U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY:

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Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract #HHSP23320100021WI between HHS's ASPE/DALTCP and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE Project Officer, Emily Rosenoff, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Emily.Rosenoff@hhs.gov.

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TABLE OF CONTENTS

LIST OF EXHIBITS

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ACRONYMS

The following acronyms are mentioned in this report and/or state profiles.

A&D	Indiana Aged and Disabled waiver program
AAA	Area Agency on Aging
ACCS	Vermont Assistive Community Care Services
ACH	Adult Care Home
ADA	Americans with Disabilities Act
ADL	Activity of Daily Living
AED	Automated External Defibrillator
AFC	Adult Foster Care
AFCH	Adult Family Care Home
AIDS	Acquired Immune Deficiency Syndrome
AL	Assisted Living
ALF	Assisted Living Facility
ALP	Assisted Living Program
ALR	Assisted Living Residence
ALSA	Assisted Living Service Agency
ALTCS	Arizona Long Term Care System
ARCH	Adult Residential Care Home
ASCU	Alzheimer's Special Care Unit
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BDS	Maine Department of Behavioral and Developmental Services
BW	Broad HCBS Waiver
CARE	Maryland Certified Adult Residential Environment program
CBRF	Community-Based Residential Facility
CCFFH	Community Care Foster Family Home
CHOICES	TennCare CHOICES in Long-Term Services and Supports program
CMS	HHS Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
CNA-M	Certified Nursing Assistant-Medication Aide
COPES	Washington Community Options Program Entry System
CPCH	Comprehensive Personal Care Home
CPR	Cardiopulmonary Resuscitation
CRCF	Community Residential Care Facility
DAAS	Arkansas Division of Aging and Adult Services
DADS	Texas Department of Aging and Disability Services

DC	District of Columbia
DHHR	West Virginia Department of Health and Human Resources
DHHS	Maine Department of Health and Human Services
	North Carolina Department of Health and Human Services
DHS	Arkansas Department of Human Services
	Iowa Department of Human Services
	Minnesota Department of Human Services
DHSS	Delaware Department of Health and Social Services
DOH	New Jersey Department of Health
DSHS	Washington Department of Social and Health Services
E-ARCH	Expanded Adult Residential Care Home
ECC	Extended Congregate Care
EOEA	Massachusetts Executive Office of Elder Affairs
FSSA	Indiana Family and Social Services Agency
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HVAC	Heating, Ventiliating, and Air Conditioning
IADL	Instrumental Activity of Daily Living
ICP	Individualized Care Plan
IDAPA	Idaho Administrative Procedure Act
ID/DD	Intellectual Disabilities and Other Developmental Disabilities
IHSP	Independent Housing with Services Program
ISM	In-kind Support and Maintenance
ISP	Individualized Service Plan
IV	Intravenous
LMH	Limited Mental Health
LNS	Limited Nursing Services
LPN	Licensed Practical Nurse
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MLTC	Managed Long-Term Care
MMSE	Mini-Mental Status Examination
NCAL	National Center for Assisted Living
NSLTCP	National Survey of Long-Term Care Providers
NSRCF	National Survey of Residential Care Facilities
OIG	HHS Office of the Inspector General
OSS	Optional State Supplement

PCA	Personal Care Aide
PNA	Personal Needs Allowance
PNMI	Private Non-Medical Institution
PRN	Pro re nata (commonly used to mean "as needed" in Latin)
QMAP	Qualified Medication Administration Person
QUEST	Hawaii Medicaid program for elderly, blind or disabled individuals
RCAC	Residential Care Apartment Complex
RCAP	Indiana Residential Care Assistance Program
RCC	Residential Care Community
RCF	Residential Care Facility
RCH	Residential Care Home
RN	Registered Nurse
RTI	Research Triangle Institute
SCU	Special Care Unit
SNAP	Supplemental Nutrition
SOURCE	Georgia Service Options Using Resources in a Community Environment program
SSI	Supplemental Security Income
SSI-E	Supplemental Security Income Exceptional Expense
TBI	Indiana Traumatic Brain Injury waiver program
UAI	Uniform Assessment Instrument

EXECUTIVE SUMMARY

Residential care settings are an important option for older adults and people with disabilities who require long-term services and supports. They provide a community-based living alternative to individuals who might otherwise require nursing home care and those who do not need this level of care but are unable to continue living in their own or a relative's home.

Based on a 2012 study conducted by the National Center for Health Statistics, the United States has an estimated 22,200 residential care settings with 713,300 residents. Just over half of settings with 50 or more units had a dementia care program or unit and 52 percent were certified to receive Medicaid payments.

Residential care settings are licensed and regulated at the state level, and all states have at least one category of residential care. The purpose of this Compendium is to summarize and compare states' residential care setting regulations.

Although states generally have provisions covering the same areas--such as staff training--their requirements vary considerably. For example, 40 states require direct care worker training, but the number of required training hours ranges from 1 to 80. This Compendium notes similarities and differences among states and provides examples from state regulations.

In 2014, the Centers for Medicare and Medicaid Services established requirements for community-based service providers, including residential care settings that receive Medicaid payment for services provided to eligible residents. The requirements address characteristics and standards that must be present for a setting to be considered non-institutional. Some states may need to revise their residential care regulations to comply with the requirements regarding, for example, person-centered planning, privacy, choice of roommate, access to food, and other issues related to autonomy and choice. Thus, this Compendium may serve as a baseline of regulations before these requirements were established.

1. INTRODUCTION

Residential care settings are a key component of states' long-term services and supports (LTSS) systems. Typical reasons that older individuals move to group residential care settings are a need for unscheduled assistance or 24-hour supervision, insufficient informal care, and the inability to pay privately for services in their own homes.

The demand for residential care settings, as with all forms of LTSS, is expected to increase as the population ages. Approximately half of individuals who reach age 65 may need LTSS during their lifetime.[1] The population of people age 85 or older, which is at a high risk of needing LTSS, is predicted to nearly triple from 6.3 million in 2015 to 17.9 million in 2050.[a]

The 2012 National Survey of Long-Term Care Providers (NSLTCP) reported that the United States has 22,200 residential care settings with 713,300 residents.[b] Based on the 2012 survey, 57 percent of residential care settings had between four and 25 beds, but only 14 percent of residents lived in a setting of this size compared with 71 percent of residents who lived in one with more than 50 beds. Just over half (52 percent) of residential care settings were certified to receive Medicaid payments. One-half of residential care settings with more than 50 beds exclusively served residents with dementia or had a distinct dementia special care unit (SCU) or wing, compared with 27 percent of settings with 26-50 beds and 14 percent of settings with 4-25 beds.

The majority of residential care residents were White and non-Hispanic (87 percent), female (72 percent), and over the age 85 (51 percent). Residents have chronic health conditions that may require ongoing monitoring, medical treatment, and/or result in physical or cognitive impairments.

The ten most frequent conditions (based on the National Survey of Residential Care Facilities [NSRCF]) were high blood pressure (57 percent), Alzheimer's disease or other dementias (42 percent),[2] heart disease (34 percent), depression (28 percent), arthritis (27 percent), osteoporosis (21 percent), diabetes (17 percent), chronic obstructive pulmonary disease and allied conditions (15 percent), cancer (11 percent),

[1] Urban Institute analysis for the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE), forthcoming. LTSS need defined as requiring assistance with at least two activities of daily living (ADLs) and/or supervision because of severe cognitive impairment.

[2] An analysis of residents age 65 and older in RCFs using the NSRCF reported the prevalence of dementia as 51 percent. Wiener, J., Feng, Z., Coots, L.A., & Johnson, R. (2014). *What is the effect of dementia on hospitalization and emergency department use in residential care facilities?* Washington, DC: HHS, ASPE. http://aspe.hhs.gov/basic-report/what-effect-dementia-hospitalization-and-emergency-department-use-residential-care-facilities.

and stroke (11 percent).[c] About a quarter of residents (26 percent) had 4-10 chronic health conditions.[d]

Residential care settings provide assistance with daily personal care needs. A 2012 study found that 61 percent of residents required help with bathing, 45 percent with dressing, 37 percent with toileting, and 18 percent with eating. Nearly all settings (94 percent) provided medication management services[e] and 76 percent provided skilled nursing or nursing services.

Residential care settings are governed almost exclusively by state laws and regulations, rather than by federal rules, and vary from state to state.[3] This Compendium describes regulatory provisions and Medicaid policy for residential care settings, including assisted living facilities (ALFs), in all 50 states and the District of Columbia (hereafter, referred to as states).[4]

Its primary focus is group residential care settings that primarily serve a population of older adults and working-age adults with physical disabilities. It does not include residential care settings that are regulated by state mental health or developmental disabilities agencies and any setting that predominantly serves people with serious mental illness and/or intellectual and other developmental disabilities.

Adult foster care (AFC)--care furnished in a provider's own home--has historically been considered a type of residential care.[f] Although it is not the focus of this Compendium, we include basic information about each state's approach to regulating this setting (e.g., licensure or certification), the maximum number of residents these settings may serve, and links to information about these settings that is available online.

The Compendium's purpose is to inform residential care policy by providing detailed information about each state's approach to regulating and funding services in residential care settings.

Terminology Used in the Report

States historically have licensed two general types of residential care for older adults and individuals with physical disabilities: (1) AFC homes that typically serve 1-5 adults in a private residence in which the provider or a paid caregiver lives; and (2) group residential care settings that may serve a small number to well over 100 residents in a range of building types, including apartment buildings, large homes, and converted

[3] No applicable federal statutes exist, other than the Keys Amendment to the Social Security Act, which is applicable to board and care facilities in which a "substantial number of SSI recipients" are likely to reside. However, residential care providers who want to be reimbursed by Medicaid, may have to meet additional requirements.

[4] This Compendium updates a prior version: Mollica, R., Sims-Kasterlein, K., & O'Keeffe, J. (November 2007). *Residential care and assisted living compendium: 2007*. Washington, DC: HHS, ASPE. http://aspe.hhs.gov/pdf-report/residential-care-and-assisted-living-compendium-2007.

nursing homes. The licensed capacity of these two setting types varies, with some states limiting AFC to 2-4 residents, others to 5-6, and one up to 20.

States use many terms for the larger group residential care settings, including board and care homes, residential care facility (RCF), rest homes, adult care homes (ACHs), domiciliary care homes, and personal care homes. Until the mid-1990s, the most frequently used terms were board and care or residential care. In the late 1980s a new model of residential care became available: assisted living. This model offered what nursing homes and traditional board and care facilities generally do not: privacy and the ability to have greater control over daily activities.

By the mid-1990s, the popularity of the new assisted living model led many residential care settings to call themselves assisted living even though they did not provide the privacy and autonomy that are the model's key features.[g,h] Some states now use the term assisted living in a general sense, to apply to preexisting residential care types, including board and care homes and rest homes, whereas other states have added assisted living as a new licensure category.

This Compendium uses the term residential care setting as a generic term that encompasses all state licensure categories; the state profiles use each state's licensure term(s).

Methodology

We first reviewed the information in the 2013 National Center for Assisted Living (NCAL) Assisted Living Regulatory Review[i] and the 2007 Residential Care and Assisted Living Compendium.[j] Next, between January and December 2014, we reviewed the regulations posted on each state's website and compared them with the information in the aforementioned reports. When possible, we contacted staff from state regulatory and Medicaid offices as well as state affiliates of NCAL and the Assisted Living Federation of America to confirm that the online information was current. We also contacted these staff when we had questions about the meaning of specific regulations. Individuals who provided information are listed at the end of each profile along with their affiliation.

Although it is convenient to have regulations publicly available online, relying on online regulations as a primary source of information has several drawbacks.

First, not all states' websites are easy to navigate, include all relevant rules, or are updated frequently to revise. States often refine or revise sections of their regulations, sometimes in response to statutory changes.[5] Although we asked our state contacts if regulations were under revision or had recently been revised, and whether the revisions

[5] In 2012, 18 states reported regulatory, statutory, or policy changes affecting assisted living and other RCFs. Polzer, K. (2013). *Assisted living state regulatory review: 2013*. Washington, DC: American Health Care Association, NCAL.

were included in the documents available online, it is possible that some states did not provide complete information or that regulatory changes were made after we completed our review. (We anticipate that states will be further revising some of their regulations in response to the new requirements for home and community-based services [HCBS] issued by the HHS Centers for Medicare and Medicaid Services [CMS]).[k]

Second, states may have additional regulatory guidance in internal documents such as memos or "dear administrator letters," which are either not available or not easily found on the website.

For both these reasons, some profiles include the phrase "provisions not identified" for certain topics.

Third, in many instances, the regulations use ambiguous language and contain conflicting information. To obtain clarification, we consulted with state agency staff and provider representatives. In some cases, we were unable to obtain the needed information, and in these instances, we either did not include the information in the state profile or included a footnote regarding the ambiguity or conflict.

Fourth, to ensure accuracy we asked regulatory and Medicaid agency staff in every state to review the final state profiles we prepared, but not all were able to do so.

Organization of the Report

Section 2 provides an overview of state regulatory provisions covering 13 general topics, and extracts from the regulations are provided as examples (see Section 5). Section 3 contains information on public financing for residential care settings, including Medicaid funding for services furnished in these settings and related policies. Section 5 provides summaries of regulations in 13 topic areas for all 50 states and the District of Columbia.

2. OVERVIEW OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS

This section of the Compendium provides a synthesis of state regulatory provisions based on the 51 state profiles included in Section 5.

The following topics are described for each state:

- regulatory terms and definitions;
- residency agreements;
- disclosure requirements;
- admission and retention policy;
- services (including service planning and requirements for third-party providers);
- medication provisions;
- food service and dietary provisions;
- staffing requirements;
- staff training requirements;
- provisions for apartments and private units;
- provisions for dementia care (including staffing, staff training, and unit requirements, if any);
- background checks; and
- inspection and monitoring requirements.

This overview also discusses a few other topics that are addressed only by a small number of states, including provisions related to financial solvency, 24-hour access to food, and roommate choice.

Terms and Definitions

The terms and definitions used to describe different types of residential care settings are important for helping consumers and others to distinguish between different categories, especially given that 23 states have more than one licensure category. Most states (44) use the term *assisted living* as a licensing or certification category. The word that follows "assisted living" varies, and includes facility, residence, program, home, and community. The next most commonly used licensure term is *residential care*, used by 20 states.

States vary--sometimes considerably--in how they define assisted living; some license both AFC homes and large group homes as assisted living. A few states regulate assisted living as a service, using the terms *assisted living services agency* (Connecticut) or *assisted living services* (Minnesota).

Describing residential care settings generically as assisted living obscures the differences among types of settings, and makes it very difficult for consumers--both private pay and Medicaid-eligible--to determine which setting will best meet their current and future needs. In a study of six states' use of Medicaid to fund services in residential care settings, (Florida, Minnesota, North Carolina, Oregon, Texas, and Wisconsin), stakeholders in all but one state cited public confusion about residential care options as a major problem.[l]

A recent trend in adding health and supportive services to federally subsidized apartment buildings designated for seniors and persons with disabilities, typically referred to as housing plus services, represents an important innovation that may allow older adults to age in place.[m] Even though some properties offer services similar to those provided by residential care settings, such as personal care, coordination of health and social services, and transportation, these settings are not licensed, are intended to be independent housing, and do not typically provide 24-hour staffing.

Adult Foster Care

AFC is a unique model of residential care that states most often define as a private residence where either the owner or a paid caregiver lives with residents who receive personal care and other supportive services. Some states limit the level of assistance that can be provided to meals, assistance with personal care, and supervision, whereas others permit AFC homes to serve individuals who meet the state's minimum nursing home level of care criteria.

The licensed capacity of AFC homes is typically less than five, though some states allow six or more. Kansas uses this term for settings that serve up to 12 residents and Michigan for settings that serve up to 20 residents.

As shown in Exhibit 1, 38 states license or certify some type of small residential home that provides personal care services; about half use a term other than AFC to describe the setting. However, additional states license or certify small residential homes under a more general residential care category, blurring the distinction between settings.

The state profiles in Section 4 of this Compendium include links to the websites containing AFC rules for each of the 38 states listed below, as well as to each state's rules for their other licensing categories.

EXHIBIT 1. States that License or Certify AFC		
State	**Adult Foster Care Term**	**Number of Residents Permitted**
Alabama	Adult Foster Care	1 only
Alaska	Adult Foster Home or Assisted Living Foster Home	1-2
Arizona	Adult Foster Care Home	1-4
Arkansas	Adult Family Home	1-3
Connecticut	Adult Family Living	1-2
Delaware	Family Care Home and Residential Care Home	2-3
Florida	Adult Family Care Home	1-5
Hawaii	Adult Residential Care Home--Type I and Community Care Foster Family Homes	1-5 1-3
Idaho	Certified Family Home	1-2
Indiana	Adult Family Care Home	1-4
Iowa	Elder Group Home	3-5
Kansas	Home Plus and Boarding Care Home	1-12
Kentucky	Family Care Home	1-3
Louisiana	Personal Care Home	2-8
Maryland	Adult Foster Care/Certified Adult Residential Environment Program	*Unstated*
Massachusetts	Adult Foster Care	1-3
Michigan	Adult Foster Care Family Homes	1-20
Minnesota	Adult Foster Home	1-4
Mississippi	Adult Foster Care	*Unstated*
Montana	Adult Foster Home	1-4
Nebraska	Adult Family Home	1-3
Nevada	Home for Individual Residential Care	1-2
New Hampshire	Adult Family Care Residence	1-2
New Jersey	Adult Family Care	2-6
New York	Family-Type Homes for the Elderly	1-4
North Carolina	Family Care Home	2-6
North Dakota	Adult Family Foster Care	1-4
Ohio	Adult Foster Home	1-2
Oregon	Adult Foster Care	1-5
Pennsylvania	Adult Foster Home	1-3
South Dakota	Adult Foster Care	1-4
Texas	Adult Foster Care Home	1-4
Utah	Adult Foster Care	1-3
Virginia	Adult Foster Care	1-3
Washington	Adult Family Home	2-6
West Virginia	Health Care Home	1-3
Wisconsin	Adult Family Home	1-4
Wyoming	Adult Foster Care Home	1-5

Residency Agreements

A residency agreement is the contract between a resident and the residential care provider and is important because it establishes the legal relationship, including rights and responsibilities, of both parties. The 2014 CMS HCBS setting rule clarified the

agency's expectation that residential settings serving individuals under the Section 1915(c), (i), and (k) Medicaid authorities provide a residency agreement and/or follow applicable landlord/tenant laws that address eviction processes and appeals, and tenants' rights and responsibilities.

Nearly all states require a residency agreement and describe the type of information that it must include. Some states also require providers to furnish a separate document to inform prospective residents about services and rates, typically called a Disclosure Statement (*see next section*). Although the content of residency agreements and disclosure documents may overlap, they are described separately here because their purposes differ. A residency agreement is a signed service contract between the provider and the resident, whereas a disclosure document provides information that prospective clients need to determine whether a setting will meet their needs and to compare different settings.

Most states specify that residency agreements must include information about basic services and fees, optional services if any, admission and discharge criteria, limits on the scope of services that may be provided, residents' rights and responsibilities, and information for reporting grievances and complaints. Thirty-five states require agreements to include admission and discharge policies. A few states specify the conditions for emergency placements, such as for individuals being discharged from a hospital.

Most states require the resident (or a representative, if there is one) to sign the contract, though the timing for doing so varies. For example, some require that the agreement be signed before move-in, others do not describe when it should be signed, and a few are silent on whether a signature is required. Only a few states specify how frequently a residency agreement must be reviewed and updated (e.g., see Wisconsin and Oregon).

Ten states require that the residency agreement include information about medication services and policies.[6] For example, Georgia requires that facilities describe medication management provisions, including the staff responsibility for refilling prescriptions, and Oregon requires facilities to describe their system for packaging medications and the resident's right to choose a pharmacy. South Dakota requires facilities to describe the responsibilities of residents and family concerning self-administration of medications.

A few states have unusual residency agreement requirements. Maryland requires that the agreement include a recommendation for review by an attorney. In Pennsylvania, if a resident chooses to opt-out of an assisted living service defined by the licensing rules, the agreement must state that the service is not being provided and that the corresponding charges reflect the reduction in services to be provided. Connecticut and Minnesota do not require a service agreement because they license

[6] The ten states are Arkansas, Georgia, Idaho, New York, New Hampshire, Oregon, South Carolina, South Dakota, Virginia, and West Virginia.

the service provider, not the housing provider. In these states, tenant/landlord rules apply to the housing provider and the tenant.

Delaware's rules provide a detailed description of both financial and non-financial components of a residency agreement:

> *Prior to executing a contract, residents must receive a statement of all charges. The contract has financial and non-financial components. Financial components include: service rates and ancillary charges; billing and payment policies; criteria for additional charges as needs change; the process for changing the rates; the party responsible for handling finances, obtaining equipment/supplies, arranging services not covered by the contract, and disposing of belongings; and payment provisions.*
>
> *Non-financial components include: basic and optional services; optional services provided by third parties; residents' rights and obligations; grievance procedures; occupancy provisions such as policies concerning modifications to the resident's living area, procedures for changing the resident's accommodations (relocation, roommate, number of occupants in the room); transfer procedures; security; staff members' right to enter a resident's room; temporary absence policy; interim service arrangement during an emergency; discharge policies and procedures; and facility obligations.*

EXHIBIT 2. Examples of Different Residency Agreement Provisions by Setting	
Arkansas Residential Care Facility (RCF) Residents must receive a copy of the resident agreement at or prior to moving in that covers: (1) services, materials and equipment, and food included in the basic charge; (2) additional services to be provided and their charges; (3) residency rules; (4) conditions and rules for termination; (5) provisions for changes in charges; and (6) refund policies.	**Arkansas Assisted Living Facility (ALF)** Prior to or on the day of admission, the ALF and the resident, or his or her responsible party, must enter into an occupancy admission agreement. The agreement must provide information about core: (1) services; (2) optional services; (3) health care services available through home health agencies; (4) medication policies; (5) fees, charges, and payment and refund policies; (6) facility rules; (7) provisions for emergency transfers; and (8) discharge criteria.
District of Columbia Community Residence Facility *No provisions identified*.	**District of Columbia Assisted Living Residence (ALR)** A written contract/resident agreement must be provided prior to admission. It must include a range of topics, including the ALRs' organizational affiliation; the nature of any special care offered; services included or excluded; residents' rights and grievance process; unit assignment procedures; admission and discharge policies; responsibilities for coordinating health care; obligations for handling finances; coordinating and contracting for services not provided by the ALR, and policies and procedures for payments and refunds.

In states that license more than one type of residential care setting, residency agreement provisions might differ, as shown in Exhibit 2. In such states, consumer protections vary depending on the licensing category.

Most states require settings to develop a service plan that describes the specific services to be provided to each resident--as well as who will provide these services, when, and how often.

In some states, the regulatory provisions regarding the completion of the residency agreements and service plans are inconsistent. For example, given that admission requirements specify that facilities must not admit individuals whose needs they cannot meet, one can logically assume that a residency agreement would not be completed until after a pre-admission screening was conducted to determine whether the applicant meets the state's or facility's admission criteria. Oregon provides a clear example:

> *Before an individual is admitted, the facility must conduct an initial screening to determine the individual's service needs and preferences, and the facility's ability to meet these needs and preferences, given the needs of other residents and its overall service capability. Once admitted, the resident is evaluated and the findings used to develop the service plan.*

Washington and West Virginia also describe pre-admission screening requirements. Yet, in some states, assessments are not required until *after* an individual is admitted. This topic is addressed further in the Admission and Retention, and Services sections, below.

Disclosure Provisions

States have an interest in protecting and informing consumers. Older adults and their families need information to guide their choice of available residential care settings. States may require settings to provide consumer information, typically in a document called a disclosure statement, that consumers may use to "comparison shop" based on facilities' services, rates, staffing, and other policies.

Thirty-nine states require residential care providers to disclose specific information to prospective residents. We were unable to identify disclosure provisions for 12 states.[7]

The 39 states with disclosure provisions vary in their requirements. Eleven require disclosure only if a facility markets itself as providing dementia care.[8] (See also, the section below on dementia care provisions.) For example, New Mexico requires facilities that provide "memory care" to disclose to prospective residents information

[7] The 12 states are Alabama, Alaska, Arizona, Colorado, Hawaii, Idaho, Iowa, Kansas, Louisiana, South Dakota, Utah, and Wyoming.

[8] The 11 states are Connecticut, Florida, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, and South Carolina.

about staff training and qualifications; types of resident diagnosis or behaviors that the facility provides services for--and which the staff are trained to address; and information about the care, services provided, and the type of secured environment provided.

In some states with multiple setting categories, not all licensed settings are subject to disclosure requirements. For example, New York licenses three categories of "adult care homes" but two of them--adult homes and enriched housing programs--have no disclosure requirements.

Sixteen states require settings to use a state-provided uniform disclosure template.[9] Maryland's eight-page form begins with the following statement: "The purpose of the Disclosure Statement is to empower consumers by describing an assisted living program's policies and services in a uniform manner. This format gives prospective residents and their families consistent categories of information so they can compare programs and services."[n] Maryland's form includes the following topics:

- facility contact information;
- sources of payment accepted (e.g., Medicaid, Supplemental Security Income [SSI], private insurance);
- definition of a residency agreement;
- a checklist of services provided (optional and required), and associated fees, if any;
- service planning process;
- the type of staff who administer medications (e.g., licensed nurse, med tech);
- a checklist of discharge and transfer criteria;
- staff training;
- staffing schedule; and
- complaint procedures.

Texas's required disclosure form includes the following topics:

- services that are not provided;
- pre-admission processes;
- services included in the base rate and those that are assessed additional fees;
- the admission process;
- discharge criteria and process;
- care planning;
- regulatory requirements regarding aging in place;
- change in condition issues;
- staff training;
- building features (call system, security to prevent wandering);

[9] The 16 states are Arkansas, Delaware, Georgia, Illinois, Indiana, Maryland, New Hampshire, New Jersey, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Virginia, Vermont, and Washington.

- residents' rights; and
- staffing schedule.[o]

Disclosure statements such as those required in Maryland and Texas can assist consumers in determining which facilities can meet their current and future needs, and which ones they can afford.

Admission and Retention Policy

A primary purpose of regulating residential care settings is to ensure that providers are able to meet the needs of the aged/disabled population they serve. One option for doing so is to specify admission, retention, and discharge criteria, thereby setting the parameters for whom can be served in these settings. These criteria help to ensure that facilities will be able to meet their residents' needs.

Most often, state restrictions address an applicant's or a resident's ability to transfer or ambulate, physical and cognitive function, behavioral health issues, and need for ongoing skilled nursing care. Many states define specific criteria that preclude admission and require discharge, including the presence of communicable diseases (primarily tuberculosis), the need for specified treatments (e.g., nasopharyngeal and/or tracheotomy suctioning, gastric feedings, intravenous (IV) use; care of an in-dwelling urinary catheter; physical or chemical restraints); the presence of certain health conditions (e.g., Stage 3 or 4 pressure ulcer), and behavior that poses a threat to self or others.

Admission and retention criteria overlap, though many states have provisions that permit continued residency to current residents who develop medical conditions or limitations that would preclude admission, as long as specified criteria are met, as described below.

Admission Criteria and Processes

Admission criteria describe the characteristics of individuals who may and may not be admitted to a residential care setting, directly related to the services the setting is authorized to provide. The most common admission criterion is that individuals who require ongoing skilled nursing services may not be admitted.

States generally prohibit the admission and retention of individuals who require "indefinite" or "ongoing" access to 24-hour nursing care but may not define its meaning. Florida is an exception, defining it as follows:

> *(Nursing) services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services shall be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel*

or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or the disease state or stage.

Many states require that applicants be capable of evacuating the building or moving to an area of safety within the building during an emergency--either independently or with minimal assistance. This criterion is often linked to the ability to ambulate or follow instructions. If residents are unable to do so, a state generally has additional requirements. For example, Missouri's ALFs may accept or retain residents with an impairment (physical, cognitive, or other) that prevents their safe evacuation with minimal assistance, only if provisions are met regarding staffing requirements to assist in evacuations and each resident has an individualized evacuation plan.

In addition to specific criteria, some states specify the timing of admission assessments, staff or professionals who must be involved in determining whether an applicant is an appropriate fit, and criteria for emergency placements.

As mentioned above, Oregon requires an initial screening to determine the applicant's service needs and preferences, and the facility's ability to meet these needs and preferences. Before admission, Utah requires facilities to first assess, in writing, an individual's current health and medical history, immunizations, legal status, and social psychological factors to determine whether placement is appropriate. In West Virginia, a physician must certify that an applicant is capable of self-preservation before admission to a residential care community (RCC).

The population served by the categories of residential care settings included in this Compendium may include individuals who have a mental health diagnosis, but does not include settings licensed specifically to treat individuals with a severe mental illness. Florida is unique in offering a specialty license for residential care settings to provide limited mental health services. In contrast, New York does not permit adult care facilities to admit or retain individuals who have a serious and persistent mental disability that warrants placement in an acute care setting or residential treatment facility; require health or mental health services that are not available; or who repeatedly behave in a manner that directly impairs the well-being, care, or safety of residents.

Pre-admission screening requirements differ from service planning and assessment policies and procedures, described in more detail in the Services section, below.

Discharge Triggers

States use discharge triggers to determine when a resident can no longer reside in a specific setting. In addition to criteria concerning breach of contract (e.g., non-payment for whatever reason and non-compliance with facility policies), most discharge triggers are associated with the resident's physical, mental, or cognitive health and abilities. Virtually all states specify in their regulations that settings must discharge

individuals whose health-related needs they cannot meet, although states vary in the level of detail in describing specific health conditions or treatments.

One set of common discharge criteria relates to resident mobility. For example, RCFs in Arkansas may not admit or retain individuals who are not physically and mentally capable of vacating the building in an emergency. All states allow discharge if a resident's behavior endangers the health or safety of others in the setting--both staff and other residents.

Discharge Criteria Exceptions

Many states specify exceptions to the discharge criteria that provide the flexibility to support residents' preference to age in place and accommodate residents in rural communities with limited HCBS options. Most states that permit exceptions require the involvement of the state agency that licenses a particular setting or health professionals, including a physician or other licensed health professional, home health agency, or hospice agency.

At least 17 states require that a physician approve exceptions to discharge requirements.[10] For example, North Carolina does not allow ACHs to care for individuals who are ventilator dependent or need continuous licensed nursing care unless a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation.

Tennessee specifies treatments that may not be provided, including nasopharyngeal or tracheotomy suctioning, nasogastric feedings, gastrostomy feedings, or IV therapy or IV feedings, unless the resident's physician certifies that the facility can safely and effectively provide the treatment. Arkansas is unique in not allowing waivers of the admission/retention criteria.

Many states allow exceptions to discharge criteria for the provision of hospice care, as long as it is provided by a licensed program. For example, Michigan does not allow residents who need continuous nursing care to be retained unless the resident is receiving services from a licensed hospice program or home health agency. This topic is described in more detail in the Third-Party Providers section, below.

An additional rationale for allowing exceptions is the ability of a given setting to manage a particular condition. For example, most states require discharge if a resident has behaviors that pose a risk of serious harm to self or others, but some states waive this requirement if a provider can effectively manage these behaviors. (See discussion in Behavioral Issues section, below.)

Iowa's Department of Inspections and Appeals, Health Facilities Division, may give approval for limited time periods if the resident whose needs exceed the state's

[10] The 17 states are Arkansas, Arizona, Colorado, Connecticut, Hawaii, Florida, Ohio, Oklahoma, Massachusetts, Missouri, North Carolina, New Mexico, New York, Nebraska, Tennessee, Texas, and Virginia.

discharge criteria makes an informed choice to remain, the program has the staff to meet the extended needs, and the health and welfare of other tenants are not jeopardized.

Some states permit settings to provide or coordinate skilled nursing care to current residents, but only for a limited number of days. For example, residents may not be retained if they require skilled nursing care or are bedridden for more than 14 continuous days in Delaware, South Carolina, and Washington; 21 days in Iowa; 30 days in Montana and Wisconsin; 60 days in Arkansas; and 90 days in Louisiana, Massachusetts, and West Virginia. A resident who requires more than the specified number of days of care can be discharged.

Behavioral Issues in Admission and Retention Policies

The categories of residential care settings included in this Compendium may serve individuals who have a mental health diagnosis and individuals with various degrees of cognitive impairment, even though they are not licensed specifically as dementia care facilities or to treat individuals with a serious mental illness.

States generally restrict residential care providers from admitting or retaining individuals with behaviors that pose a safety risk to themselves or others; some states add a caveat: unless they can be handled by the staff. Generally, discharge polices include advance notice requirements, but if a resident's behavior poses an immediate threat to health or safety, providers may terminate residency without notice.

Some states list behaviors that preclude admission or retention, such as disruptive behaviors (Colorado and Wyoming); aggressive behaviors (Florida and Tennessee); and behavior or actions that repeatedly and substantially interfere with the rights, health, or safety of residents of others (Oregon).

Illinois assisted living and shared housing establishments may not admit or retain residents who are a danger to themselves or others; are not able to communicate their needs and do not have a representative residing in the facility; and individuals with a severe mental illness (among other admission/discharge criteria).

(Behaviors associated with dementia are described in more detail in the Provisions for Residents with Dementia, below.)

Services

Residential care settings generally can provide a wide range of services. Although the type and scope of services offered, especially in relation to those offered by nursing facilities, has been a topic of debate in many states, state requirements for basic services do not vary greatly, except for the level of detail they provide. In general, settings must meet residents' needs as long as they do not exceed the admission and

retention criteria. The most commonly described services include personal care (e.g., assistance with ADLs) and instrumental activities of daily living (IADLs), including laundry and housekeeping, supervision and protective oversight, transportation, and social and recreational services. Most states require that access to services be available 24 hours daily.

However, states vary regarding requirements for nursing services, the type of medication services provided (described in the following section), and mental health services. As discussed above, many states do not allow residential care providers to furnish skilled nursing services except on a short-term basis and when delivered by a licensed nurse or an outside, or third-party, agency. In Oregon, residential care settings must provide nursing services, which are defined as

> *…assessing resident health and well-being; delegating and teaching staff to perform tasks in accordance with Board of Nursing rules; participating on the service planning team, as needed; providing health care teaching and counseling based on service plans; and providing intermittent direct nursing services, as needed.*

States may specify whether services are optional or required by using words such as may, must, and/or shall. For example, Alaska rules indicate that facilities may provide health-related services, including assistance with self-administration of medication, intermittent nursing services, 24-hour skilled nursing for up to 45 days, and hospice services. It is unclear, based on this description, whether a facility must provide these services should a resident require them or if the resident would need to be relocated without their provision.

The following subsections describe the service planning process (including timing and staff involved in service planning or assessment); managed or negotiated service agreements; and provisions regarding third-party service providers such as home health or hospice agencies.

Service Planning

Most states have specific provisions regarding when and how residents' and prospective residents' needs should be assessed, the content of the assessment, participants in the service planning process (including health professionals who are not employed by the residential care setting), and the type of service plan to be based on the assessment (sometimes referred to as an evaluation).

Washington provides a very detailed example of an assessment:

> *Except in cases of emergency, the facility must not admit an individual before obtaining a thorough assessment of his or her needs and preferences. The assessment must cover recent medical history; necessary and contraindicated medications; a licensed medical or other health professional's diagnosis, unless the individual objects for religious reasons; significant known behaviors or*

symptoms that may cause concern or require special care; mental illness; level of personal care needs; activities and service preferences; and preferences regarding other issues important to the resident applicant, such as food and daily routines.

Based on the assessment, the facility must complete an initial resident service plan upon move-in to identify the resident's immediate needs and to provide direction to staff and caregivers. Within 14 days after move-in, the facility must complete a full assessment of the resident's functional and health needs-as specified in regulation. Facilities must repeat a limited assessment when a resident's condition changes and the resident's negotiated service agreement no longer addresses the resident's needs.

Like Washington, some states specify that an assessment be completed before admission for the purpose of determining whether admission is appropriate (e.g., Delaware, Mississippi, Oregon, and Pennsylvania). The written care plan must be completed some days after admission, for example, within 7 days (Connecticut), 14 days (Arizona), 30 days (Alaska, District of Columbia), and 45 days (West Virginia).

Because the assessment typically includes health and functional status, states may require input from the applicant's health care provider or a professional employed by or associated with the residential care setting. However, some states simply require, for example, a comprehensive assessment of physical, health, behavioral, and social needs without specifying who is responsible for conducting the assessment. Several states require an assessment of the residents' ability to self-administer medications or their need for medication services (e.g., New York, Ohio, Vermont).

The service plan is based on the assessment, and states generally require that residents be involved in the planning process, as well as a family representative, if appropriate. Service plans are most often completed by facility staff, though some states require a licensed nurse to review the plan, which must specify the type, scope, and frequency of services that will be provided, and the resident's preferences regarding service provision. For example, Kansas requires that if a resident needs health care services, a licensed nurse must develop a health care service plan that specifies the skilled nursing services to be provided and the licensed person or agency that will provide the services.

States generally require that assessments and service plans be updated periodically. Most states specify a time frame, such as 6 months or annually, in addition to requiring reassessment following a change in the resident's health or behavior, a hospitalization, or if requested by the resident or a responsible person. The service plan must be modified to reflect any changes based on the assessment.

Some states refer generally to addressing residents' "preferences" in service plans. Details are rarely included, although a few states address resident preferences in the context of managed or negotiated risk agreements.

Managed/Negotiated Risk Agreements

The use of negotiated risk agreements in residential care settings was considered an important topic several years ago.[p] However, very few states address the topic in regulation, possibly because persons with cognitive impairment that limits their ability to make informed decisions may not enter into such agreements and because of concerns about the legal validity of such documents, particularly regarding liability issues if a resident suffers harm as a consequence of engaging in risky activities.[q]

Oregon's rules specify that a managed risk plan cannot be entered into or continued with or on behalf of a resident who is unable to recognize the consequences of his or her behavior or choices. Of 15 states that had risk agreement provisions in 2005, less than half (seven) specifically addressed the residents' cognitive capacity to understand and sign the agreement.

Utah is an anomaly in that it requires facilities to document, before admitting a resident into a dementia care unit, that a wandering risk management agreement has been negotiated with the resident or that the resident's responsible person has signed the agreement as a proxy. Such an agreement raises legal concerns because it is questionable that a person being admitted to a dementia care unit is legally competent to enter into such an agreement, or that a relative or other person may accept risk on behalf of an individual with cognitive impairment.

A few states incorporate managed risk agreements into service planning. Florida's extended care community regulations define managed risk agreements as follows:

> *…the process by which facility staff discuss the service plan and the resident's needs with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney-in-fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly.*
>
> *"Shared responsibility" means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney-in-fact, and the facility to develop a service plan that best meets the resident's needs and seeks to improve the resident's quality of life.*

Most states' regulations do not address the use of risk agreements. The extent to which residential care settings use risk agreements in states that do not define them is not known.

Third-Party Providers

The use of third-party providers is important because these providers may assist residents with short-term illnesses and prevent transfers of residents with terminal illnesses. States take different approaches to the use of third-party providers--some *permit* them whereas others *require* that residents be allowed to contract with them. Only one state, Mississippi, does not have provisions addressing their use, and seven states have provisions for one licensing category but not another; for example, Tennessee has provisions for assisted care living facilities but not for residential homes for the aged.

The two most commonly mentioned third-party providers are home health agencies (24 states) and hospice agencies (32 states). Other states refer more generally to licensed health care providers, outside agencies, or third parties; or use similar terms. Only four states require that facilities make arrangements with mental health providers on behalf of residents who require these services (Arizona, New York, Virginia, and West Virginia). The use of third-party providers allows residents to receive services that states do not permit residential care providers to furnish, such as skilled nursing services, and additional services that residents might prefer, such as transportation other than that offered by the facility, companionship, and additional baths/showers, given that many facilities provide assistance with this ADL only twice a week.

It is reasonable for residential care settings to establish policies and procedures that specify any limitations, conditions, or requirements that must be met before a third-party provider is permitted on-site. Some states require residential care providers to ensure that third-party providers deliver contracted services, and they may also require facilities to verify that these providers have undergone criminal background checks. Washington specifies that the facility is not responsible for supervising third-party agency staff, but that it must coordinate their services with the other services a resident receives. New Jersey is unique in specifying that facilities and residents who are not Medicaid-eligible may contract with outside health care professionals for services that the facility does not provide.

Of the 32 states that permit third-party hospice services to be provided, 19 refer to hospice care as an exception to the state's discharge criteria. An additional 13 states allow hospice services to be delivered but do not link this service to discharge criteria. The lack of regulatory provisions for hospice services does not mean that hospice or any other third-party providers are prohibited, so it is possible that the number of states in which hospice care is provided to residential care setting residents is higher than 32. Regardless, it is clear that hospice services enable residents who need these services to avoid potentially disruptive transfers.

Four states have very detailed provisions regarding the furnishing of hospice services: Iowa, South Dakota, Texas, and Wyoming. The South Dakota rules are summarized here:

A facility that admits or retains a resident who has elected hospice: must have the resident's physician order identifying the terminal illness; must have a written agreement with the hospice agency that delineates responsibilities; must provide the licensing agency with specified information about each hospice client; must be approved for medication administration; must be equipped with an automatic sprinkler system if a hospice patient becomes incapable of self-preservation; must have at least two staff on duty at all times if the hospice resident care needs require additional staffing or the resident is not capable of self-preservation, except when the hospice plan of care provides for adequate 24 hour bedside care, which can be provided by either family members or hospice staff during their intermittent visits.

The facility must include family members or hospice staff on a staffing schedule; each staff member must attend training within 30 days of employment and annually specific to the care for terminally ill residents; and training, including a competency evaluation by the facility nurse, nursing consultant, or hospice agency nurse, must include the following topics:

- *Ambulation;*
- *Changing an occupied bed;*
- *Position resident on side in bed;*
- *Toileting using a bedpan;*
- *Partial bed bath;*
- *Transfer using a gait belt;*
- *Urinary emptying drainage bag;*
- *Hospice history and philosophy;*
- *Ethical and privacy considerations;*
- *Definitions of team roles and eligibility;*
- *Communication techniques;*
- *Spiritual care services;*
- *Bereavement and grief explorations; and*
- *Alternative therapies.*

The HHS Office of the Inspector General (OIG) analyzed Medicare hospice care provided in ALFs (ALFs) between 2007 and 2012.[r] During that time period, Medicare payments for hospice care in ALFs more than doubled. Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Hospice beneficiaries in ALFs often had diagnoses that usually require less complex care. Hospices typically provided fewer than 5 hours of visits and were paid about $1,100 per week for each beneficiary receiving routine home care in ALFs. Also, for profit hospices received much higher Medicare payments per beneficiary than non-profit hospices.

These and other findings led the OIG to recommend hospice care payment reforms, with which CMS concurred. Thus, the role of hospice care in these settings might change in the next few years.

Medication Provisions[11]

Medication services are an important, and debated, component of residential care. Although medication administration is a traditional nurse function in institutional settings, it is also standard practice to teach laypersons to self-administer medications and/or administer medications to a child, parent, or other relative.[s] Nurse Practice Acts in many states permit registered nurses (RNs) to delegate nursing tasks, including medication administration, to unlicensed staff who work in a wide range of home and community-based settings, including group residential care.

States often restrict the type of medications that unlicensed staff may administer to those prescribed for stable or predictable conditions. They also often prohibit the administration of as-needed (*pro re nata*, or PRN) medications because such medications require an assessment of symptoms to determine whether it should be taken--either by the individual for whom the drug is prescribed or by a licensed nurse.

The policy of permitting unlicensed staff to assist with and/or administer medications has not been universally accepted as a safe practice. A California-based advocacy group recently argued that ALFs "pretend" that medication is always self-administered but that in fact unlicensed staff administer medications under the pretense that they are only assisting with medications.[t] Research indicates that unlicensed staff do not make more errors than licensed staff, although the authors cautioned that the potential for errors remained because unlicensed staff had less understanding of medications than licensed nurses.[u]

Assistance with Self-Administration vs. Medication Administration

Most states specify whether residential care settings may provide assistance with medications (sometimes called assistance with self-administration) and/or administration of medications. Assistance typically includes reminders, assistance opening a container, offering liquids, and may or may not include centralized storage and record-keeping. Medication administration typically involves removing the correct dosage from a medication container and handing it to a resident or putting it in their mouth, or the direct application of a medication dose (e.g., topical, injectable) to a resident.

However, state regulations may specify what constitutes *assistance with* versus *administration of* medications in different ways. As shown in Exhibit 3, there is overlap between these two terms, with the result that residents may be receiving similar services under different names.

[11] Regulations not discussed in this section include those related to medication records, storage, and disposal, or guidelines for assessing residents' ability to self-administer medication.

EXHIBIT 3. Comparison of State Descriptions of Medication Assistance and Administration	
Assistance with Medications	**Medication Administration**
Assistance with medication includes reminders to take the medication, removing the medication from a container, assistance with removing caps, assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act; and observing the resident take the medication. (Wyoming)	Medication administration includes reading labels for residents, observing residents taking their medications, checking the dosage, removing the dosage, filling a syringe and administering insulin and bee sting kits, and keeping a medication record for each resident. (Maine)
Assistance with medication includes holding the container, opening the container, and assisting the resident in taking the medication (other than by injection), following the directions, and documenting in the medication log that each medication has been taken by the resident. (Delaware)	Medication administration includes routine prompting, cueing and reminding; opening containers or packaging at the resident's direction; reading instructions or other label information; and/or transferring medications from the original container into suitable medication dispensing containers. (Iowa)

That is, assistance in one state might be defined as administration in another--specifically, removing the correct dosage from a non-unit dose container is considered administration in most states but assistance in others. Assistance with medications provisions typically requires that the resident be capable of self-administration with limited assistance.[v] Alabama is unique in permitting residents of dementia care (in specialty care facilities) to self-administer and store medication in their unit if they are "aware" of their medications.

A few states have especially detailed descriptions of certain medication services. For example, Connecticut's rules provide extensive provisions for the use of non-prescription topical medications and for medications administered by routes other than oral. Oklahoma has very detailed provisions regarding bulk medications, including the type of staff who may dispense from bulk medication containers and permitted types of bulk medications (e.g., oral analgesics, antacids, laxatives). Colorado has a draft guideline for the use of medical marijuana in ALRs.[w]

Licensed vs. Unlicensed Staff and Training

Most likely reflecting differences in State Nurse Practice Acts, states vary regarding provisions about who is authorized to assist with or administer medications. As shown in Exhibit 4, 36 states permit unlicensed staff to administer medications and 18 permit unlicensed staff to assist with medications. Fifteen states require a licensed health care professional to administer all medications, and nine require licensed health care professionals to administer specific medications such as injections or Schedule II medications.[12] Some states specify whether licensed health care professionals must be employed by the residential care setting or contracted as a consultant or a third-party agency.

[12] Those with a high potential for abuse.

EXHIBIT 4. State Staffing Requirements for Medication Assistance and Administration			
Licensed Health Care Professional Administer All Medications	**Licensed Health Care Professional Required to Administer Only Certain Medications**	**Unlicensed Staff Person May Administer Medications**	**Unlicensed Staff Person May Assist Residents with Medications**
Alabama (SCU) Arizona Arkansas California Connecticut (ALSA) Delaware Florida Idaho Illinois Massachusetts Mississippi New York Tennessee West Virginia (RCC) Wyoming	Colorado Indiana Iowa Kansas Missouri Nevada Rhode Island Utah Wisconsin	Alaska Colorado Connecticut (RCH) District of Columbia Georgia Hawaii Indiana Iowa Kansas Maine Maryland Michigan Minnesota Missouri Montana Nebraska Nevada New Hampshire New Jersey New Mexico North Carolina (ACH) North Dakota Ohio Oklahoma Oregon Pennsylvania Rhode Island South Carolina South Dakota Texas Utah Virginia Vermont Washington West Virginia (ALR) Wisconsin	Alabama Arizona Arkansas California Connecticut (ALSA) Delaware Florida Idaho Illinois Kentucky Louisiana Massachusetts Mississippi New York North Carolina Tennessee West Virginia (RCC) Wyoming
15	**9**	**36**	**18**
NOTE: Some states have different requirements for different residential care settings.			

If states do not require that licensed staff administer medications, they have two primary approaches to training requirements for unlicensed staff who will be assigned to administer medications:

- Unlicensed staff who will administer medications must receive classroom-based training that some states use to certify individuals as certified medication aides or technicians.

- Unlicensed staff are taught how to assist with or administer medications by a licensed nurse and this nurse formally delegates the responsibility for medication administration to specific trained staff. Delegation means the transfer to a competent (unlicensed) individual the authority to perform a selected nursing task in a selected situation, as described in the state's Nurse Practice Act.[x]

Exhibit 5 lists state training requirements for unlicensed staff. All states require staff who assist with or administer medications to be trained, though training requirements vary. Twenty-four states require unlicensed staff to take a medication training course, and 21 states permit training through nurse delegation or training provided by a licensed health care professional such as a RN or physician.

EXHIBIT 5. Training Requirements for Unlicensed Staff Who Assist with or Administer Medications

Unlicensed Staff Who Assist With or Administer Medications Must Complete an Approved Course	Unlicensed Staff May Be Delegated/Trained by a Health Care Professional at the Facility
California	Alaska
Colorado	Arizona
Connecticut	Arkansas
Delaware	Hawaii
District of Columbia	Iowa
Georgia	Louisiana
Idaho	Michigan
Indiana	Minnesota
Kansas	Montana
Maine	New Hampshire
Maryland	Oregon
Missouri	South Carolina
Nebraska	South Dakota
Nevada	Texas
New Jersey	Utah
New Mexico	Vermont
North Carolina	Washington
North Dakota	Wisconsin
Ohio	Wyoming
Oklahoma	
Pennsylvania	
Rhode Island	
Virginia	
West Virginia	
24	**19**

Of the 24 states that require unlicensed staff to take a medication course, 13 require them to pass an examination.[13] Thirteen states specify that unlicensed staff must complete continuing education on medications.[14] None of the 21 states that permit nurse delegation require continuing education for unlicensed staff, possibly

[13] The 13 states that require an examination are California, Colorado, Connecticut, Kansas, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Pennsylvania, Rhode Island, Virginia, and West Virginia.

[14] The 13 states that require continuing education are Arkansas, California, Delaware, District of Columbia, Maine, Maryland, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, and Virginia.

because the formal delegation of medication administration by licensed nurses requires ongoing assessment of skills and the provision of training as needed.

Provisions for Injectable Medications

Administration of injectable medications is a frequently described medication task for which states have widely varying requirements. The administration of medications by injection is generally considered to be a skilled nursing task because incorrect technique can significantly harm the recipient. Based on NSRCF, 45 percent of RCFs provide injectable medications, with larger facilities twice as likely to do so as smaller settings (62 percent vs. 31 percent, respectively). In settings that employ or contract with licensed practical nurses (LPNs) or RNs for some amount of time, more than 60 percent provide this service, compared with 36 percent of settings without LPNs or RNs.

Many states restrict the scope of medication services based on the route (e.g., injections, inhalants), use of controlled substances, and use of as-needed (PRN) medications. However, two states allow unlicensed staff to assist residents who self-administer injection medications (Alabama and Montana), and eight states permit unlicensed staff to administer medications by injection.[15] Georgia permits certified medication aides to perform several tasks that other states require a licensed nurse to perform, including the following: administering insulin, epinephrine, and vitamin B-12 by injection; and administering medications via a metered dose inhaler.

Massachusetts does not allow even licensed nurses to administer medications by injection (though they may administer medications delivered through other routes: topical, inhalers, eye and ear drops, medicated patches, and suppositories).[16] Maine permits unlicensed staff to administer insulin and bee sting kits by injection but no other type of injectable medication.[17]

Provisions for Psychotropic Medications

In recent years there has been an increasing focus on reducing overuse of psychotropic medications for residents in long-term care facilities.[y] Seven states describe provisions for psychotropic/psychoactive medications used to treat behavioral conditions.[18] Vermont and Oregon are unique, even specifying that unlicensed staff may administer PRN psychotropic medications.

West Virginia has very detailed guidelines for psychotropic and behavior-modifying medications. If these medications are used, the facility must ensure the following: that the dosage is based on age recommendations; that the diagnosis justifies the

[15] The eight states are Hawaii, Maine, North Carolina, Oregon, South Carolina, Vermont, Washington, and West Virginia.

[16] Given that the administration of medications by all routes is permitted by Nurse Practice Acts, the reason for this prohibition is unknown.

[17] The regulations did not specify whether the insulin in the syringes had to be pre-filled by a licensed nurse.

[18] The seven states are Arkansas, Idaho, Mississippi, New Mexico, Oregon, West Virginia, and Vermont.

medication use; that staff monitor daily for side effects or adverse effects; that adverse effects are reported to the resident's physician; and that measures to reduce the dose over time are taken. In addition, monthly evaluation by a licensed health care professional is required and a physician must review the resident's record every 6 months and assess the need for continued use of the prescribed medication and the potential to decrease the dose. West Virginia permits approved Medication Assistive Personnel who have completed a competency-based training program to administer medications.

Oregon's and Idaho's rules state that psychoactive medications are not to be used for the convenience of the staff. Specifically, Idaho rules state that psychotropic medication must not be the first resort to address behaviors and that the facility must attempt non-drug interventions to assist and redirect residents' behavior.

Provisions for Pharmacist Review

Older persons are at risk of negative health consequences due to inappropriate medication prescribing, medication administration errors, and adverse drug events. Medicare-certified nursing facilities are required to employ or obtain the services of a consultant pharmacist to assist with medication regimen review.[z] At view, at least 14 states require facilities to have a consultant pharmacist to review residents' medication records for medication appropriateness and/or potential prescribing or administration errors.[19] Some states require an RN or physician to conduct a medication review.

Given that 68 percent of RCFs report that a physician or pharmacist reviews residents' medications for appropriateness, it seems likely that some facilities are exceeding regulatory requirements for medication review.

Arkansas's ALFs (Level II) regulations provide an example of detailed consultant pharmacist requirements. Each facility must contract with, or otherwise employ, a consultant pharmacist, who must prepare a written report to the facility at least quarterly each year describing:

- Any areas in which the consultant pharmacist determines that the methods employed by the facility are deficient, or have the potential to adversely affect the health, safety, or welfare of residents.

- Recommended alterations to the methods, or additions to the methods, to correct any methods determined to have the potential to adversely affect the health, safety, or welfare of residents.

The consulting pharmacist must also review all orders for medication prescribed since the last review and prepare a report to the facility describing: (1) all instances in

[19] The 14 states are Arkansas, Delaware, Georgia, Kansas, Maryland, Missouri, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and West Virginia.

which medication has been improperly prescribed or administered; and (2) instances in which, in the opinion of the consultant pharmacist, the facility should seek physician review of the number or types of prescribed medications for residents.

Kansas rules for pharmacist review are among the most prescriptive, requiring a review at least quarterly and following any significant change in the resident's condition. The review must include the following:

- lack of clinical indication for use of medication;
- the use of a subtherapeutic dose of any medication;
- failure of the resident to receive an ordered medication;
- medications administered in excessive dosage, including duplicate therapy;
- medications administered in excessive duration;
- adverse medication reactions;
- medication interactions; and
- lack of adequate monitoring.

Based on the findings of this review, the pharmacist or licensed nurse must notify the resident's medical care provider of any issue that requires the medical provider's immediate action.

South Dakota requires facilities to have a monthly pharmacist review that includes the resident's diagnosis, the drug regimen, and any pertinent laboratory findings and dietary considerations. The pharmacist must report potential drug therapy irregularities and make recommendations for improving residents' drug therapy to the resident's prescriber and the facility administrator.

The frequency of medication record review requirements varies: two states require monthly/every other month, six require quarterly review, and others require twice yearly or less often.

Provisions for Family Assistance with Medications

Some states permit family members to assist resident relatives with medications. Such assistance offers the benefit of continuing established caregiver relationships and may save the resident money if medication services are not included in the basic rate.

Montana permits families to set up medications, including insulin administered by injection. Louisiana permits the resident's relatives or a personal representative to transfer medication from the original container to a pill organizer box the resident uses to self-administer medication. However, facilities differ regarding monitoring whether medications are being administered as prescribed. Utah permits family members or a designated responsible person to administer medications after signing a waiver indicating that they will agree to assume the responsibility to fill prescriptions, administer medications, and document their administration.

Food Service and Dietary Provisions

Residential care settings traditionally provide both lodging and meals (i.e., "board"). State regulations vary regarding specific requirements for meals, snacks, and therapeutic diets. (All states have requirements for food storage and safety, cooking equipment, and food service staffing, which are not included here.)

All but six states require providers to furnish three daily meals. The exceptions include Iowa's assisted living programs, Maine's assisted living programs, and New York's enriched housing programs--each of which are required to provide only one daily meal. Minnesota and Illinois require two daily meals (Illinois requires the provision of a breakfast bar in this case if a facility does not provide breakfast). Ohio is unique in allowing RCFs to choose whether to serve no meals--or one, two, or three meals.

Facilities that do not provide three meals must ensure that each resident unit is equipped with facility-maintained food storage and preparation appliances.

All but 16 states require the provision of snacks, with some specifying one daily snack, and others "between meal snacks."[20] Only a few states specify the maximum amount of time that may elapse between meals.

Several states require providers to furnish therapeutic and modified diets, sometimes referred to as special diets when ordered by a physician. For example, the District of Columbia requires facilities

> *…that admit and retain residents who need special or therapeutic diets to provide for those diets to be planned, prepared, and served as prescribed by the attending physician. Facilities must consult regularly with a dietitian, who must have access to the resident's record containing the physician's prescriptions for medications and special diet and must document in that record all observations, consultations, and instructions regarding the resident's acceptance and tolerance of prescribed diets. The dietitian and the residence director, or a qualified person designated by the residence director, must review residents' therapeutic diets at least every six months.*

States typically require that meals and snacks meet recommended dietary and nutrition standards, most frequently those of the Food and Nutrition Board of the National Academy of Science, National Research Council. However, some states refer more generally to federal guidelines or national standards. In addition, states may require that a dietitian review menus and recipes to assess whether meals meet nutritional standards.

[20] The 16 states are Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Ohio, Oklahoma, Rhode Island, Texas, and Wyoming.

The 2014 CMS regulatory requirements for HCBS settings include the provision of "access to food at any time." We specifically searched regulations to determine whether any states required such access and found that very few states addressed the availability of food to residents at all times. Pennsylvania requires that between meal snacks and beverages be available "at all times, unless medically contraindicated."

Colorado's requirements for Alternative Care Facilities, the state's term for settings certified to receive Medicaid reimbursement, include a 2009 revision that requires facilities to provide clients "unscheduled access" to food and food preparation areas if the resident is determined capable of appropriately handling cooking activities.[aa] This provision is described under residents' rights.

Delaware's rules do not specifically use the term "access at any time" but do require ALFs to provide access to a central kitchen if residents' units do not have kitchens. Thirty-five states specify that snacks should be available between meals but do not specify that they should be available at any time between the evening and morning meal.

Presumably, residents in private apartments and rooms that have kitchens with food storage appliances will have access to food any time they want it. States that do not require units with kitchens or access to a central kitchen may need to revise their regulations to comply with the new CMS requirement.

Staffing Requirements

Staffing is an important topic in all LTSS settings because studies indicate that staff have a significant impact on the health and well-being of residential care residents.[bb] States have an interest in requiring that residential care settings have a sufficient number of staff who are qualified to provide services that residents require.

All states require residential care settings to employ a manager, director, or an administrator who is responsible for daily operations, including staffing, oversight, and complying with regulatory requirements. Generally, the administrator is expected to be employed full-time, but states may permit smaller settings with a licensed resident capacity under a specified number to employ a part-time administrator. For example, Delaware permits facilities licensed for 5-24 residents to employ an administrator for 20 hours per week, and homes with 1-4 residents are required to have a director on-site for 8 hours weekly in addition to a health service manager (8 hours weekly) and a full-time house manager.

State provisions regarding RNs and other licensed health professionals are more varied but use three basic approaches: (1) a licensed nurse must be on staff (RN or LPN); (2) a licensed nurse must be available, either through employment or as a consultant; or (3) licensed nurse requirements are not specified. Thirty-eight states require residential care settings to have a licensed nurse or other licensed health

professional (e.g., physician, physician assistant) either available (24 states) or on staff at least some hours each week (14 states). NSLTCP found that less than half of all residential care settings employ an RN (the survey did not report facilities that contract with RNs).

The primary function of licensed nurses in residential care settings is the provision and oversight of nursing services that are covered by the state's Nurse Practice Acts. For example, Montana's rules specify that Category B ALFs must employ or contract with a RN to provide or supervise nursing services, which include: (1) general health monitoring for each resident; (2) performing a nursing assessment on residents when and as required; (3) assistance with the development of the resident health care plan and, as appropriate, the development of the resident service plan; and (4) routine nursing tasks, including those that may be delegated to LPNs and unlicensed assistive personnel in accordance with the Montana Nurse Practice Act. A small number of states require licensed nurses to administer medications, as listed in Exhibit 4.

In addition to administrators and licensed health professionals, states require residential care settings to employ direct care workers to provide personal care and related daily services to residents. States use a variety of terms to describe these staff, including personal care assistant, attendant, and caregiver. In virtually all states, these staff are unlicensed, though states may require training and/or certification, described below.

In addition to the staff types described above, other staff involved in resident care that states may require include medication assistants or technicians, consultant pharmacists (described in the Medication Provisions section), case managers, social services staff, and activities staff. Ohio requires facilities to employ or contract with a psychologist or physician if any residents have specified conditions associated with late-stage cognitive impairment and/or who have a serious mental illness. Missouri is unique in requiring each facility to be under the supervision of a physician who is kept informed of treatments or medications prescribed by any other professional authorized to prescribe medications.

Staffing Ratios

States use two basic approaches to staffing levels: (1) flexible, or as-needed, staffing; and (2) minimum ratios based on either the number of staff to the number of residents, or a specified number of staff hours per resident per day or week. (*Additional staffing requirements for dementia care units are described in the section below*.)

Flexible, or as-needed, staffing is the most common staffing approach, though at least one of 32 states that use this approach also specify minimum requirements. A common regulatory provision requires that residential care settings provide a "sufficient" number of staff who are adequately trained, certified, or licensed to meet residents' needs and to comply with applicable state laws and regulations.

Many states also specify that at least one employee with cardiopulmonary resuscitation (CPR) and first-aid certification must be on-duty at all times. In addition, states may require certain staff to be on-duty if current residents have specific needs--for example, if residents require nursing services, sufficient nursing staff must be available.

Nineteen states specify required staffing ratios, typically for direct care staff but some for nursing staff as well. About half of these states specify different direct care staff-to-resident ratios depending on the work shift. For example, Missouri requires 1:15 during the day shift; 1:20 during the evening shift; and 1:25 during the night shift; and the employment of a licensed nurse, whose required hours are based on the number of residents: 8 hours/week for 3-30 residents; 16 hours/week for 31-60 residents; 24 hours/week for 61-90 residents; and 40 hours/week for more than 90 residents.

Arkansas, Florida, New York, and North Carolina have very detailed requirements for staffing ratios. New York is unique in requiring case manager hours based on the number of residents, and West Virginia is unique in requiring ratios of direct care staff based on the numbers of residents who have two or more of the following care needs: dependence on staff for eating, toileting, ambulating, bathing, dressing, repositioning, special skin care, or one or more specified inappropriate behaviors that reasonably require additional staff to control.

Some states do not require overnight staff to be awake based on the number of residents. For example, rules for New Hampshire's RCFs, whose residents must be capable of independently evacuating the building, state the following:

> *At least one awake staff must be on duty at all times except for facilities with 16 or fewer beds if they have an electronic communication system, an installed wandering prevention system for facilities serving residents with dementia, and the facility can at all times meet residents' needs.*

Nevada requires awake staff only in residential facilities with 20 more residents, and in Texas, night shift staff in Type A ALFs with 16 or fewer residents must be immediately available, but they are not required to be awake. In Type B facilities, night shift staff must be immediately available and awake, regardless of the number of licensed beds.

Training Requirements

Staff training requirements are an important topic because a trained, qualified workforce can improve residents' quality of life and care.[cc] States' regulations typically require initial and ongoing training requirements for staff and administrators, and rarely for licensed health care professionals. The degree of specificity in training requirements varies considerably.

Some states' regulations require only that staff be trained, whereas others specify numerous topics that must be covered, the number of training hours required, the completion of approved courses, or some combination thereof, described below. (This Compendium does not discuss required pre-employment qualifications or certifications.)

States specify initial orientation and training requirements for administrators, ranging from 6 to 70 hours. Florida's rules are among the most extensive, requiring administrators to complete a 26-hour core training and an examination, covering a list of specified topics, which include licensure process, administrator duties, record-keeping, residency requirements, food service, personal care and services, special needs populations (dementia, mental health, hospice), resident rights, and inspection and monitoring. Other states with detailed training requirements include Pennsylvania, Texas, and Washington.

Forty-four states require continuing education and/or ongoing in-service training for administrators and/or direct care staff. The number of annual continuing education hours required for administrators ranges from 6 to 30 (average 15.5 hours).

Direct Care Worker Training

States' requirements for direct care worker training similarly vary. Forty states require an orientation, with the number of hours ranging from 1 (Missouri) to 80 (North Carolina). Among the states that did not specify orientation, all but one required training but did not specify the timing. North Carolina requires ACH direct care staff to complete an 80-hour personal care training and competency evaluation program established by the state. The training must include at least 34 hours of classroom instruction and 34 hours of supervised practical experience. The competency evaluation covers observation and documentation; basic nursing skills, including special health-related tasks; personal care skills; cognitive and behavioral skills, including interventions for individuals with mental disabilities; basic restorative services; and resident's rights.

South Carolina's training topics provide an example:

- Basic first-aid to include emergency procedures as well as procedures to manage/care for minor accidents or injuries.

- Procedures for checking and recording vital signs (for designated staff members only).

- Management/care of persons with contagious and/or communicable disease (e.g., hepatitis, tuberculosis, HIV infection).

- Medication management including storage, administration, receiving orders, securing medications, interactions, and adverse reactions.

- Care of persons specific to the physical/mental condition being cared for in the facility (e.g., Alzheimer's disease and other dementias, cognitive disability) to include communication techniques (cueing and mirroring), understanding and coping with behaviors, safety, activities.

- Use of restraints (for designated staff members only).

- Occupational Safety and Health Administration standards regarding blood-borne pathogens.

- CPR for designated staff members/volunteers to ensure that there is a certified staff member/volunteer present whenever residents are in the facility.

- Confidentiality of resident information and records and review of the Bill of Rights for Long-Term Care Facilities.

Forty states also require continuing education or in-service training for direct care workers, ranging from 4 to 16 hours; 13 states do not specify the number of hours, as shown in Exhibit 6.

EXHIBIT 6. Direct Care Worker Continuing Educations Requirements			
Hours Unstated	**1-5 Hours**	**6-10 Hours**	**11+ Hours**
Alaska	California	Arkansas	Alaska
Iowa	Indiana	Hawaii	Connecticut
Kansas	Iowa	Idaho	Delaware
Kentucky	Minnesota	Illinois	District of Columbia
Louisiana		Massachusetts	Georgia
Maine		Nevada	Nebraska
Mississippi		Ohio	North Carolina
New Hampshire		Oklahoma	Oregon
North Dakota		Rhode Island	Pennsylvania
South Carolina		Texas	Vermont
South Dakota			Virginia
Vermont			Washington
West Virginia			Wisconsin

Most states exempt licensed health care professionals from direct care worker training requirements. However, a few require them to receive training in the care of specific resident populations. For example, Texas requires facilities that employ licensed nurses, certified nurse aides, or certified medication aides to provide annual in-service training, on one or more of several suggested topics, including:

- Communication techniques and skills useful when providing geriatric care (skills for communicating with the hearing impaired, visually impaired and cognitively impaired; therapeutic touch; recognizing communication that indicates psychological abuse).

- Geriatric pharmacology, including treatment for pain management, food and drug interactions, and sleep disorders.

- Common emergencies of geriatric residents and how to prevent them, for example, falls, choking on food or medicines, injuries from restraint use; recognizing sudden changes in physical condition, such as stroke, heart attack, acute abdomen, acute glaucoma; and obtaining emergency treatment.

- Ethical and legal issues regarding advance directives, abuse and neglect, guardianship, and confidentiality.

Background Checks

Because residential care settings often serve vulnerable residents with physical and/or cognitive impairments, ensuring their safety is a major concern for states. Federal regulations prevent nursing facilities that accept payment from Medicaid and Medicare from employing individuals who have been found guilty of certain crimes or who are listed on state nurse aide registries.[dd] Given that states regulate residential care settings, no similar federal regulations apply to these settings.

States require background checks for residential care setting staff, though the requirements vary greatly regarding the extent of checks required. States most often require background checks for administrators and direct care workers, and some also require checks for volunteers and contractors who work in the facility.

Many states require a criminal background check (often with fingerprinting) and the checking of statewide nurse aide abuse registries, but some states provide more extensive requirements, specifying how the check is to be conducted.

For example, in Florida, all ALF owners (if individuals), administrators, financial officers, and employees must have a criminal history record check obtained through a fingerprint search through the Florida Department of Law Enforcement and the Federal Bureau of Investigation to determine whether screened individuals have any disqualifying offenses. An analysis and review of court dispositions and arrest reports may also be required to make a final determination. The cost of the state and national criminal history records checks are borne by the licensee or the person being fingerprinted. All individuals who are required to have an initial background screen must be re-screened every 5 years. New Jersey also has extensive requirements.

The timing of criminal background checks is of concern because, presumably, an employee without a criminal history could acquire one during his or her employment tenure. Some states require periodic criminal background checks on current employees. Several states, including Georgia, require owners, administrators, and other employees to self-report criminal charges and convictions to the licensing agency. The effectiveness of this approach is unknown.

Some states permit exceptions to criminal background screening requirements. For example, Wisconsin has a Rehabilitation Review process by which caregivers convicted of certain offenses may request a formal review that may result in their being permitted to work in a community-based residential facility.[ee]

New Hampshire and Missouri have waiver processes that allow the hiring of persons who have committed specified violations. Federal employment rules have identified criminal background checks, in some cases, to be a form of employment discrimination, and have provided language requiring businesses to re-evaluate exclusions for certain criminal offenses. The assisted living provider industry has taken a formal position that seeks to maintain protections given the nature of highly personal care provided and the health status of many residents.[ff] However, states may choose to adopt exceptions for residential care setting employees as these and other states have done.

Provisions for Residents with Dementia

Policymakers, researchers, and providers recognize that persons with dementia require specialized care.[gg] Regulatory requirements for dementia care in residential care settings are of major interest because at least half of residents have some form of dementia.[21]

Residential care settings have responded to this prevalence by developing and promoting separate units or programs that are designed to meet the special needs of persons with dementia. States have developed rules and regulations for such units and programs, though the level of detail varies widely. This section addresses state provisions for residents with dementia, including dementia care staffing, staff training, and living unit requirements.

A dementia care unit may be a stand-alone facility or a section of a building (e.g., a dedicated floor or wing), which provides specialized care and services for residents with Alzheimer's disease and other dementias. Ten states have no or minimal provisions related to dementia care. Four of these states have requirements only to address wandering and egress (Alaska, Arizona, Missouri, and New Hampshire); one that addresses only staff training (District of Columbia); one that addresses admission criteria (Kansas); and four states have no provisions (Hawaii, Michigan, North Dakota, and Vermont). The lack of requirements does not mean that specialized dementia care facilities or units are prohibited.

Six states require a separate license or certification for dementia care units or programs: Alabama, Colorado, Mississippi, New York, West Virginia, and Oregon

[21] Wiener et al., 2014 (see footnote 2). Based on analysis of NSRCF data using a broader definition of cognitive impairment, Zimmerman, Sloane, & Reade (2014) found that 70 percent of residents had some level of cognitive impairment.

(which endorses the facility's license for dementia care). Aspects of these states' rules are described below.

One common requirement among states is that residential care providers disclose to potential residents the availability of dementia care services, as well as a description of dementia-specific services, staff training, and building amenities, if any. Fifteen states require a written disclosure statement.[22]

Maryland's requirements for disclosure state that:

> *Programs with an Alzheimer's Special Care Unit must complete the Department's disclosure form that describes: a statement of philosophy or mission; staff training, job titles, and patterns; admission and discharge procedures; assessment and care planning protocols; a description of the physical environment and any unique design features appropriate to support the functioning of cognitively impaired individuals; a description of activities, including frequency and type, how the activities meet the needs of residents with dementia, and how the activities differ from activities for residents in other parts of the program; fees for services provided; and any services, training, or other procedures that are over and above those that are provided by the assisted living program.*

Twelve states specify admission criteria that designate who may be admitted to a dementia care unit (Exhibit 7).

For example, Mississippi requires that the following:

> *Before admission, a complete medical examination must be conducted by a physician, nurse practitioner, or physician assistant, and an assessment by a licensed practitioner whose practice includes the assessment of cognitive, functional, and social abilities, must be conducted. These assessments must demonstrate that the individual is appropriate for placement.*

New Mexico requires a pre-admission assessment to evaluate whether less restrictive alternatives are available and the basis for the admission to the secured environment, including a physician diagnosis of Alzheimer's disease or other dementia. Utah requires that residents admitted to secure dementia units must be assessed using the Folstein mini-mental status examination on admission, and at least annually thereafter, and must score between 20 and 10.

[22] The 15 states are Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Maryland, New Mexico, Oklahoma, Ohio, Oregon, Rhode Island, Texas, and Wisconsin.

EXHIBIT 7. State Provisions for Dementia Care Units and Programs			
Building Design Features	**Disclosure Statement**	**Admission Screening**	**Staffing Requirements**
Alabama	Arkansas	Colorado	Alabama
Alaska	Colorado	Kansas	Arkansas
Arkansas	Connecticut	Illinois	California
California	Delaware	New Mexico	Georgia
Colorado	Florida	Oregon	Illinois
Florida	Georgia	Pennsylvania	Indiana
Georgia	Illinois	Tennessee	Massachusetts
Illinois	Maryland	South Dakota	Mississippi
Iowa	Nebraska	Texas	Nevada
Louisiana	New Mexico	Utah	New York
Maine	New Jersey	Virginia	North Carolina
Massachusetts	New York	Wyoming	Oklahoma
Mississippi	Ohio		Pennsylvania
Montana	Oklahoma		Rhode Island
Nevada	Oregon		Texas
New Mexico	Texas		Virginia
North Carolina	Washington		West Virginia
Oregon	West Virginia		Wyoming
Pennsylvania	Wisconsin		
Rhode Island			
South Dakota			
Texas			
Virginia			
Washington			
West Virginia			
Wyoming			
26	**19**	**12**	**18**

Dementia Care Staff

Most states' provisions for dementia care staff reference general staffing requirements and do not require additional staffing. Seventeen states simply require that dementia care units must have at least one awake staff person and/or staff "sufficient" to meet resident needs in a dementia care unit. A few states have detailed and specific requirements, such as West Virginia, which requires that:

> *Special care units and programs must have a staff person with experience and training in dementia care to coordinate outside services, offer monthly educational and family support meetings, and advocate for residents. Staffing patterns must enable the facility to provide 2.25 hours of direct care time per resident per day. At least two staff must be present for units serving more than five residents. An RN must be available if residents require nursing procedures. Appropriate activities must be provided by a therapeutic specialist, occupational therapist, or activities professional.*

Seven states specify that an RN must be available a minimum number of hours.[23] North Carolina specifies minimum staff-to-resident ratios and a resident care manager.

[23] The seven states are Alabama, Arkansas, Mississippi, New Jersey, Rhode Island, West Virginia, and Wyoming.

Seven states require an additional manager or administrator for a dementia care unit that is not a stand-alone facility.[24]

Dementia Staff Training

People with dementia require staff who are trained to address their specific health and behavioral care needs. This section addresses required staff training after employment--orientation and continuing education--as well as training topics and any required certifications. All but six states have staff training requirements for dementia care, even if other dementia care provisions are minimal or lacking. Most training requirements are for unlicensed direct care staff, but some states also require training for other staff, including licensed professionals and administrators.

Twenty-three states specify the number of hours of initial training or orientation required for staff who work in dementia care units; the number of hours ranges from 2 to 30; of these, 15 require at least 8 hours of initial training.[25] Most of the states that specify the number of training hours also specify continuing education, ranging from 2 to 12 hours annually.

The specificity of required training topics varies across the states. In Illinois, training must cover the following topics: encouraging independence in and providing ADL assistance; emergency and evacuation procedures specific to the dementia population; techniques for successful communication and minimizing challenging behaviors; residents' rights and choice for persons with dementia; and caregiver stress and working with families.

Arkansas has very detailed requirements:

> *Staff must have 30 hours of training on (1) policies (one hour); (2) etiology, philosophy, and treatment of dementia (three hours); (3) stages of Alzheimer's disease (two hours); (4) behavior management (four hours);(5) use of physical restraints, wandering, and egress control (two hours); (6) medication management (two hours); (7) communication skills (four hours); (8) prevention of staff burn-out (two hours); (9) activities (four hours); (10) ADLs and individual-centered care (three hours); and (11) assessment and individual service plans (three hours).*
>
> *Staff must receive 2 hours of on-going in-service training each quarter to include such topics as positive therapeutic interventions and activities; developments and new trends in the fields of Alzheimer's disease and other dementias, and treatments for same; and environmental modifications to minimize the effects and problems associated with these conditions.*

[24] The seven states are Alabama, Illinois, Indiana, Massachusetts, Nevada, Oregon, and Texas.

[25] The 15 states are Arkansas, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Louisiana, Maine, Minnesota, North Carolina, Pennsylvania, Texas, Virginia, and West Virginia.

The individual providing the training must have a minimum of 1 year uninterrupted employment in the care of residents with dementia, or training in the care of individuals with dementia, or is designated by the Alzheimer's Association or its local chapter as being qualified to provide training.

Dementia Unit Requirements

The health and safety of persons with dementia may be enhanced by environments with features designed to accommodate cognitive and physical impairments.[hh] Thirty-five states have provisions for the physical features of dementia care units, including the residents' living units, access to bathrooms, and external locking doors or controlled methods of egress to prevent unsafe exits.[26]

One standard feature of a dementia care unit is that it is secured to prevent wandering. A commonly described provision is for external exit door controls that prevent residents who are at risk of wandering from exiting the building while still allowing occupants to safely evacuate the building in an emergency. For example, Alabama requires that:

[f]acilities must have a secure boundary or perimeter to safely accommodate residents who wander. Delayed-egress locks must comply with detailed requirements. Locks on exit doors, if installed, must be electrical locked or electrical delayed-egress locking devices. In group and congregate facilities, panic hardware must be installed on all exit doors, except where electrically controlled door hardware is used.

Maine requires that:

[t]he unit must be designed to accommodate residents with dementia, enhance their quality of life, and promote their safety. In addition to the physical plant standards required for licensure, an Alzheimer's/dementia care unit must have adequate space for dining, group and individual activities and family visits, and must provide freedom of movement between common areas and residents' rooms. Residents may not be locked inside or outside their rooms. Residents are encouraged and assisted to decorate their unit with personal items and furnishings and facilities must individually identify each resident's room to help with recognition.

In addition, a few states specify the features of outdoor environments. For example, Georgia requires secured outdoor spaces and walkways that are wheelchair accessible and allow residents to ambulate safely while preventing undetected egress.

State regulations are generally silent about the provision of shared or private apartments or rooms, private bathrooms, and roommate choice for dementia care units.

[26] States without any provisions are Connecticut, District of Columbia, Delaware, Indiana, Kentucky, Minnesota, Maryland, Missouri, Nebraska, New Jersey, Ohio, Oklahoma, South Carolina, Tennessee, Utah, and Wisconsin.

Unless otherwise specified, general residential care setting building requirements also apply to dementia care.

Provisions for Apartments and Private Units

When ALFs first became popular, starting in the early 1990s, one of their defining features was respect for resident privacy, and thus facilities were expected to offer residents a private room or apartment with a private bathroom, often with cooking appliances in a small kitchen area. Although some states have developed or revised regulations to require private apartments or rooms, most states have not.

Twenty-five states have at least one licensing category that requires private apartments. Of these, six states (Ohio, Oklahoma, Texas, Utah, Washington, and Wyoming) require private apartments only as a condition of Medicaid certification.

Nebraska does not require apartments but has provisions for facilities that choose to provide them. States with provisions specify that apartment units may be single-occupancy or double-occupancy but that the second occupant must be chosen by the resident. Washington specifies that shared units are not permitted unless the residents are married, and both agree and understand that they are entitled to separate apartments. Oregon's rules describe in detail the type of apartment required in ALFs:

> *All resident units are individual apartments with a lockable door, private bathroom, and kitchenette facilities conforming to relevant state and federal building codes as well as the Americans with Disabilities Act and Fair Housing Act. Shared units are allowed by resident choice. Unit bathrooms must have a toilet, sink, and a roll-in, and curbless shower. Each unit must have a kitchen area equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, space for food preparation, and storage space. All units must have an escape window that opens directly onto a public street, public alley, yard, or exit court.*

Many states require single-occupancy or double-occupancy units that have their own bathroom, but not a kitchen. Several states license two categories of residential care that have different living unit requirements, as in North Dakota:

> ***Assisted Living Facilities**. Private apartments are not required. A resident living unit must include a sleeping area, an entry door that can be locked, and a private bath with a toilet, sink, and a bathtub/shower. Units may be single or double occupancy.*
>
> ***Basic Care Facilities**. Resident rooms may be single or multiple occupancy (three or more). At least 1 toilet and sink is required for every 4 residents, and 1 bathtub/shower for every 15 residents.*

Most (41) states have at least one residential care licensing category that allows multiple-occupancy units (e.g., three or more residents) and/or toilets and bathing

facilities shared by several residents. Rarely are four adults permitted to share a room, but more often states permit shared toilets (usually for up to eight residents) and shared bathing/showering facilities (usually for 10-12 residents, with a range of 4-20). States have been revising some of these standards, which often remain from former board and care regulations, and some require new construction to provide a higher number of bathrooms per resident and rooms with no more than double-occupancy.

Although a state's regulations set the parameters for what may be provided, what is actually provided may differ. Shared units may be allowed, but the market may produce very few or no new facilities that offer shared units. The NSRCF found that 80.5 percent of resident units are private apartments or rooms for one person. About one-third of all units (32.6 percent) are apartments with a private bathroom and kitchen, and 74.9 percent of residents do not have a roommate.[27]

Finally, states have two broad approaches regarding roommate requirements. First, couples that want to share a single or private room may be explicitly permitted to do so, though minimum square-foot requirements may prevent sharing of the smallest units. When facilities are required to offer private apartments or private units, the expectation is that these units are shared only by choice.

Second, states may require facilities that offer double-occupancy units to allow residents to choose their roommate. However, it is unclear how facilities comply with this requirement if one double unit is available to two applicants who both want a private unit. And individuals who cannot afford a private room generally have little choice of roommate when first admitted to a residential care setting.

Examples of state approaches to roommate choice include the following:

- *Colorado*. Alternative care facility providers must accommodate requests regarding roommate choice within reason.

- *Georgia*. Personal care home residents must choose in writing to share a private bedroom or living space with another resident of the home.

- *Florida*. Facilities participating in the Medicaid Long-Term Care Managed Care program must offer a private room or apartment or a unit that is shared only with the approval of the waiver participant.

- *Washington*. No more than two residents may live in an apartment, and both must mutually agree to share a sleeping room.

- *Wisconsin*. Residential Care Apartment Complexes offer only apartments, and multiple-occupancy of an independent apartment is limited to a spouse or a roommate chosen at a resident's initiative.

[27] Unpublished analysis of NSRCF data by RTI International.

- *Indiana*. An assisted living resident has the right to share a room with his or her spouse when: (1) married residents live in the same facility and both spouses consent to the arrangement; or (2) a room is available for residents to share. The facility must have written policies and procedures to address the circumstances in which persons of the opposite sex, other than husband and wife, will be allowed to occupy a bedroom if such an arrangement is agreeable to both.

Many states do not specifically address the subject of roommate choice.

Inspection and Monitoring

States inspect and monitor residential care settings to determine whether regulatory requirements are being met, both at initial licensing and then on an ongoing basis.

All states require entities seeking licensure as a residential care setting to first comply and show proof of compliance with all applicable standards, regulations, and requirements established by state, local, and municipal regulatory bodies. These bodies generally include the Office of Sanitation or Public Health; the Office of the State Fire Marshal; the City Fire Department, if applicable; and the applicable local governing authority, such as a zoning, building department, or permit office.

All states have some licensing inspection requirements. However, requirements for pre-licensure inspections were not always evident in the rules. Some states require an initial inspection after a small number of residents have been admitted.

Annual license renewal requirements are standard, though some states have biannual renewals. Inspections may occur every year, 15 months, 2 years, or more, or "as-needed" based on complaints received by the licensing agency. Some states extend the renewal period for facilities that have gone a specified period of time without a negative finding. States may make scheduled and/or unannounced visits. All states have a process for receiving, reviewing, and investigating complaints and for assessing sanctions, corrections, or revoking a license.[28]

[28] For more information about inspections, the website Assisted Living 411 has a review of state survey laws, regulations and policies. Assisted Living 411. Assisted Living Oversight Across the U.S.: Overview and Summaries of States' Requirements and Practices. 2011. http://www.assisted-living411.org/nationaloverviewstateassistedlivingoversight.php.

3. PUBLIC FINANCING OF SERVICES

Medicaid is the largest public payer of LTSS.[29] In federal fiscal year 2012, Medicaid LTSS spending was $140 billion, representing 34.1 percent of all Medicaid spending. Expenditures on HCBS--which include those provided in residential care settings--accounted for 49.5 percent of total LTSS spending, with significant variation across states: from less than 30 percent (New Jersey and Mississippi) to more than 70 percent (Minnesota and Oregon).[ii]

Medicaid is an important source of financing for services provided in residential care settings. NSRCF found that nearly 20 percent of residents were Medicaid beneficiaries and 42 percent of facilities served at least one Medicaid beneficiary.[jj]

Medicaid Financing for Services in Residential Care Settings

Federal law does not allow Medicaid to pay for room and board in residential care settings but provides several options for states to finance services in these settings.

- HCBS waiver programs (also called §1915[c] waiver programs) can cover services in participants' homes and in residential care settings. Some states have implemented specialized assisted living waiver programs that provide services only in residential care settings.[30]

- Section 1115 research and demonstration waivers (hereafter referred to as §1115 waivers), give states the ability to test new policies for coverage and delivery of Medicaid services. Historically, this authority was used to implement capitated managed care programs. When such programs replace existing HCBS waiver programs, they generally cover the same services as did the HCBS waiver program, including services in residential care settings.

- Section 1915(b) waivers are one of several options available to states that allow the use of managed care in the Medicaid program. When using §1915(b), states have four options: (1) §1915(b)(1) allows states to implement a managed care

[29] This section of the report draws liberally and verbatim in parts from O'Keeffe et al. (2010). *Understanding Medicaid Home and Community Services: A Primer*. http://aspe.hhs.gov/pdf-report/understanding-medicaid-home-and-community-services-primer-2010-edition.

[30] States also use HCBS waiver programs to cover services in group provider-operated residential care settings that serve persons with intellectual disabilities and other developmental disabilities (ID/DD), but information about these waiver programs is not included in this Compendium. However, individuals with ID/DD who meet a state's nursing home level of care criteria may also be served in Aged or Aged/Disabled waiver programs. But only persons with developmental disabilities can be served in ID/DD waiver programs because the level of care criteria for ID/DD waiver programs require a specific diagnosis of ID or DD to be eligible.

delivery system that restricts the types of providers that people can use to get Medicaid benefits; (2) §1915(b)(2) allows a county or local government to act as a choice counselor or enrollment broker) to help people pick a managed care plan; (3) §1915(b)(3) allows states to use the savings they get from a managed care delivery system to provide additional services; and (4) §1915(b)(4) allows states to restrict the number or type of providers that can provide specific Medicaid services, such as transportation.

- State Plan services include personal care, which can be provided in residential care settings through the optional Personal Care benefit or the §1915(i) HCBS benefit.

EXHIBIT 8. Medicaid Authorities States Use to Finance Services in Residential Care Settings for Older Adults and Younger Adults with Physical Disabilities

Waiver Only[1]	State Plan Only	State Plan and Waiver
Alaska	Michigan	Arkansas (*AL & BW*)
Arizona (*§1115*)	Missouri	Florida (*§1915(b)*)
California (*AL*)	North Carolina	Idaho
Colorado	South Carolina	Maine
Connecticut		Massachusetts
Delaware (*§1115*)		New York
District of Columbia		North Dakota
Georgia		Vermont (*§1115*)
Hawaii (*§1115*)		Washington
Illinois (*§1915(b) & BW*)		Wisconsin (*§1915(b) & BW*)
Indiana		
Iowa		
Kansas (*§1115*)		
Maryland		
Mississippi (*AL*)		
Minnesota		
Montana		
Nebraska		
Nevada		
New Hampshire		
New Jersey (*§1115*)		
New Mexico (*§1115*)		
Ohio (*AL & §1915(b)*)		
Oklahoma		
Oregon		
Rhode Island (*§1115*)		
South Dakota		
Tennessee (*§1115*)		
Texas (*§1115 & BW*)		
Utah		
Virginia (*AL*)		
Wyoming (*AL*)		
32	**4**	**10**

1. Unless indicated as an *§1115 or §1915(b) waiver*, the states provide coverage either under: (1) a broad HCBS waiver (BW) that covers services in participants' homes and in residential care settings (25 states and the District of Columbia); or (2) an exclusive Assisted Living (AL) HCBS waiver that covers services only in residential care settings (6 states), or both (1 state).

Exhibit 8 presents the Medicaid authorities that states use to provide services in residential care settings for older adults and younger adults with disabilities. In 2014, 46 of the 50 states and the District of Columbia used either a waiver program, the State Plan personal care option, or both to provide services in residential care settings for older persons or younger persons with physical disabilities. Of the 42 states that used waiver programs, 32 states and the District of Columbia used an HCBS waiver program, ten states used an §1115 waiver program, and four used a §1915(b) waiver program. Of the 14 states that used the State Plan, ten also used some type of waiver. No states used the §1915(i) HCBS authority.

Six states use non-Medicaid state-funded programs as well as Medicaid to provide some services in residential care settings (Connecticut, Indiana, Maine, Maryland, Oklahoma, and Wisconsin).

Five states do not use Medicaid or non-Medicaid state-funded programs to pay for services in residential care settings: Alabama, Kentucky, Louisiana, Pennsylvania, and West Virginia. However, Kentucky, Pennsylvania, and West Virginia supplement the cost of room and board and some services through the Social Security optional state supplementation program or other state financial assistance programs, as discussed below in the section on enabling Medicaid beneficiaries to pay for room and board.

Service Differences Between State Plan and Home and Community-Based Services Waiver

Congress authorized HCBS waivers in 1981 under Section 1915(c) of the Social Security Act. Under this provision, states may apply to CMS for a waiver of certain federal requirements to allow states to provide home and community services to individuals who would otherwise require services in an institution. Under the HCBS waiver authority, a state can provide services not covered by its Medicaid program as long as they are required to keep a person from being institutionalized.

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. Nursing home eligibility is not required for beneficiaries using State Plan services.

Second, services provided under Medicaid waiver programs are not entitlements and states may limit their provision to particular geographic areas, target groups, and care settings. Additionally, states may limit the number of waiver participants and further reduce this number during state budget cutbacks. Consequently, states may have long waiting lists if waiver slots are not available. If so, individuals who meet the state's nursing home level of care criteria and cannot be maintained in their own or a family member's home may need to be admitted to a nursing home.

In contrast, State Plan services are an entitlement and all beneficiaries who meet the service eligibility criteria must be served if providers are available and willing to serve them. Personal care is the most common service covered in residential care settings under the State Plan. The 37 states that do not already cover personal care through their State Plan have been reluctant to add it because it is an entitlement and services must be provided statewide. However, CMS has allowed states to limit the provision of personal care provided under the State Plan to specific providers, which may address state concerns about adding an open-ended entitlement to personal care under its State Plan. South Carolina, for example, allows only licensed community RCFs to provide personal care under the State Plan.

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: (1) the SSI level of income ($733 per month in 2015); (2) an amount above the SSI standard up to 100 percent of the federal poverty level; or (3) the state's medically needy income standard.

For nursing home and HCBS waiver applicants, states may use the special income standard, an optional eligibility category that allows individuals with income up to 300 percent of the federal SSI benefit ($2,199 per month in 2015) to be eligible. However, states can offer this option in HCBS waiver programs only if they offer it to nursing home applicants. The importance of this higher income standard is discussed below, in the section on enabling Medicaid beneficiaries to pay for room and board.

Medicaid Contracting Considerations

State licensing rules set the minimum requirements for Medicaid providers; for example, state regulations may establish certain staff-to-resident ratios or may specify awake overnight staff. However, the Medicaid program may set more stringent standards. For example, Medicaid contracting requirements may specify additional training and staffing requirements beyond what the licensure regulations require. Similarly, although a state may allow RCFs to offer rooms shared by two, three, or more residents, Medicaid can choose to contract only with facilities that offer single-occupancy units unless the resident chooses to share a unit.

A state's Medicaid program may also choose to contract only with facilities that comport with the assisted living philosophical approach to residential care that supports privacy, autonomy, and consumer choice. Several states do so--including North Dakota, Oregon, and Washington--by requiring RCFs that call themselves "assisted living," and want to contract with Medicaid, to offer apartment-style units rather than rooms. Residential care settings in those states that provide only shared rooms can contract with Medicaid as long as they do not market themselves as assisted living.

Centers for Medicare and Medicaid Services Rule for Community Settings and Their Implications for Residential Care Settings

In January 2014, CMS issued rules--effective March 2014--that establish requirements for HCBS settings. The purpose of these rules is to ensure that individuals receiving LTSS through HCBS programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate, and to enhance the quality of HCBS and provide protections to participants.[kk,ll] The rules also apply to 1115 waiver programs that cover HCBS. Key provisions of the rules are summarized in Exhibit 9.

EXHIBIT 9. Summary of Requirements for Community-Based Settings
Medicaid-compliant settings must: - be integrated in and support full access to the greater community; - be selected by the individual from among setting options; - ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint; - optimize autonomy and independence in making life choices; and - facilitate choice regarding services and who provides them.
In addition, provider-owned or provider-controlled home and community-based residential settings must also ensure that: - the individual has a lease or other legally enforceable agreement providing similar protections; - the individual has privacy in their unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit; - the individual controls his/her own schedule and has access to food at any time; - the individual can have visitors at any time; and - the setting is physically accessible.

Any modification to the first four items concerning provider-owned or provider-controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan in accordance with CMS guidance.

The final rule includes a transition period for states to ensure that their waiver programs and Medicaid State Plans meet the new CMS requirements. New §1915(c) waiver programs and §1915(i) and (k) State Plan programs must meet the new requirements to be approved. States with currently approved §1915(c) waiver programs and §1915(i) and (k) State Plans will need to evaluate the settings currently covered to assess whether they comply with the regulations. If settings do not fully meet the final rule's requirements, states must work with CMS to develop a plan to bring them into compliance.

Enabling Medicaid Beneficiaries to Pay for Room and Board

Because Medicaid will not cover room and board costs in residential care settings,[31] Medicaid beneficiaries with limited income may not be able to afford these expenses unless states take specific steps to make them affordable. For Medicaid purposes, room and board comprises real estate costs (debt service; building maintenance, upkeep, and improvements; utilities; and taxes) and food. The costs of laundry assistance, light housekeeping, and preparing, serving, and cleaning up after meals can be covered as a waiver service.[32]

Although Medicaid beneficiaries are responsible for paying for room and board, state Medicaid programs have several options to help make the cost affordable. They may do the following:

- Limit the amount facilities can charge Medicaid clients for room and board to the federal SSI benefit, which in 2015 is $733, minus a state-designated personal needs allowance (PNA).

- For HCBS waiver programs, use the 300 percent of SSI income-eligibility standard, and set the maintenance allowance at a level that allows residents to retain sufficient income to pay for room and board.

- Allow income supplementation by families or trusts to increase the funds available for room and board, particularly to pay the difference in cost between a shared and a private room.

States may also provide an income supplement through a non-Medicaid state-funded program for persons living in residential care settings with incomes below a specified amount--generally, the special income standard, which is the amount of the maximum income supplement plus the federal SSI benefit.

Another approach to enabling Medicaid beneficiaries to pay for room and board is for the state to limit by policy the amount residential care settings can charge them for room and board.

The states that adopt this policy generally do so by capping the amount that can be charged at the federal SSI payment for a single elderly beneficiary living in the community ($733 in 2015[33]) plus the maximum state supplemental payment, if any. In states with relatively large supplements, residential care providers can use the amount received to pay for some services as well as room and board.

[31] Medicaid will pay for room and board in limited circumstances, for example, when providing respite care.

[32] Including all coverable services in the state's assisted living service payment reduces the beneficiary's monthly payment solely to room and board and any other charges that Medicaid does not cover.

[33] The federal SSI benefit is adjusted each January based on the cost of living index.

Another approach to limiting the amount that can be charged for room and board is to set a combined "rate" for Medicaid beneficiaries that includes service costs and room and board costs, but the state pays only for services, which essentially caps the room and board rate that Medicaid beneficiaries pay. (This approach can cause confusion for consumers and their advocates because the combined rate implies that Medicaid covers room and board, which it does not.)

These approaches guarantee that Medicaid beneficiaries can afford room and board costs in facilities that accept Medicaid. But if providers feel that the room and board rate is too low to cover their costs, they may decide not to participate in the Medicaid program. However, some states require RCFs to accept a specified number of Medicaid beneficiaries. For example, New Jersey enacted a law requiring facilities licensed after September 2001 to set aside 10 percent of their units to serve Medicaid residents within 3 years after licensing.

In 2014, 27 states reported that they limited room and board charges for Medicaid beneficiaries in one or more residential care settings.[34] See Exhibit 10, below, for a list of these states.

EXHIBIT 10. States That Limit Room and Board Charges for Medicaid Beneficiaries

Arkansas	Maine	Pennsylvania
California	Maryland[1]	South Carolina
Colorado	Montana	South Dakota
Delaware[1]	Nebraska	Tennessee
Georgia	New Jersey	Texas
Hawaii	North Dakota	Vermont
Idaho	Ohio	Virginia
Illinois	Oklahoma	Washington
Indiana	Oregon	Wisconsin

1. Delaware and Maryland do not explicitly state that the cap applies to Medicaid participants, but it can be inferred through each state's room and board supplementation policy.

Although 23 states and the District of Columbia do not restrict the amount that can be charged for room and board, providers need to understand their states' Medicaid income-eligibility rules and cost-sharing requirements to determine how much Medicaid beneficiaries can afford. Persons eligible for Medicaid because they are receiving SSI have no income other than the federal payment and a state supplement (if any). Those eligible under the 300 percent of SSI special income rule, may have more income to spend on room and board, depending on the state's cost-sharing requirements for services (see discussion below).

Providing State Supplements to the SSI Payment

To increase access to residential care settings in areas with high housing costs, states can provide an income supplement--generally called an optional state supplement (OSS)--for residents in these settings, and limit what providers may charge

[34] We were unable to obtain current information from several states.

to the amount of the federal SSI payment plus the state supplement.[35] This amount is generally called the state supplementary payment standard.[36]

Within a given state, the amount of the state supplement varies because it is calculated individually, based on the difference between a resident's income and the supplementary payment standard (i.e., the combined SSI federal benefit and OSS) minus a state-specified PNA.

States may pay different supplement amounts based on a person's living arrangement. A few states have developed a supplemental payment rate specifically for SSI recipients in RCFs to increase the amount of income they have to pay for room and board.

For 2014, we were able to determine that 22 states and the District of Columbia provided a monthly income supplement, which varied considerably: from $78.40 in Florida to $854 in North Carolina.

Providers may use state supplements--particularly if the supplements are generous--to pay for services as well as to supplement the amount residents pay for room and board. For example, Kentucky does not use Medicaid or non-Medicaid state-funded programs to pay for services in residential care settings. However, the state provides an OSS to every aged, blind, and disabled person who is an SSI recipient and resides in a personal care home or a family care home. In 2014, the maximum amount paid to a personal care home was $1,241 a month: $520 from the state and $721 from the resident's federal SSI payment. A personal care home must accept as full payment for room, board, and cost of care the amount of the combined OSS and SSI payment less a $60 PNA that is retained by the resident.

Using the 300 Percent of SSI Standard and Providing an Adequate Personal Maintenance Allowance

States have the option to use more liberal income-eligibility criteria for their HCBS waiver programs than for State Plan programs. States may allow individuals with incomes up to 300 percent of the federal SSI payment--$2,199 per month in 2015--to be eligible for HCBS waiver services. Doing so expands waiver programs to include beneficiaries who are better able to afford room and board costs.

However, beneficiary cost-sharing requirements can reduce the amount of income available to pay for room and board. To make this option effective, states must allow

[35] Individual states may 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.

[36] Up to 2011, the Social Security Administration reported information about the amount of the supplements in all of the states. The Administration stopped doing so in 2012 because of difficulty obtaining accurate data. It still reports the information for eight of the states for which it administers the supplement. The limited information presented in this section was obtained from the Social Security Administration's website and from state staff who were able to provide current information.

eligible persons to retain enough of their income to cover "maintenance needs," including the room and board charges in residential care settings.[37]

Under Medicaid's post eligibility treatment of income rules for HCBS waiver programs, states are allowed to use "reasonable standards" to establish the maintenance allowance, and may vary the allowance based on the beneficiary's circumstances. For example, states can permit Medicaid beneficiaries to keep sufficient income to pay for the needs of a dependent, health care costs not covered by Medicaid, and other necessary expenses.

States typically set a single maintenance needs allowance for all HCBS waiver participants. Many states set their maintenance needs allowance at 300 percent of the SSI federal benefit. Because 300 percent of the SSI federal benefit is the highest amount of income a person can have and still be subject to share-of-cost requirements, setting the maintenance needs allowance at that level allows waiver participants to keep all of their income to pay for living expenses. It also eliminates the administrative burden for states to calculate cost-sharing requirements.

If a state does not want to set a single maintenance needs allowance, Medicaid rules allow states to set different maintenance allowances for each individual, or for groups of individuals, if it believes that different amounts are justified.

Beneficiaries living in residential care settings may have different income needs depending on the type of facility: private market rate facility or subsidized housing facility. The rent component of the monthly fee charged by facilities built with low-income housing tax credits will be lower than the rent charged by privately financed facilities. Through tax credits, rents can be reduced to around $400 per month. A lower maintenance amount for individuals with rent subsidies means that participants have more income to share the cost of services.

Setting the maintenance allowance based on the area's average monthly charge for room and board may be overly generous when applied to residents in subsidized units. On the other hand, setting the maintenance allowance based on the amount paid by residents in subsidized units may be too low for private market facilities and create access barriers. If a state wants to improve access to both private and subsidized RCFs, it can set a separate maintenance allowance for each setting.

Allowing Income Supplementation by Family Members or Trusts

Family members may be able and willing to help with room and board costs when the beneficiary is unable to pay them. Although this discussion focuses on payments by family members, payments may also be made by a special needs trust on behalf of its

[37] Setting a higher maintenance allowance may allow more beneficiaries to be served in residential care settings; however, it will increase Medicaid's service payment given that it reduces the "excess income" that is applied to the cost of services.

named beneficiary. Many families set up such trusts for adult children with disabilities to ensure that they will be adequately taken care of throughout their lives.

Because Medicaid does not pay for room and board in residential care settings, federal rules prohibiting supplementation of Medicaid payment rates for *services* do not apply.[38]

In 2014, as shown in Exhibit 11, 20 states reported that their Medicaid programs allowed family supplementation for individuals in residential care settings, six states did not allow supplementation, and four states had no policy. The remaining states either did not cover services in residential care settings or did not report whether they had a supplementation policy.

EXHIBIT 11. Income Supplementation Policy

Allow Supplementation	No Policy	Prohibit Supplementation
Connecticut	Indiana	California
Delaware	Massachusetts	Nebraska
Florida	Mississippi	Rhode Island
Georgia	Ohio	South Carolina
Idaho		South Dakota
Illinois		Vermont
Iowa		
Maine		
Minnesota		
New Jersey		
North Carolina		
North Dakota		
Oklahoma		
Pennsylvania		
Tennessee		
Texas		
Virginia		
Washington		
West Virginia		
Wisconsin		

States that allow supplementation vary regarding allowable expenditures. For example, Wisconsin allows family supplementation to cover room and board, a private room, or service enhancements that are not covered by the Medicaid payment. But Virginia does not allow supplementation for the cost of a private room, only for goods and services in addition to those covered by the total SSI payment. Maine permits payment by a relative to cover the cost of a private room, a telephone, television, and any non-Medicaid-covered services. Some states, for example, Pennsylvania and Texas, allow supplementation only for amenities not included in the room and board rate.

[38] Because Medicaid pays for room, board, and services in nursing homes with a single per diem payment, families of nursing home residents may not supplement Medicaid payments.

States that allow supplementation may or may not count the amount as income for Medicaid eligibility purposes, depending on the specific form the supplementation takes. For example, money given directly to the individual will count as unearned income. Money paid directly to the facility for a private room will not count as income on a dollar-for-dollar basis but will be counted under the in-kind support and maintenance (ISM) rules unless a state has specifically exempted such payments from being counted as ISM, or has elected to not count ISM at all when determining Medicaid eligibility.[39]

To prevent beneficiaries from losing Medicaid eligibility, states can amend their State Plan, with approval from CMS, to exempt in-kind income that supports a person's accommodations or services not covered by the Medicaid payment in residential care settings. Section 1902(r)(2) of the Social Security Act allows states to use less restrictive income and resource methodologies than are used by SSI when determining eligibility for most Medicaid eligibility groups. States can elect to disregard different kinds or greater amounts of income and/or resources than SSI, giving states more flexibility to design and operate their Medicaid programs.

However, although a state may limit its less restrictive methodologies to eligibility groups it selects, the group(s) must still be among those specifically listed in §1902(r)(2)--for example, buy-in groups for working persons with disabilities, most poverty-related groups, and the medically needy. States are not permitted to carve out a subgroup of their own definition (e.g., based on place of residence).

Whether or not the Medicaid program disregards ISM when determining income-eligibility, the amount of the supplementation is considered in determining financial eligibility for SSI. Federal SSI regulations contain provisions for treating unearned income during the eligibility determination process. Under SSI rules, the entire amount of a family contribution paid directly to an individual is counted as unearned income. As a result, supplementation can lead to a reduced SSI payment or the loss of SSI altogether, and with it, potentially Medicaid as well. Even if an individual is not receiving SSI, this unearned income could cause him or her to lose Medicaid if it raises countable income above the Medicaid income limit.

If, however, the family contribution is paid directly to a RCF on the beneficiary's behalf, it is treated somewhat differently (i.e., as an "in-kind" payment). This amount is also considered to be unearned income, just as a direct payment from the family to the individual would be, with similar potential consequences. The difference is that an in-kind payment cannot be valued at more than one-third of the SSI benefit, whereas the entire amount of a direct payment to the individual is countable.

Under SSI (and therefore Medicaid) rules, ISM--no matter how much--is valued at only one-third of the monthly SSI benefit, or approximately $244 in 2015. If the family documents that the actual amount of an in-kind payment is less than one-third of the

[39] It is more likely that a state would exempt ISM entirely than count ISM but specifically exempt family supplementation. Roy Trudel, Trudel Consulting LLC. Personal communication, May 2015.

SSI monthly payment, the actual amount of the payment will be used instead of the higher one-third amount.

Because the federal rule states that the maximum reduction to an SSI payment is only one-third of the benefit, there is no limit on the amount of money that can be paid to a facility on behalf of an SSI beneficiary. A family can pay for private room and board in a more expensive facility without jeopardizing an individual's eligibility for SSI. However, the payment could result in the loss of Medicaid eligibility, depending on how the state treats family supplementation.

A respondent in one state said that family supplementation very rarely occurred for SSI beneficiaries because their families cannot afford it, and that it is much more likely to occur for waiver participants who are not on SSI (i.e., those who qualify under the 300 percent of income-eligibility rule). For these Medicaid beneficiaries, potential loss of SSI is not a consideration.

Effect of Medicaid Medically Needy Rules on the Ability to Pay for Room and Board

States have the option of covering medically needy beneficiaries under their Medicaid programs. The medically needy are persons who, except for income, would qualify under one of the other Medicaid eligibility groups covered under the State Plan (such as people receiving SSI or the optional aged and disabled poverty level group). Medicaid payments can begin for medically needy persons once they have "spent down"--that is, incurred expenses for medical care in an amount at least equal to the amount by which their income exceeds the medically needy income level. As discussed in the previous section, any family supplementation is considered part of the excess income that must be spent down. If it is paid to a RCF *on behalf of an SSI recipient*, the one-third rule applies and it is still treated as unearned income.

The medically needy eligibility option can allow people who have income greater than 300 percent of SSI to become eligible for Medicaid services. But federal law imposes two significant constraints on the use of this option:

- The state must cover medically needy children and pregnant women before it can elect to cover any other medically needy group. Additionally, the state may not place limits on who is eligible for Medicaid by using such characteristics as diagnosis or place of residence. Thus, it cannot use medically needy policies to extend Medicaid services only to HCBS waiver beneficiaries in residential care settings.

- The maximum income-eligibility limit that a state's medically needy program may use is based on its welfare program for families, which are typically lower than SSI. The income level must be the same for all medically needy groups in the state (i.e., states are not permitted to establish higher income-eligibility levels for

selected subsets of the medically needy, such as beneficiaries in residential care settings).

These rules have several implications that states need to consider when trying to make the medically needy eligibility option work for higher income individuals in residential care settings. First, these individuals may find it more difficult to incur sufficient medical expenses to meet the spend down requirements while living in the residential care setting than they would in a nursing home. The higher their "excess" income, the higher the amount of their spend down, which means that only beneficiaries with extremely high medical expenses may become eligible for Medicaid.

Second, community providers may be less willing to deliver services during the spend down period, given that payment cannot be guaranteed and collection may be difficult. Third, spend down rules combined with low medically needy income-eligibility levels mean that individuals may not have enough total income to pay both the bills they incur under the spend down provision and room and board. Permitting spend down to a higher amount--such as 300 percent of SSI instead of a state's medically needy standard for HCBS waiver eligibility--would require a change in the Medicaid statute.

Supplemental Nutrition Assistance Program (SNAP)

The use of the SNAP program to pay for meals can subsidize the board component of the room and board cost, making it more affordable for Medicaid beneficiaries and others with low incomes. U.S. Department of Agriculture regulations allow meals provided in certain group living arrangements to elderly, blind, or disabled residents to be supported by SNAP (7 Code of Federal Regulations §271.2). Group living arrangements are defined as a public or non-profit residential care setting that serves no more than 16 residents.

Facilities that can participate as SNAP vendors receive food stamps from beneficiaries, which are used as payment toward meal costs. Supportive Living Facilities in Illinois and Community-Based Residential Care Facilities in Wisconsin have been approved as food stamp vendors.

One final approach states can use to make room and board costs more affordable is to examine the facility's monthly room and board charges to identify any coverable services--such as laundry assistance, light housekeeping, or food preparation--that Medicaid can reimburse for beneficiaries who require assistance with these IADLs. Including all coverable services in the state's assisted living service payment reduces the beneficiary's monthly payment solely to room and board and any other charges that Medicaid does not cover.

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COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

The continuation of this report (the state profiles) is available at http://aspe.hhs.gov/pdf-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-continuation

Also available is a list of URLs for separate state pages (see next page).

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Files Available for This Report

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Executive Summary	http://aspe.hhs.gov/execsum/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-executive-summary
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SEPARATE STATE PROFILES

[***NOTE***: These profiles are available in the full HTML and PDF versions, as well as each state available as a separate PDF listed below.]

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