously mentally ill; and
- lack of friends or relatives able or willing to provide assistance.

Substantial medical conditions include significant deterioration of physical or mental health in the past 12 months; a need for daily monitoring of fluid and solid intake; uses six or more prescriptions at least three days a week; needs assistance with medications; incontinence; physician-ordered turning or repositioning; daily range of motion exercises to prevent skin breakdown; direct assistance with health care needs five days a week; being over 85 and unable

to manage medical conditions; and other conditions. People with dementia who do not need regular nursing care are not eligible.

Units
RCAC units consist of independent apartments, each having an individual lockable entrance and exit. Each unit must have a kitchen, including a stove or microwave oven, an individual bathroom, sleeping and living areas. RCAC units may not be shared. CBRFs are not required to offer apartment-style unit, and shared units are permitted.

Mental health services
Case managers screen applicants for mental health needs and arrange services from outside providers. Facility staff is not required to screen for mental health needs.

Wyoming

Licensing category Assisted Living Residences

Coverage summary
Services are covered under a §1915 (c) waiver that only covers assisted living services. Enrollment is capped at 168 participants. Although the number served increased over time, state contacts reported there is a lack of providers in most areas of the state.

Facilities				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	13	12	10	7

Participants				
Source	**2009**	**2007**	**2004**	**2002**
§1915 (c) waiver	156	130	100	40

Rate methodology and payment
Facilities are reimbursed under a three-tier payment schedule that is based on a score derived from the Long-Term Care 101 form, the required screening tool as defined by the program division and performed by a registered nurse. The methodology allows facilities to receive a higher payment for residents with higher assessment scores.

The payment rates are $42 per day for Tier I; $46 per day for Tier II, and $50 per day for Tier III. Rates do not inlude room and board. Rates have not changed since the 2007 update. Provider associations have proposed higher rates which are considered by the Medicaid staff and the legislature.

Medicaid Payment Rates (2009)	
Level	**Payment**
Level I: 13–14 points	$42
Level II: 15–16 points	$46
Level III: 17+ points	$50

Room and board policy
Room and board charges are determined by the facility and are not capped by state policy. Family members may supplement the room and board rate. The personal needs allowance is not specified, and there is no state supplement to the federal SSI payment.

Services covered
The services include 24-hour supervision, personal care, and medication assistance.

Waiver level of care criteria
Individuals scoring 13 or more points on 10 assessment items are eligible. The items include eating, meal preparation, diet; medication management; skin care and dressing treatment; speech, vision and hearing; dressing and personal grooming; bathing; continence; mobility; behavior/motivation; and socialization. Nursing home placement is allowed for individuals who need care but for whom services are not available, who lack a support system, are intermittently confused and/or agitated and need a structured environment, who wander extensively; or who have total confusion or apathy.

Units
Apartment-style living units are required. Units may be shared by choice of the residents. State policies do not address who is responsible for furnishing the unit.

Mental health services
Assisted living staff are responsible for determining the appropriateness of placement for residents with mental health needs. Case managers are responsible for arranging mental health services.

Section 3: Results Tables

Table 10: Coverage

State	1915 c		State plan	§1115	State revenues
	AL only	Broad waiver			
AK		x			
AZ				x	
AR	x		x		
CA	x				
CO		x			
CT	x				x
DE	x				
DC		x			
FL	x	x	x		
GA		x			
HI				x	
ID		x	x		
IL	x				
IN		x			
IA		x			x
KS		x			
LA		Submitted			
ME			x		
MD		x			x
MA			x		
MI		*	x		
MN		x			
MS	x				
MO*	x		x		
MT		x			
NE		x			
NV	x				
NH		x			
NJ		X			
NM		X			
NY			x		
NC	Planned		x		
ND		X			x
OH	x				
OK		Submitted			
OR		X			
PA	Planned				
RI	x			x	
SC			x		
SD		X	x		
TN		x			
TX		x			
UT		x			
VT			x	x	
VA	x				x
WA		x	x		
WV					x
WI		x			
WY	x				
Total	13	24	13	4	6
		Waiver total 37			

MO: An HCBS waiver was approved by CMS but has not been implemented.

Table 11: Rate methodology

State	Source	Flat	Tiered	Case mix	Care plan	Negotiated
AK	Waiver		x			
AZ	Waiver					x
AR	Waiver		x			
	State plan				x	
CA	Waiver		x			
CO	Waiver	X				
CT	Waiver		x			
DE	Waiver		x			
	State plan					
DC	Waiver	X				
FL	Waiver	X				
	State plan	X				
GA	Waiver	X				
HI	Waiver		x			
ID	Waiver					
	State plan				x	
IL	Waiver	X				
IN	Waiver		x			
IA	Waiver				x	
KS	Waiver				x	
LA	Waiver		x			
ME	State plan			x		
MD	Waiver		x			
MA	State plan	X				
MI	State plan	X				
MN	Waiver		x	x		x
MS	Waiver					
MO	Waiver		x			
	State plan				x	
MT	Waiver		x			
NE	Waiver		x			
NV	Waiver					
NH	Waiver	X				
NJ	Waiver	X				
NM	Waiver	X				*
NY	State plan			x		
NC	State plan		x			
ND	Waiver				x	
OH	Waiver		x			
OK	Waiver					
OR	Waiver		x			
RI	Waiver	X				
SC	State plan	X				
SD	Waiver	X				
TN*	Waiver					
TX	Waiver			x		
UT	Waiver	X				
VT	Waiver		x			
	State plan	X				
VA	Waiver	X				
WA	Waiver		x			
WV*	General revenue					
WI	Waiver					X
WY	Waiver		x			
Total		17	19	4	6	3

AZ: Rates are negotiated based on the level of service provided.
IL: Rates vary by region.
MN: Rates are negotiated with providers based on an assessment and plan of care within limits that vary by acuity.
NM: Rates are shifting from flat to negotiated rates as the state's managed long term care program is implemented.
OK: Waiver submitted.

TN: Rates are cost based with a cap. A tiered methodology will be considered.

WI: Rates are negotiated by county Human Service agencies and are capped at 85% of the cost of nursing home care excluding room and board.

WV: The payment is based on the difference between $1,122.23 a month and the resident's income.

Table 12: Number of facilities

State	§1915 c or §1115				State plan				General revenues			
	2009	2007	2004	2002	2009	2007	2004	2002	2009	2007	2004	2002
AK	277	235	174	126	-	-	-	-	-	-	-	-
AZ	1,084	866	NR	NR	-	-	-	-	-	-	-	-
AR	20	15	5	NA	NR	NR	NR	NR	-	-	-	-
CA	53	20	NA	NA	-	-	-	-	-	-	-	-
CO	283	281	273	266					-	-	-	-
CT	43	25	34	NA	-	-	-	-	-	-	-	-
DE	12	15	29	11	-	-	-	-	-	-	-	-
DC	2	NA	NA	NA	-	-	-	-	-	-	-	-
FL	546	478	581	299	NR	NR	1,527	1,565	-	-	-	-
GA	754	375	465	444	-	-	-	-	-	-	-	-
HI	1,075	801	0	NA	-	-	-	-	-	-	-	-
ID	292	279	265	35	NR	NR	NR	NR	-	-	-	-
IL	108	81	41	13	-	-	-	-	-	-	-	-
IN	50	43	14	8	-	-	-	-	-	-	-	-
IA	NR	155	73	54	-	-	-	-	NR	NR	NR	NR
KS	178	155	155	NR	-	-	-	-	-	-	-	-
ME	-	-	-	-	145	211	150	151	-	-	-	-
MD	997	975	763	362	349	300	NR	259	-	-	-	-
MA	-	-	-	-	NR	112	101	44	-	-	-	-
MI	-	-	-	-	NR	NR	NR	NR	-	-	-	-
MN	615	588	396	281	NA	NA	325	247	*	*	325	247
MS	NR	14	6	1					-	-	-	-
MO	-	-	-	-	794	614	494	569	-	-	-	-
MT	167	133	165	111	-	-	-	-	-	-	-	-
NE	220	217	187	130	-	-	-	-	-	-	-	-
NV	88	74	52	66	-	-	-	-	-	-	-	-
NH	71	75	42	37	-	-	-	-	-	-	-	-
NJ	229	162	159	118	-	-	-	-	-	-	-	-
NM	40	19	NR	NR	-	-	-	-	-	-	-	-
NY	-	-	-	-	70	62	57	53	-	-	-	-
NC	-	-	-	-	1,242	1,497	2,200	2,389	-	-	-	-
ND	NR	56	42	NR	-	-	-	-	NR	NR	NR	NR
OH	169	60	NA	NA	-	-	-	-	-	-	-	-
OR	352	328	335	172	-	-	-	-	-	-	-	-
RI	38	38	35	35	-	-	-	-	-	-	-	-
SC	-	-	-	-	60	52	35	NA	-	-	-	-
SD	NR	109	140	110	NR	101	90	NR	-	-	-	-
TN	31	NA	NA	NA	-	-	-	-	-	-	-	-
TX	230	220	300	309	-	-	-	-	-	-	-	-
UT	125	77	NR	NR	-	-	-	-	-	-	-	-
VT	57	NR	43	39	NR	84	85	73	-	-	-	-
VA	-	NR	NA	NA	-	-	-	-	-	-	-	-
WA	577	584	526	539	-	-	-	-	-	-	-	-
WV	-	-	-	-	-	-	-	-	62	50	NR	NR
WI	NR	NR	NR	125	-	-	-	-	-	-	-	-
WY	13	12	10	7	-	-	-	-	-	-	-	-
Total	8,796	6,845	5,310	3,698	2,660	3,033	5,064	5,350	62	50	325	247

NA = Not applicable; NR = not reported.

HI: The number of facilities includes ALFs, E-ARCH and Foster Care Homes.

MN: Terminated coverage using state revenues.

MO: The 2004 number is unduplicated annual total for 2003; 2007 and 2009 are counts for a particular month.

OR: Numbers for 2004 and 2007 include both Assisted Living and Residential Care Facilities

WI: 2002 data only includes Residential Care Apartment Complexes

Table 13: Number of participants

State	§1915 c or §1115				State plan				General revenues			
	2009	2007	2004	2002	2009	2007	2004	2002	2009	2007	2004	2002
AK	650	730	632	492	-	-	-	-	-	-	-	-
AZ	4,989	4,034	3,076	2,300	-	-	-	-	-	-	-	-
AR	350	211	50	NA	NR	NR	1,155	1,178	-	-	-	-
CA	1,000	205	NA	NA	-	-	-	-	-	-	-	-
CO	4,007	3,800	3,804	3,773	-	-	-	-	-	-	-	-
CT*	137	439	65	NA	-	-	-	-	354	*	*	
DE	179	217	14	NR	-	-	-	-	-	-	-	-
DC	13	NA	NA	NA	-	-	-	-	-	-	-	-
FL	2,513	3,623	4,167	2,681	12,250	7,766	14,188	9,990	-	-	-	-
GA	2,705	2,300	2,851	2,759	-	-	-	-	-	-	-	-
HI	1,200	1,405	0	NA	-	-	-	-	-	-	-	-
ID	2,899	2,231	1,870	720	NR	NR	NR	NR	-	-	-	-
IL	5,204	4,681	1,602	293	-	-	-	-	-	-	-	-
IN	400	NR	71	22	-	-	-	-	-	-	-	-
IA	677	497	126	129	-	-	-	-	1,757	NR	NR	NR
KS	1,819	NR	769	769	-	-	-	-	-	-	-	-
ME	-	-	-	-	3,600	4,571	3,762	3,096	-	-	-	-
MD	1,314	1,798	1,473	730	-	-	-	-	716	528	350	520
MA	-	-	-	-	NR	NR	1,120	922	-	-	-	-
MI	-	-	-	-	6,498	10,300	14,138	13,000	-	-	-	-
MN	8,795	7,369	4,114	2,895	-	-	-	-	*	*	2,328	1,588
MS	NR	200	68	15	-	-	-	-	-	-	-	-
MO	-	-	-	-	7,401	6,000	8,125	7,300	-	-	-	-
MT	858	614	475	400	-	-	-	-	-	-	-	-
NE	1,776	1,693	1,500	605	-	-	-	-	-	-	-	-
NV	375	380	222	121	-	-	-	-	-	-	-	-
NH	356	243	176	178	-	-	-	-	-	-	-	-
NJ	2,730	2,966	2,195	1,500	-	-	-	-	-	-	-	-
NM	180	254	189	76	-	-	-	-	-	-	-	-
NY	-	-	-	-	3,701	3,335	3,315	3,034	-	-	-	-
NC	-	-	-	-	21,078	20,442	24,000	18,533	-	-	-	-
ND	NR	NR	31	NR	-	-	-	-	-	-	-	-
OH	1,115	235	NA	NA	-	-	-	-	-	-	-	-
OR	6,181	5,983	4,858	3,600	-	-	-	-	-	-	-	-
RI	433	411	230	220	-	-	-	-	-	-	-	-
SC	-	-	-	-	820	829	600	NA	-	-	-	-
SD	NR	938	500	250	NR	160	227	NR	-	-	-	-
TN	177	NA	NA	NA	-	-	-	-	-	-	-	-
TX	2,359	2,393	2,851	2,263	-	-	-	-	-	-	-	-
UT	642	548	380	400	-	-	-	-	-	-	-	-
VT	317	298	157	152	890	1,186	487	468	-	-	-	-
VA	NR	9	NA	NA	-	-	-	-	-	-	-	-
WA	5,682	6,193	5,735	3,762	-	-	-	-	-	-	-	-
WV	-	-	-	-	-	-	-	-	490	475	NR	NR
WI	NR	8,542	3,822	2,605	-	-	-	-	-	-	-	-
WY	156	130	100	40	-	-	-	-	-	-	-	-
Total	74,970	65,570	48,173	33,750	56,238	54,589	71,117	57,521	3,317	1,003	2,678	2,108

NA = Not applicable; NR = not reported

CT: Figures for 2004 and 2007 included were included in the waiver figures.

KS: Figures are estimates

MN: Terminated coverage with state revenues

MO: The 2004 number is an unduplicated count for 2003; the 2007 number is for the month of July 2007

NY: The figure represents the capacity rather than the actual number of participants.

OR: Numbers for 2004 and 2007 include both Assisted Living and Residential Care Facilities

WA: 1915 (c) data include state plan participants. Figure for 2002 only includes participants receiving assisted living services; other years also include Expanded Adult Residential Care and Adult Residential Care

WI : Figures include residential care apartment complexes and community based residential facilities

Table 14: Room and board policy

State	Rates include R&B	Cap R&B Charges	Allow family supplementation	State SSI supplement	SSI payment	PNA
AK	N	N	Y	Y	$932	$100
AZ	Y	Y	Y*	N	$674	$101
AR	N	NR	NR	N	$674	$61
CA	N	Y	N	Y	$1,075	$125
CO	N	Y	Y	N	$674	$101
CT	N	NR	Y	N	$674	$164.10
DE	N	Y	Y	Y	$814	$122
DC	N	Y	Y	Y	$1,159	$100
FL	N	N	Y	Y	$752.40	$54
GA	N	Y	Y	N	$674	$95
HI	N	Y	N	Y	$1,275.90	$50
ID	N	N	NR	N	$674	$90
IL	N	Y	N	N	$674	$90
IN*	N	Y	NP	N	$674	$52
IA	N	N	NR	N	$674	$90
KS	N	NR	Y	N	$674	NR
LA	NR	NR	NR	N	$674	NR
ME	N	Y	Y	Y	$908	$70
MD	N	Y	N	Y	$858	$68
MA	N	N	NP	Y	$1,128	NR
MI*	N	N	N	Y	$831.50; $853.30	$44
MN	N	N	Y	Y	$776	NR
MS	N	NR	NR	N	$674	NR
MO	N	N	Y	Y	$830; $966	$30
MT	N	Y	N	Y	$768	$100
NE	Y	Y	N	N	$674	$60
NV	N	N	Y	Y	$1,065	$110
NH	Y	N	Y*	Y	$735	$56
NJ	N	Y	Y	Y	$824.05	$100
NM*	N	N	Y	N	$674	*
NY	N	N	N	Y	$1,368	$178
NC*	N	N	Y	Y	$1,253	$65
ND	N	Y	Y	N	$674	$60
OH	N	Y	N	N	$674	$50
OK	N	Y	Y	Y	$606.60	$46
OR	N	Y	N	N	$674	$141
PA*	-	-	-	-	$1,113.30	-
RI	Y	N	Y	Y	$1,232	$100
SC	N	Y	N	Y	$1,100	$57
SD	N	NR	N	N	$674	$60
TN	N	Y	Y	N	$674	NR
TX	N	Y	N	N	$674	$85
UT*	N	N	Y	N	$674	*
VT	N	Y	N	Y	$722.38	$60
VA*	N	NR	NR	Y	$1,350; $1,189	$75
WA	Y	Y	Y	N	$674	$60.78
WV	NA	NA	NA	NA	$674	NA
WI	N	N	Y	Y	$853.77	$65
WY	N	N	Y	N	$674	NR
Total Y	6	23	25	24		
Total N	40	17	14	23		

NP: No policy.

* Data from the 2007 Assisted Living Compendium.

*AZ: Family supplementation allowed for room upgrades.

*IN: No policy on supplementation.

*MI: Adult foster care $831.50; homes for the aged, $853.30.

*NC: Supplementation allowed for private rooms.

*NH: Supplementation allowed on a case by case basis.

*NM: The PNA is specified in an informed consent agreement.

*PA: SSI payment is for personal care homes. The SSI payment in ALFs has not been set but is likely to be $674.

*UT: PNA varies by client.

*VA: $1,350 in Planning District 8 and $1,189 in all other areas.

Table 15: Unit requirements

State	Apartments required	Allow shared units	Shared by choice	Furnishes the unit		
				ALF	Resident	Not addressed
AK	N	Y	N	Y		
AZ	N	Y	Y	Y		
AR*	Y	Y	Y	Y	Y	
CA	Y	Y	Y	Y	Y	
CO	N	Y	Y	Y		
CT	Y	Y	Y	Y	Y	
DE	N	Y	N			**
DC	N	Y	N	Y		
FL	Y	Y	Y			**
GA	N	Y	N	Y		
HI	N	Y	N	Y		
ID	N	Y	N	Y		
IL	Y	Y	Y		Y	
IN	Y	Y	Y		Y	
IA	Y	Y	Y			**
KS	Y	Y	Y		Y	
LA	Y	Y	Y			
ME*	Y	Y	Y		Y	
MD	N	Y	N	Y	Y	
MA	Y	Y	N			**
MI	N	Y	N	Y		
MN	N	Y	Y		Y	
MS	NR	NR	NR	NR	NR	NR
MO	N	Y	N	Y		
MT	N	Y	N	Y		
NE	N	Y	Y	Y		
NV*	N	Y				**
NH	N	Y	Y	Y		
NJ	Y	Y	N			**
NM	N	Y	N			**
NY	Y	Y	N	Y		
NC	N	Y	Y	Y	Y	
ND	NR	NR	NR	NR	NR	NR
OH	Y	Y	Y			**
OK	Y	Y	Y		Y	
OR*	Y	Y	Y	Y		
RI*	Y	Y	Y		Y	
SC	N	NR	NR			
SD	NR	NR	NR	NR	NR	NR
TN	NR	N			Y	
TX	Y	Y	Y	Y		
UT	Y	Y	Y		Y	**
VT*	Y	Y	Y	Y		
VA	NR	NR	NR	NR	NR	NR
WA	Y	N	NA	Y	Y	
WV	N	Y		Y	Y	
WI	Y	N				
WY	Y	Y	Y			**
Yes	23	40	24	23	17	15
No	20	3	14	0	0	

Table 16: Mental health screening

State	Screening		Who provides mental health services			
	Case manager	ALF	ALF provides	ALF arranges	HCBS case manager arranges	Not addressed
AK	Y	N			Y	
AZ	Y	Y	Y			
AR	N	N				*
CA	Y	NR	Y	Y	Y	
CO	Y	Y		Y		
CT	Y	Y		Y	Y	
DE	Y	N				*
DC	Y	N		Y	Y	
FL	*	*		Y	Y	
GA	N	N			Y	
HI	Y	N			Y	
ID	N	N		Y		
IL	Y	N		Y		
IN	Y	Y		Y		
IA	Y	Y				*
KS	N	N		Y	Y	
LA	NR	NR	NR	NR	NR	NR
ME	N	N				
MD	N	N		Y	Y	*
MA	N	N				*
MI	Y	N			Y	
MN	Y	Y				
MS	NR	NR			Y	
MO	N	Y		Y	Y	
MT	Y	N			Y	
NE	Y	NR				*
NV	Y	Y				
NH	N	N		N	N	
NJ	N	N				*
NM	Y	Y			Y	
NY	N	Y		Y		
NC	NR	NR		Y		
ND	NR	NR				
OH	Y	NR			Y	
OK	Y	Y			Y	
OR	N	Y				*
RI	N	Y		Y		
SC	N	Y		Y		
SD	NR	NR				
TN	N	N				*
TX	NR	Y			Y	
UT	N	N				*
VT	N	Y	Y			
VA	NR	NR				
WA	NR	NR			Y	
WI	Y	N			Y	
WV	N	Y		Y		
WY	N	Y			Y	
No	19	19	0	1	1	10
Yes	20	18	3	16	20	0
NR	8	10	1	1	1	1
Total	47	47	4	18	22	-

Notes

FL: Mental health screening is part of the level of care process.
MI: Case manager from Community Mental Health Dept completes screening and arranges services.

NJ: Considering using PASRR.

Table 17: Services included in the rate

State	Personal care	Medication assistance	Nursing services	Nursing evaluation	Therapies	Housekeeping/laundry/ homemaker	Social/recreation activities	Transportation	Oversight/24 hr supervision	Assistive devices	Meal preparation	Emergency response	Service coordination	Chore services	Other
AK	x					x	x	x			x		x		x
AZ	x	x	x												
AR	x	x	x	x			x	x							
CA	x	x				x	x	x	x		x		x		
CO	x	x				x			x		x		x	x	x
CT	x					x	x	x				x		x	x
DE	x		x										x		
DC	x					x		x	x				x		x
FL	x	x	x		x	x	x					x	x		x
GA	x	x							x						
HI	x	x				x					x				x
ID	x	x				x	x	x			x				x
IL	x	x	x	x		x	x		x						x
IN	x	x				x	x							x	x
IA	x		x					x		X		x		x	x
KS	x			x						X		x			x
LA	x	x	x			x		x							
ME	x					x									x
MD	x	x					x	x					x	x	x
MA	x												x		x
MI	x														
MN	x	x	x			x			x		x	x			x
MS	x	x	x			x	x	x				x		x	
MO	x	x													
MT	x	x				x	x		x			x			
NE	x	x				x	x	x							x
NV	x	x				x	x							x	x
NH	x	x				x	x		x			x	x		x
NJ	x	x	x	x		x		x			x			x	
NM	x	x				x	x	x	x		x		x		
NY	x		x		x										x
NC	x							x							
ND	x						x		x						
OH	x	x	x			x	x	x	x		x				
OK	x	x	x			x	x				x				x
OR	x	x				x	x	x							
RI	x					x					x		x		x
SC	x	x													x
SD*															
TN	x	x				x									
TX	x	x					x	x	x						x
UT	x	x	x		x	x	x		x		x			x	
VT	x	x	x	x		x	x		x						
VA	x	x	x			x	x		x					x	x
WA	x	x	x												
WV	x														
WI*	x		x			x			x		x				x
WY	x	x							x						
Total	47	32	18	5	3	29	23	17	17	2	13	8	11	10	25

Notes: Nursing services may include intermittent services, limited nursing services and delegation.

Other services:

AK: Managing money, writing letters, using the telephone.

CA: Social services.

CO: Shopping.

CT: Maintenance services.

DC: Personal care aide or homemaker aide.

FL: Behavior management; specialized medical equipment.

HI: Delegated procedures.

ID: Assistance with personal finances.

IL: Health promotion and exercise programs; ancillary services.

IN: Companion.

IA: Senior companion; nutritional counseling.

KS: Comprehensive support; wellness monitoring.

ME: Dietary service; see state summary.

MD: Personal hygiene supplies; nursing supervision and delegation.

MA: Nursing oversight

MN: Home care aide and home health aide tasks; central storage of medications.

NE: Escort; adult day care; essential shopping; health maintenance activities.

NV: Companion services.

NH: Must provide access to nursing services, rehabilitation and behavioral health.

NY: Personal care is covered by the SSI State Supplement; home care; medical equipment and adult day health care.

OK: Cognitive orientation.

RI: 24-hour staffing; minor assistive devices; case management.

SC: Incontinence supplies.

TX: Home management; escort services.

UT: Nursing and skilled therapies are incidental to the provision of adult residential services.

VA: Companion.

WI: Services covered in RCACs. Supportive services mean meals, housekeeping, laundry, arranging access to transportation and medical services. Other – counseling/psychotherapy.

Section 4: State and National Statistics on Nursing Homes and ALFs

Residential and Nursing Home Bed Supply Ratios						
	Licensed residential bed supply/1000 65+			NF supply/1000 65+		Percent HCBS (A/D)*
State	2007 65+	Supply	Beds/1000	NF supply	Beds/1000	
AL	625,756	9,509	15.2	26,336	42.1	13.1
AK	47,935	1,912	39.9	725	15.1	50.6
AR	397,108	5,018	12.6	24,449	61.6	25.9
AZ	820,391	27,000	32.9	15,862	19.3	64.0
CA	4,003,593	161,586	40.4	121,964	30.5	52.1
CO	492,685	14,237	28.9	19,758	40.1	34.9
CT	472,284	2,808	5.9	29,612	62.7	20.7
DE	117,678	1,804	15.3	4,689	42.8	13.7
DC	69,741	509	7.3	2,984	42.8	34.9
FL	3,098,364	75,480	24.4	81,808	26.4	17.5
GA	942,832	26,500	28.1	40,159	42.6	24.0
HI	183,994	4,284	23.3	4,043	22.0	17.8
ID	174,946	6,819	39.0	6,052	34.6	40.4
IL	1,548,781	16,800	10.8	97,413	62.9	24.9
IN	795,441	14,655	18.4	49,204	61.9	14.5
IA	438,448	13,072	29.8	32,620	74.4	26.2
KS	360,216	7,186	19.9	23,276	64.6	35.2
KY	549,504	6,802	12.4	25,739	46.8	18.9
LA	522,334	4,889	9.4	35,310	67.6	26.8
ME	194,986	8,703	44.6	7,196	36.9	26.6
MD	661,809	20,093	30.4	29,149	44.0	15.9
MA	858,939	11,900	13.9	49,465	57.6	26.4
MI	1,280,152	46,095	36.0	46,549	36.4	19.0
MN	636,216	NA	-	33,529	52.7	46.6
MO	788,371	21,166	26.8	50,839	64.5	31.1
MS	364,614	5,133	14.1	18,296	50.2	2.2
MT	133,578	4,351	32.6	7,118	53.3	29.3
NE	236,648	10,063	42.5	15,959	67.4	22.3
NV	285,654	3,941	13.8	5,643	19.8	35.1
NH	165,742	4,283	25.8	7,768	46.9	14.4
NJ	1,134,636	17,761	15.7	50,779	44.8	21.0
NM	250,235	NR	-	6,808	27.2	60.7
NY	2,546,405	39,170	15.4	120,359	47.3	39.3
NC	1,103,413	41,642	37.7	43,498	39.4	42.7
ND	93,285	3,472	37.2	6,387	68.5	6.3
OH	1,545,085	44,005	28.5	92,491	59.9	20.8
OK	480,140	9,302	19.4	29,522	61.5	28.7
OR	488,936	22,130	45.3	12,449	25.5	56.5
PA	1,889,660	71,831	38.0	87,570	46.3	12.7
RI	146,847	3,574	24.3	8,758	59.6	12.6
SC	573,098	16,279	28.4	18,000	31.4	23.0
SD	113,555	3,578	31.5	6,553	57.7	11.5
TN	793,117	16,289	20.5	37,043	46.7	1.3
TX	2,394,157	45,853	19.2	122,635	51.2	44.3
UT	233,982	5,256	22.5	7882	33.7	10.7
VA	909,522	31,964	35.1	31,005	34.1	26.8
VT	84,425	2,610	30.9	3,242	38.4	28.5
WA	757,852	26,829	35.4	22,340	29.5	55.6
WV	280,666	3,510	12.5	10,905	38.9	23.4
WI	736,301	31,782	43.2	37,350	50.7	30.7
WY	63,901	1,436	22.5	3,052	47.8	20.4
Total	37,887,958	974,871	25.7	1,671,238	44.1	31.0

* The percent HCBS is the percentage of Medicaid long-term care spending for HCBS.

The number of licensed residential settings was reported by state licensing agencies. See Mollica, R., Sims-Kastelein, K., and O'Keeffe, J. Residential Care and Assisted Living Compendium: 2007. US DHHS, Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm.

Number of certified licensed nursing facility beds									
State	**Dec-01**	**Dec-02**	**Dec-03**	**Dec-04**	**Dec-05**	**Dec-06**	**Dec-07**	**Dec-08**	**Change**
US	1,695,446	1,699,647	1,689,937	1,681,917	1,676,413	1,673,085	1,671,238	1,668,895	-1.6%
AK	744	749	738	718	695	705	725	725	-2.6%
AL	25,572	26,036	26,187	26,466	26,354	26,581	26,336	26,809	4.8%
AR	24,385	24,723	24,369	23,840	24,151	24,634	24,449	24,395	0.0%
AZ	16,155	15,824	15,825	16,112	16,155	15,602	15,862	15,747	-2.5%
CA	122,680	123,879	125,706	123,996	123,406	122,564	121,964	121,950	-0.6%
CO	19,644	20,054	19,815	19,821	19,839	19,954	19,758	19,943	1.5%
CT	31,001	30,751	30,602	30,280	30,169	29,662	29,612	29,265	-5.6%
DC	3,071	3,112	3,114	3,061	3,036	2,988	2,984	2,645	-13.9%
DE	4,273	4,279	4,350	4,320	4,200	4,475	4,689	4,787	12.0%
FL	82,378	81,421	81,797	81,891	81,645	81,630	81,808	81,498	-1.1%
GA	39,748	39,761	39,938	40,054	40,112	39,900	40,159	39,726	-0.1%
HI	3,985	3,973	3,682	4,026	4,019	4,032	4,043	4,142	3.9%
IA	34,297	33,942	33,421	33,301	33,363	32,925	32,620	32,301	-5.8%
ID	6,368	6,328	6,258	6,270	6,065	6,195	6,052	6,034	-5.2%
IL	99,602	99,442	99,227	98,425	97,458	97,331	97,413	96,226	-3.4%
IN	54,464	52,138	48,464	47,994	47,991	48,488	49,204	49,081	-9.9%
KS	24,522	24,471	24,611	24,244	23,712	23,295	23,276	23,017	-6.1%
KY	24,809	25,057	25,197	25,469	25,816	25,513	25,739	25,526	2.9%
LA	37,588	37,759	37,296	37,592	37,420	35,714	35,310	35,401	-5.8%
MA	53,200	52,874	51,211	50,750	50,157	49,736	49,465	48,510	-8.8%
MD	27,901	29,363	29,386	29,144	29,197	29,020	29,149	28,800	3.2%
ME	7,710	7,567	7,425	7,377	7,368	7,329	7,196	7,201	-6.6%
MI	47,684	47,292	47,529	47,138	47,102	46,286	46,549	46,848	-1.8%
MN	39,406	40,182	37,693	37,185	35,389	34,777	33,529	33,144	-15.9%
MO	50,720	50,250	49,336	50,302	50,211	50,832	50,839	51,752	2.0%
MS	17,428	17,983	18,124	18,290	18,339	18,309	18,296	18,340	5.2%
MT	7,549	7,492	7,452	7,447	7,329	7,336	7,118	7,016	-7.1%
NC	40,849	42,083	42,596	42,736	42,968	43,127	43,498	43,205	5.8%
ND	6,581	6,586	6,527	6,529	6,508	6,502	6,387	6,395	-2.8%
NE	16,294	15,919	15,561	15,787	15,809	15,835	15,959	15,963	-2.0%
NH	7,742	7,772	7,705	7,745	7,817	7,818	7,768	7,708	-0.4%
NJ	50,769	50,777	50,510	50,627	51,195	51,816	50,779	51,130	0.7%
NM	6,891	7,245	7,352	7,163	6,909	6,881	6,808	6,750	-2.0%
NV	5,049	5,100	5,138	5,072	5,360	5,554	5,643	5,613	11.2%
NY	117,502	122,140	122,482	121,189	120,807	120,800	120,359	120,101	2.2%
OH	92,714	93,521	93,058	92,212	91,351	91,730	92,491	92,484	-0.2%
OK	31,578	31,583	32,231	32,198	31,237	30,516	29,522	29,667	-6.1%
OR	12,718	12,541	12,715	12,634	12,696	12,561	12,449	12,473	-1.9%
PA	94,147	92,766	90,136	89,075	88,878	88,407	87,570	87,860	-6.7%
RI	9,943	9,474	8,764	8,594	9,044	8,867	8,758	8,850	-11.0%
SC	17,372	17,240	17,670	17,769	17,767	17,948	18,000	18,328	5.5%
SD	7,196	7,417	7,363	7,208	7,108	6,706	6,553	6,530	-9.3%
TN	38,051	37,570	37,520	36,944	37,215	36,874	37,043	36,598	-3.8%
TX	109,572	109,896	112,806	114,741	115,313	119,055	121,731	122,635	11.9%
UT	7,572	7,295	7,290	7,498	7,787	7,685	7,882	7,933	4.8%
VA	29,386	30,098	30,689	30,951	31,146	31,156	31,005	31,535	7.3%

Number of certified licensed nursing facility beds									
State	**Dec-01**	**Dec-02**	**Dec-03**	**Dec-04**	**Dec-05**	**Dec-06**	**Dec-07**	**Dec-08**	**Change**
WA	23,695	24,420	23,322	22,455	22,472	22,415	22,340	22,194	-6.3%
WI	45,019	43,736	42,166	39,769	38,899	37,665	37,350	37,022	-17.8%
WV	11,214	11,133	11,073	11,006	10,929	10,924	10,905	10,831	-3.4%
WY	3,086	3,061	3,061	3,061	3,051	3,049	3,052	2,993	-3.0%

Source: OSCAR data compiled by the American Health Care Association.

Medicaid nursing facility census									
State	**Dec-01**	**Dec-02**	**Dec-03**	**Dec-04**	**Dec-05**	**Dec-06**	**Jun-07**	**Dec-08**	**Change**
US	977,678	971,398	961,774	949,575	939,728	928,876	913,784	896,495	-8.3%
AK	535	543	518	490	507	510	455	456	-14.8%
AL	17,169	17,133	17,050	16,977	16,784	16,500	16,246	15,950	-7.1%
AR	13,826	13,318	13,090	12,739	12,393	12,638	12,377	12,279	-11.2%
AZ	8,571	8,496	8,704	8,560	8,274	7,733	7,737	7,664	-10.6%
CA	67,996	68,719	71,077	70,138	70,836	69,251	68,229	67,698	-0.4%
CO	10,151	9,748	9,718	9,496	9,652	9,725	9,689	9,603	-5.4%
CT	19,281	19,330	19,188	18,484	18,491	18,017	17,959	17,765	-7.9%
DC	2,336	2,291	2,340	2,221	2,077	2,140	2,224	1,996	-14.6%
DE	2,213	2,263	2,323	2,230	2,226	2,251	2,345	2,248	1.6%
FL	43,079	43,406	44,197	44,379	43,542	42,681	41,903	41,347	-4.0%
GA	28,090	28,334	28,160	27,643	27,454	26,719	26,386	25,628	-8.8%
HI	2,748	2,758	2,495	2,766	2,755	2,769	2,721	2,688	-2.2%
IA	14,247	14,348	13,809	13,607	13,323	13,253	12,923	12,474	-12.4%
ID	2,755	2,856	2,952	2,866	2,794	2,796	2,737	2,670	-3.1%
IL	52,014	51,113	50,188	49,629	49,070	48,257	48,300	47,387	-8.9%
IN	27,421	27,137	26,328	25,789	25,202	24,903	24,773	24,371	-11.1%
KS	11,415	11,381	11,340	11,126	10,887	10,515	10,419	10,187	-10.8%
KY	16,712	16,388	16,502	15,533	15,502	15,487	15,634	15,357	-8.1%
LA	23,545	23,142	21,847	21,878	21,568	20,552	19,428	19,062	-19.0%
MA	34,002	33,293	31,899	30,948	30,030	29,765	29,312	27,607	-18.8%
MD	14,908	15,652	15,627	15,534	15,459	15,457	15,481	15,351	3.0%
ME	4,906	4,906	4,793	4,826	4,480	4,446	4,349	4,309	-12.2%
MI	28,001	27,924	27,639	27,426	27,577	26,850	26,253	25,413	-9.2%
MN	22,846	22,128	21,391	20,677	19,774	19,147	18,194	17,448	-23.6%
MO	25,610	24,579	23,962	23,709	23,746	23,842	23,315	22,739	-11.2%
MS	12,795	12,656	12,747	12,809	12,459	12,434	12,608	12,496	-2.3%
MT	3,438	3,336	3,246	3,227	3,138	3,174	3,011	2,977	-13.4%
NC	26,636	26,730	26,448	26,718	26,684	26,431	25,802	25,448	-4.5%
ND	3,505	3,491	3,347	3,315	3,331	3,306	3,294	3,207	-8.5%
NE	7,640	7,432	7,308	7,184	7,162	6,992	6,883	6,662	-12.8%
NH	4,939	4,874	4,797	4,861	4,669	4,656	4,491	4,439	-10.1%
NJ	29,834	29,014	28,927	29,000	29,185	29,064	28,572	28,791	-3.5%
NM	4,329	4,554	4,471	4,216	4,152	4,036	3,916	3,478	-19.7%
NV	2,614	2,706	2,598	2,614	2,676	2,793	2,743	2,757	5.5%
NY	81,085	84,891	83,663	83,004	81,328	81,142	80,109	78,249	-3.5%
OH	53,174	52,625	52,091	51,806	51,961	51,905	51,198	50,938	-4.2%
OK	14,368	14,105	13,936	13,735	13,461	13,409	12,859	12,960	-9.8%
OR	5,856	5,737	5,300	5,047	5,039	4,910	5,013	5,002	-14.6%
PA	53,147	52,110	51,744	51,565	51,055	51,775	50,797	50,105	-5.7%
RI	6,374	6,091	5,708	5,560	5,523	5,365	5,344	5,164	-19.0%
SC	11,715	11,563	11,615	11,472	11,539	11,196	10,930	10,946	-6.6%
SD	3,966	4,044	4,019	3,842	3,762	3,727	3,720	3,703	-6.6%
TN	25,106	24,312	23,886	22,899	22,394	21,697	21,558	21,276	-15.3%
TX	62,050	60,240	60,741	60,227	60,153	59,787	58,686	57,268	-7.7%
UT	3,285	3,174	3,200	3,100	3,034	2,986	2,975	2,907	-11.5%

Medicaid Nursing Facility Census									
State	**Dec-01**	**Dec-02**	**Dec-03**	**Dec-04**	**Dec-05**	**Dec-06**	**Jun-07**	**Dec-08**	**Change**
VA	17,760	18,002	17,642	17,935	17,815	17,691	17,196	16,882	-4.9%
VT	2,225	2,120	2,157	2,165	2,081	1,941	1,997	2,007	-9.8%
WA	13,290	13,169	12,659	12,157	12,014	12,111	11,668	11,205	-15.7%
WI	25,229	24,389	23,693	22,783	22,058	21,488	20,465	19,431	-23.0%
WV	7,363	7,307	7,162	7,155	7,175	7,164	7,120	7,039	-4.4%
WY	1,578	1,540	1,532	1,508	1,477	1,492	1,440	1,461	-7.4%

Source: CMS OSCAR Form 672: F75 - F78

Compiled by the American Health Care Association - Health Services Research and Evaluation

Policy Guidance: Addendum

Housing

Qualified Residence

(B) Apartment with an individual lease

July 30, 2009

DHHS/Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Guidance for How Community Residential Settings Can Meet the MFP Statutory Definition of Qualified Residence (B) Apartment with an individual lease

The CMS MFP Team prepared the following guidance for MFP grantees to help clarify the conditions under which community residential settings, including Assisted Living Facilities or Settings (ALS) may meet the requirements of a "qualified residence" under the MFP statute. CMS believes this guidance preserves the intent of the Money Follows the Person Demonstration to offer participants options to live in apartment settings that promote independence, choice and privacy.

The MFP Team identified seven issues in the MFP Housing Guidance previously distributed by CMS that may limit participation of key community residential and Assisted Living providers in the demonstration. Each of these issues is described below, followed by the conditions which must be met in order for a community residential provider or (hereto referred to as an ALS) to participate in the MFP demonstration as a qualified residence.

ISSUES

1. Must have a lease.

A lease is a contract in which the legal right to use and occupy property is conveyed in exchange for payment or some other form of consideration. It is generally for a fixed period of time, although it may be a term for life, or may be terminable at any time. States need to evaluate if the following mandatory elements of a lease exist in the ALS resident agreement or contract.

- A provision that specifies that the ALS provider (possessor of real property) conveys the right to use and occupy the property. The ALS may also offer and provide a set of healthcare services and supports in exchange for rent or a fee.
- A provision that specifies the period of time that is governed by the agreement/contract agreed to by the resident and the ALS, including rights of termination by the resident and the provider and document a formal appeal process for resident terminations.
- A written instrument with a conveyance and covenants detailing the services and residence that will be provided in the Assisted Living agreement or Assisted Living contract.
- Provisions that the residents tenancy rights can be terminated only for violations including non-payment of rent, posing a direct threat to others, and property damage.
- The resident is provided sufficient information and opportunity to consider the possession of the ALS residence and related services and supports to be provided.
- The lease/agreement must state that the ALS will meet all Federal and State Fair Housing Laws.

2. Must be an apartment with living, sleeping, bathing and cooking areas

If apartments are not required by the States' ALS licensing regulations, MFP may only contract with ALSs that offer apartment units.

3. Unit must have lockable access and egress.

ALSs that serve participants with cognitive impairments must include design features that maximize the participants' capacity to live as independently as possible. Conditions that limit a person's activities must be addressed in the plan of care, be related to risks to the individual's health and welfare, and agreed to by the individual or caregiver in writing.

The ALS must provide the resident with lockable access and egress to and from the resident's apartment, and means to access or leave the facility. This may include key, ID card, keypad number, electronic scanner, or watchman made available to the participant, family member or guardian based on a person-centered plan of care. Participants who are not cognitively impaired and have a plan of care that indicates the capacity to live independently with supports must have full access and egress from their residence.

4. **A qualified residence cannot require that services must be provided as a condition of tenancy or from a specific company for services available in addition to those included in the rate.**

   Participants have the right to choose their living arrangements, and one residential option is an ALS that meets the requirements of a qualified setting under MFP. While one of the defining characteristics of an ALS is that the landlord is also the provider of services either directly or through contract, participants who choose to live in an ALS have a choice of providers of Medicaid services that are available in addition to the services that are included in the service rate paid to the ALS. Traditional ALS services usually include, depending on the needs of the individual, housekeeping, meal preparation, transportation, personal care, and assistance with medication administration.

   For an ALS to be eligible as a MFP qualified residence, the tenant (or responsible party) must participate in the care planning process, and there must be a formal process for resolving care plan differences between the ALS and the tenant. Regulations that provide for managed or negotiated risk meet this requirement. If the regulations do not provide a process for resolving care plan differences between the ALS and the tenant, the agreement/contract must define a process.

   The agreement/contract should indicate that when the tenant chooses to pay room and board for a unit, they also choose the ALS as their provider for services that are included in the Medicaid rate. Assisted living must be a voluntary choice made by the consumer. Participants cannot be denied services or ALS due to physical, sensory and/or mental health conditions. Before choosing an ALS, the individual should be provided with a choice of potential residences and service providers appropriate to their needs. ALS should not be the only option available to a transitioning individual.

5. **ALSs may not require notification of absences from the facility**.

   Notice of absences cannot be a condition of the agreement/contract but can be part of the ALS operating practices as long as the expectation is reasonable, noted in the plan of care, and related to one of the following criteria.

   - Notice of absence may be required based on an individual assessment, risk to the tenant and the need to assure health and welfare.
   - Notification of absence may be required in order to ensure that Medicaid is not billed for days on which services were not delivered.
   - Absences for less than 30 days cannot result in termination/discharge.
   - To assure health and welfare requirements, the tenant may have to inform the ALS when the tenant leaves the building. The length of the absence that needs to be communicated to the ALS can vary by the predetermined risk as noted in the care plan.

6. Aging in place must be a common practice of the ALS

An ALS can participate as a qualified residence only if it allows aging in place. This means that a resident contract may not be terminated due to declining health or increased care needs. The state may contract for MFP reimbursed services with ALSs that include aging in place opportunities as provided for in State licensing regulations.

Residents whose service needs cannot be met under the resident agreement or contract may bring in an outside service provider to meet the additional needs if allowed by state regulation; or if able, the ALS may provide the additional services. Additional Medicaid payments to an outside provider would only be made for services that are not included in the rate paid to the ALS.

7. Leases may not reserve the right to assign apartments or change apartment assignments.

Agreements/contracts may not reserve the right to assign apartments or change apartment assignments beyond the normal provisions of landlord tenant law. However, changes based on the plan of care developed with the resident may be made. In such cases, the written agreement should be modified to reflect the new agreement with the tenant.

Appendix B: CMS Waiver Review Guidelines

11. Assisted Living Services

Core Service Definition

Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not be 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 I-5.

Instructions

- Modify or supplement the core definition to reflect the scope of assisted living services furnished under the waiver.
- Indicate whether payment for assisted living services includes any of the following:
  - Home health care
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Medication administration
  - Intermittent skilled nursing services
  - Transportation specified in the service plan
  - Periodic nursing evaluations
  - Other specified services
- When assisted living services are furnished in living arrangements subject to §1616(e) of the Social Security Act (the Keys Amendment), the standards for such services must address the topics specified in Appendix C-2 (item C-2-c-ii), including assuring that the living arrangement is homelike rather than institutional in character.

Guidance

- Note: While this version of the waiver application continues to list “assisted living” as a service definition, CMS encourages states to use a more accurate name for the service. The term assisted living describes a setting, not a service. Medicaid never pays for “assisted living” in the ordinary sense of the monthly fee to the facility for room, board and services. Medicaid may cover, as a waiver service, some of the supportive services provided to assisted living residents. These services may be appropriately titled to reflect their nature and scope.
- Payment for assisted living services may encompass a comprehensive array of services and

supports that are normally furnished on an integrated basis by an assisted living provider to residents.

- When the scope of assisted living services includes services (e.g., personal care or chore services) that are also covered as distinct services under the waiver, there must be mechanisms that ensure, when such services are included in the comprehensive rate that is paid to the assisted living provider, the services may not also be billed separately.
- When a comprehensive payment is made to a provider for assisted living services, the provider's own employees must directly furnish some or all services to residents. The provider may arrange for the provision of some services on a contractual basis.
- The scope of assisted living services may include services that may be offered through the State plan to the extent such services are normally furnished as part of a comprehensive array of on-site assisted living services. There must be mechanisms to ensure that, when such services are included in the comprehensive rate that is paid to the assisted living provider, the services may not also be billed separately as State plan services.
- When a waiver includes assisted living services, the locations of service delivery must meet criteria described in Appendix C-2 with regard to the home and community based nature of the facility.