Alzheimer's Disease/Dementia Assisted Living Waiver Report

Pursuant to the 2004 Appropriation Act, Item 326.SS

The Department of Medical Assistance Services

October 2004

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Preface

The 2004 General Assembly through Item 326.SS of the 2004 Appropriations Act mandated that the Director of the Department of Medical Assistance Services (DMAS) develop a 1915(c) Medicaid-funded Home and Community-Based Waiver for individuals with Alzheimer's Disease or a related dementia. DMAS must report to the Governor and the Chairman of the Joint Commission on Health Care by October 1, 2004 in order that the fiscal impact of such waiver can be considered during the development of the 2005-2006 budget.

DMAS enlisted the assistance of stakeholders to assist in the development of this Waiver proposal. The following individuals were involved in this process:

Alzheimer's Association	Mr. Carter Harrison
Caregiver of Individual with Alzheimer's Disease	Ms. Blanche Castelow
Caregiver of Individual with Alzheimer's Disease	Ms. Carol Rotelli
Department for the Aging	Ms. Ellen Nau
Department of Medical Assistance Services	Ms. Vivian Horn
Department of Social Services – Adult Services	Ms. Terry Smith
Department of Social Services – Licensing	Ms. Deborah Lloyd
Sentara Life Care Corporation	Mr. Bruce Robertson
State Long Term Care Ombudsman	Ms. Joani Latimer
Sunrise Senior Living	Ms. Maribeth Bersani
Virginia Association for Home Care	Ms. Marcia Tetterton
Virginia Association of Area Agencies on Aging	Ms. Diana Wallace
Virginia Association of Homes for Adults	Mr. Grant Goldman
Virginia Association of Non-Profit Homes for the Aging	Ms. Dana Steger
Virginia Association of Personal Care Providers	Ms. Kathy Miller
Virginia Health Care Association	Ms. Beverley Soble
Whispering Pines and Hawksbill Assisted Living Facilities	Mr. Brian Phelps

We wish to extend our appreciation for the time and hard work the members of the workgroup gave to the development and review of this report.

INTRODUCTION

Item 326.SS of the 2004 Appropriation Act directed the Director of the Department of Medical Assistance Services (DMAS) to develop a Medicaid-funded Home and Community-Based Waiver for persons diagnosed with Alzheimer's Disease or a related dementia. This Waiver will be piloted in some areas of the state and will serve 200 individuals. These individuals must reside in an assisted living facility, meet Virginia's criteria for nursing facility placement, and be receiving an Auxiliary Grant. In order to participate in this Waiver, the assisted living facility must meet the criteria outlined in this proposal. Per the 2004 Appropriation Act, it was estimated that the Medicaid payment for each Waiver recipient would be approximately $50 a day. (See Appendix A for a copy of the legislation). This report addresses the issues related to implementing such a Waiver. DMAS must report to the Governor and the Chairman of the Joint Commission on Health Care by October 1, 2004, in order that the fiscal impact of such Waiver can be considered during the development of the 2005-2006 budget.

Individuals eligible to be placed on this Waiver are currently either (a) remaining at home where an adult child is typically serving as primary care giver; (b) residing in an assisted living facility without the benefit of specialized services, which are not provided in the base $30 per day rate; or (c) residing in a more expensive institutionalized nursing facility setting. Through the proposed Alzheimer's Disease/Related Dementia Waiver, recipients would be able to receive an appropriate level of care within special care units of assisted living facilities.

While individuals admitted to this Waiver will receive services in assisted living facilities (ALF), it is important to remember that they must meet nursing facility admission criteria in order to receive Medicaid Waiver services. In addition, the individuals in this Waiver must be diagnosed with Alzheimer's disease or a related dementia. Therefore, while current ALF regulations meet the requirements for people at the regular assisted living level of care they are not deemed to be sufficient to meet the health and welfare requirements for a Medicaid Waiver. DMAS must demonstrate to the Centers for Medicare and Medicaid Services that sufficient safeguards are in place to serve this vulnerable population.

Study Methods

DMAS used the following methods to conduct this study.

- DMAS formed an advisory group of stakeholders to collaborate on the development of a Waiver proposal. The advisory group consisted of representatives of the Virginia Department of Social Services, the Virginia Department for the Aging, State Long Term Care Ombudsman, the Alzheimer's Association, the Virginia Association of Non-Profit Homes for the Aging, the Virginia Health Care Association, Virginia Association of Area Agencies on Aging, Virginia Association for Home Care, Virginia Association of Homes for Adults, Virginia Association of Personal Care Providers, Sunrise Senior Living, Sentara Life Care Corporation, two caregivers of individuals with Alzheimer's disease, and DMAS.

- DMAS researched other states with Alzheimer's disease/dementia units provided in assisted living facilities regarding qualifications of staff, training, and other relevant issues. Specifically, the state of Alabama's approved Waiver was reviewed in detail.

- Not all of the members of the advisory group agreed with all of the requirements listed in this report. All suggestions were carefully considered; however, due to the requirements of a Medicaid Waiver, and health, safety, and quality standards that must be met, some suggestions were not accepted.

Summary of Findings

- Waiver services must be provided in licensed assisted living facilities that meet the requirements of a "safe, secure environment" according to DSS licensing regulations.

- DMAS will pre-approve each assisted living facility before that facility may provide services to individuals on the Waiver.

- Administrators of participating assisted living facilities must be licensed as nursing facility administrators, or licensed or registered as long term care administrators. The Department of Health Professions is developing a Long Term Care Board to license or register assisted living facility administrators. Once this option is available, administrators of participating assisted living facilities must be licensed as a nursing facility administrator or licensed or registered by the Long Term Care Board of the Department of Health Professions.

- There must be sufficient staff, and staff with the appropriate credentials, to care for Waiver participants.

- Qualified staff must provide services. Services include personal care, homemaker, chore, attendant care, medication oversight, therapeutic and recreational programming, intermittent skilled nursing, and medication administration.

- This Waiver must meet Medicaid requirements for a Home and Community Based Services Waiver, which includes protections of health and welfare.

- Room and board are to be paid by an Auxiliary Grant, which is $1,058 for Northern Virginia and $894 for the remainder of the state, which is approximately $35 and $30 per day, respectively.[1]

- Medicaid payment for this Waiver would be approximately $50 per day. (Medicaid payment is payment in full – the resident could not be charged extra for Medicaid-covered services)

- No Waiver funds will be used to pay for room and board in the assisted living facility.

- Of the 631 licensed assisted living facilities in Virginia, 106 have special care units with 2,931 residents. It is possible that some of these residents would be eligible for a Medicaid Waiver in addition to people who reside in nursing facilities or in the community.[2]

BACKGROUND

Medicaid Waivers

Medicaid Waivers afford States the flexibility to develop and implement alternatives to institutionalizing Medicaid eligible individuals. States may request waivers of certain federal rules which impede the development of Medicaid community-based treatment alternatives. The program recognizes that many individuals who would otherwise be institutionalized can be cared for in their homes and communities at a cost no higher than that of institutional care.

To receive approval to implement a Waiver, a State Medicaid agency must assure the Centers for Medicare and Medicaid Services (CMS) that it will not cost more, on average, to provide home and community based services than providing institutional care. The average costs of individuals on the Waiver are compared to the average costs of individuals in the institution.

The authority to establish Home and Community Based Services (HCBS) Waivers is found in section 1915 (c) of the Social Security Act. Under this authority states can waive statewideness, comparability of services, community income and resource rules, and rules that require States to provide services, on an equal basis, to all persons in the State. This gives states the flexibility to design each Waiver and select the mix of services that best meets the needs of the population they wish to serve. HCBS Waivers are approved for an initial three-year period and renewed every five years.

In order to develop a Home and Community Based Waiver for individuals with Alzheimer's disease or a related dementia, there must be an alternative institutional placement. According to federal regulations, the alternative institutional placement for individuals with Alzheimer's disease or a related dementia is a nursing facility.

In order to have a Waiver approved by CMS, it must be cost effective. This Waiver will be cost effective in the aggregate, that is, the average cost to Medicaid of individuals on the Waiver cannot exceed the average cost to Medicaid of individuals in the alternative institutional placement. All Medicaid covered services are included in this calculation, not just Waiver services. Since the alternate institutional placement is a nursing facility, the average cost to Medicaid of individuals residing in a nursing facility must be used for this calculation. In fiscal year 2003, the average cost to Medicaid of individuals residing in a nursing facility was $24,398.[3]

The Commonwealth of Virginia currently has six HCBS Waivers: HIV/AIDS; Elderly and (or) Disabled (E&D); Consumer Directed Personal Attendant Services (CD-PAS); Individual and Family Developmental Disabilities Support (IFDDS); Mental Retardation; and Technology Assisted. This Waiver would be the seventh and would serve individuals who have a diagnosis of Alzheimer's disease or a related dementia who live in an assisted living facility.

Philosophy of Assisted Living

Although the need for assistance often increases with age, elderly individuals, like all adults, still value their autonomy. Most older persons want to live in their own homes and remain as independent as possible. Many who require assistance cannot remain at home, however, due to a loss of social supports and their inability to qualify for independent housing, residential living, or congregate care due to physical or cognitive impairments (that necessitate substantial service or supervision).

The philosophy of assisted living emphasizes personal dignity, autonomy, independence, and privacy. The focus of assisted living is to maintain or enhance the capabilities of frail older persons and persons with disabilities so they can remain as independent as possible in a home-like environment. The combination of residential housing and personal care services tailored to meet the needs of the individual help to promote the ability of residents to "age in place."[4]

Assisted living meets the adults' desires to:

- Remain in a home-like setting for as long as possible or until substantially impaired;
- Enter a residential setting only when they develop substantial service needs;
- Remain in a residential environment that maximizes their autonomy, privacy, and dignity, even if they require a high level of services; and
- Avoid or delay placement in an institutional setting.[4]

Assisted living is the fastest growing type of senior housing in the United States. The industry has experienced a fifteen to twenty percent annual growth rate in recent years, with an estimated 600,000 residents living in 25,000 to 30,000 facilities nationwide. States are responsible for oversight, but their regulations vary greatly. There are no uniform federal assisted living standards.[5]

Residents and their families are increasingly demanding individuality and choice, and state regulators are responding to these consumer demands. State regulators also recognize the need to establish and enforce minimum guidelines for the industry. These provisions are intended to protect the independence of individual residents, while protecting the residents' health and safety.[5]

Assisted living facilities frequently provide special care for residents with Alzheimer's disease and other forms of dementia. This care may be offered in a discrete area within a larger facility, or in a separate facility.[5] Assisted living is not designed for persons requiring 24-hour skilled nursing care.

Current Statistics[6]

- As of 2002, thirty-two states and the District of Columbia have licensing categories or statutes that use the term *assisted living*. Thirty-six states, eight more than in 2000, now have requirements for facilities serving people with Alzheimer's disease or dementia.

- By October 2002, forty-one states had approval to cover services in residential settings, either assisted living or board-and-care licensing categories, through Medicaid.

- In Fiscal Year 2001, Medicaid programs in forty-one states reported serving about 102,000 residents in assisted living or residential care settings in Fiscal Year 2001.
  - Thirty-seven states provide services through a Medicaid Waiver.
  - Ten states provide services through the Medicaid state plan (Highest number of recipients).
  - Twelve states use state funding.

In Virginia in fiscal year 2003, there were 631 licensed assisted living facilities. Of these 631 facilities, 106 have special care units serving 2,931 residents. Out of 626 licensed assisted living facilities in the state, 373 accept Auxiliary Grant recipients.[2]

Auxiliary Grant

The Auxiliary Grant (AG) is a supplement to the income of residents of SSI and certain other aged, blind, or disabled individuals residing in a licensed ALF or in an adult foster care home. This assistance is available through local departments of social services to ensure that recipients maintain a standard of living that meets a basic level of need. The AG program is specifically for individuals who live in a licensed ALF or in an adult foster care home approved by the local department of social services.[7]

The AG program is a state (80%) and locally (20%) funded financial assistance program, which is administered by DSS. Its purpose is to provide supplemental income for a SSI recipient or an adult who would be eligible for SSI except for excess income, who resides in an ALF or in adult foster care.[7] The maximum rate is determined by the Virginia General Assembly and is adjusted as necessary. Effective January 2004, the monthly minimum rate was set at $996 for northern Virginia and $866 for the remainder rest of the state.[1] Effective October 1, 2004, the Auxiliary Grant rate will be approximately $1,058 for Northern Virginia and $928 for the remainder of the state.[1]

Advantages of an Assisted Living Waiver

In order to avoid or delay nursing facility placement for residents who meet the nursing facility level of care, Virginia would like to take advantage of the flexibility afforded to the states for Waiver programs. DMAS must assure the Centers for Medicare and Medicaid Services (CMS) of the cost effectiveness of this Waiver and allow residents to receive services that will help them maintain their independence while living in a more homelike environment. Virginia currently does not have a Waiver specifically designed for individuals with Alzheimer's disease or related dementia. Since there are no federal standards, states are responsible for the oversight of assisted living. Virginia will be responsible for this oversight, and the health and safety of the

recipients must be assured.

An individual who currently resides in a safe, secure unit of a DMAS-approved assisted living facility may be eligible for the Waiver provided that they first apply for, and receive an Auxiliary Grant. If an individual does not reside in a safe, secure unit of a DMAS-approved assisted living facility, the individual may choose to move to a DMAS-approved facility in order to receive services provided through this Waiver.

THE ASSISTED LIVING ALZHEIMER'S AND RELATED DEMENTIA WAIVER

Determination of Eligibility

In order to be eligible for this Waiver, an individual must meet the following criteria:

(1) The individual must meet the criteria for admission to a nursing facility as determined by a preadmission screening team using the full Uniform Assessment Instrument;

(2) The individual must have a diagnosis of Alzheimer's disease or a related dementia as diagnosed by a licensed clinical psychologist or a licensed physician. The individual must not have a diagnosis of mental illness or mental retardation in addition to a diagnosis of Alzheimer's disease or a related dementia;

(3) The individual must currently be receiving an Auxiliary Grant; and –

(4) The individual must be at least 55 years of age at admission to the Waiver.

Eligibility for admission to this Waiver will be determined through Virginia's preadmission screening process as outlined in the *Code of Virginia* 32.1-330 (Appendix B). Individuals will be placed on the Waiver on a first-come, first served basis. The preadmission screening team will give the recipient a list of DMAS-approved assisted living facilities and will in no way determine the facility for the recipient. This list will be separated into those facilities offering private rooms and those offering semi-private rooms. The individual or his authorized representative will have the option of selecting the provider of his choice from among those providers that can appropriately meet his needs. DMAS or its agent will perform preauthorization of services for this Waiver.

If 50% or more of an assisted living facility's rooms are private rooms, the facility must offer a private room to the Waiver recipient unless the recipient or his authorized representative, through informed choice, chooses a semi-private room. A semi-private room is defined as two individuals residing in one bedroom. This choice must be thoroughly documented in the resident's file. The assisted living facility cannot interfere in any way with this decision. Recipients who are private pay and then become Waiver recipients must not be moved from their private room on the basis of being admitted to the Waiver.

Individuals who are not eligible for this Waiver include individuals who have one of the prohibited conditions as outlined in the DSS regulations, such as G-tubes, nasogastric tubes,

ventilator dependency, or dermal ulcers III and IV except those stage III ulcers which are determined by an independent physician to be healing. (Appendix C)

Provider Requirements

1. Medicaid will only pay for services that are provided in a "safe, secure environment" as defined by DSS licensing regulations. (22VAC40-71-10).

2. If 50% or more of an assisted living facility's rooms are private rooms, the facility must offer a private room to the Waiver recipient unless the recipient or his authorized representative, through informed choice, chooses a semi-private room. This choice must be thoroughly documented in the resident's file. The assisted living facility cannot interfere in any way with this decision. Recipients who are private pay then become Waiver recipients must not be moved from their private room on the basis of being admitted to the Waiver. This Waiver is intended to pay for assisted living that is offered to the general public. It is not intended to be a second (lower) level of care.

3. Payment to the assisted living facility from Waiver funds will be made for a total of 14 days a year for hospital admissions, visits home, therapeutic leave, etc.) If the resident does not receive services in the assisted living facility for 15 or more days, the assisted living facility may choose to hold the bed for the resident, but the Waiver will not continue to pay for the service. The Waiver slot will be held for a total of 30 days. After that time the Waiver slot will not be held and the next person on the waiting list will be notified of the availability of the slot. The resident's authorized representative may choose to pay for holding the bed using other funds and must pay the assisted living facility directly for days 15-30. The rate shall be negotiated between the resident's authorized representative and the assisted living facility.

4. Administrators of participating assisted living facilities must be licensed as nursing facility administrators, or licensed or registered long-term care facility administrators. The Department of Health Professions is developing a Long Term Care Board to license/register assisted living facility administrators. Once this option is available, administrators of participating assisted living facilities must be licensed as a nursing facility administrator or licensed/registered by the Long Term Care Board of the Department of Health Professions.

5. The medical care of residents shall be under the direction and supervision of a physician. This can be the individual's private physician. The assisted living facility must ensure that residents have appointments with their physicians at least annually and as needed as determined by the physician. DMAS will perform yearly level of care assessments. The level of care assessments are performed to ensure that individuals receiving services in the Waiver continue to meet the criteria for the Waiver.

6. Each facility shall have at least one registered professional nurse (RN) to assess the medical and therapeutic needs of residents in the special care unit. The RN must complete a comprehensive assessment of each resident upon admission, when a significant change in

health status or behavior occurs, and when a monthly assessment identifies a problem in any of the following areas: weight loss, falls, elopements (leaving the facility without notice), behavioral symptoms, adverse reactions to prescribed medications, dehydration, pressure ulcers, fecal impaction. A RN shall identify resident care problem areas and formulate interventions to address those problems and to evaluate if the planned interventions were successful. The RN is responsible for staff training, resident assessment, plans of care, and medication oversight.

7. There must be an RN awake, on duty, and on-site in the facility for at least eight hours a day for five days each week and on call 24 hours day. The person on-call must be able to arrive at the facility within one hour. A licensed practical nurse (LPN) may provide services in facility the rest of the time, but there must be a nurse awake and on-site 24 hours a day since the recipients in this Waiver will meet nursing facility criteria.

8. Based on the individual resident assessment, the RN, in coordination with other caregivers including the resident's authorized representative, shall develop the resident's plan of care to address the specific problems identified. The RN shall evaluate both the facility's implementation and the resident's response to the plan of care. The plan of care shall be reviewed and updated at least monthly and more often when necessary to meet the needs of the resident.

9. There shall be a unit coordinator, on-site in the unit, who will manage the daily routine operation of the specialty unit. This person shall have completed dementia-specific training prior to providing services to Waiver recipients. In a facility with more than 16 beds, the facility's RN may also serve as the administrator or the unit coordinator, but not as both. The unit coordinator must be available to the facility 24 hours a day. The unit coordinator may be an RN or an LPN, who is serving as the assisted living facility's daily nurse. In the event the unit coordinator is not available, an alternate qualified (RN or LPN) staff member may serve in this capacity as long as they are in the special care unit for the period of time that the unit coordinator is not available. Each assisted living facility must establish its own written protocol and assure that only qualified staff fulfill this requirement. In all instances where the facility's RN is assigned other duties as an administrator, unit coordinator, or both, the facility must assure that the RN devotes sufficient time and effort to all clinical duties.

10. In order to provide services in this Waiver, the assisted living facility must use certified nursing aides (CNA) in the specialty unit at all times. The assisted living facility must have sufficient qualified and trained staff to meet the needs of the residents at all times.

11. There must be at least two awake direct care staff in the special care unit at all times and more if dictated by the needs of the residents.

12. All staff who have contact with residents, including the administrator, shall have completed 12 hours of dementia-specific training prior to resident contact. A licensed professional with expertise in dementia must conduct this training. The licensed professional must be acting within the scope of the requirements of his profession and have had at least 12 hours of training in the care of individuals with cognitive impairments due to dementia prior to

performing the training.

13. All direct care staff must receive at least eight hours of training annually in the care of residents with dementia and medical nursing needs. This training may be incorporated into the existing training program and must address the medical nursing needs specific to the each resident in the special care unit. This training must also incorporate problem areas which may include weight loss, falls, elopements, behavioral symptoms, and adverse reactions to prescribed medications. A licensed professional with expertise in dementia must conduct this training. The licensed professional must be acting within the scope of his profession and have had at least 12 hours of training in the care of individuals with cognitive impairments due to dementia prior to performing the training.

SERVICES

The services that are provided as a part of the Auxiliary Grant rate will not be included for payment from the Waiver. Payment for services in this Waiver will be above and beyond the current requirements provided by the Auxiliary Grant rate. See Appendix B for a listing of the services provided as part of the Auxiliary Grant.

The following are covered services in this Waiver:

1. Assisted Living

Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The facility must have a central dining room, living room or parlor or common activity centers (which may also serve as living rooms or dining rooms).

Care must be furnished in a way which fosters the independence of each resident to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services also include:

- Medication administration, as defined below;
- Intermittent skilled nursing services, as defined below;
- Periodic nursing evaluations, as defined below; and

- Therapeutic activities, as defined below

Payment for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the resident's immediate family.

2. Personal Assistance Services

Personal assistance services means providing assistance with activities of daily living, which include: eating/feeding; dressing; transferring; ambulation; toileting; bathing (shall be provided in accordance with the individual's service plan and as often as necessary, but no fewer than three baths per week); oral hygiene (assisted with oral hygiene to keep mouth, teeth, or dentures clean, and measures shall be used to prevent dry, cracked lips); care of the hair (shampooing, combing, and brushing of the individual's hair); nail care as allowed by law; and shaving (men shall be assisted with shaving or to be shaved as necessary to keep them cleaned and well-groomed). Personal assistance also includes food service (food service may be provided in a resident's room during temporary illness if necessary); personal safety (residents shall be provided assistance with personal safety); medication monitoring; and monitoring of health status and physical condition.

3. Medication Administration

Medications may be administered only by an individual who is currently licensed to administer medications (physician, physician assistant, pharmacist, nurse practitioner, RN, or LPN). While this might seem to be a high standard to some, the individuals in this Waiver will meet nursing facility criteria, and have a diagnosis of Alzheimer's disease or a related dementia. Generally they will not have the ability to direct their medication administration in any way, nor are they likely to be able to articulate side effects of medications. For this reason, licensed professionals must administer medications. Those same licensed professionals are trained to detect the side effects of those medications.

4. Intermittent skilled nursing services

"Skilled nursing services" means nursing services that are used to complete resident assessments and administer medications, and provide training, consultation, and oversight of direct care staff. Skilled nursing services must be provided by a RN or by a LPN under the supervision of a RN who is licensed to practice in the state and provided in accordance and within the scope of practice specified by state law. An RN must complete resident assessments. Administration of medications, training, consultation and the oversight of direct care staff may be completed by an RN or a LPN.

5. Periodic nursing evaluations

The RN must complete a comprehensive assessment of each resident upon admission, when a significant change in health status or behavior occurs, and when a monthly assessment identifies

a problem in any of the following areas: weight loss, falls, elopements, behavioral symptoms, adverse reactions to prescribed medication. A RN shall identify resident care problem areas and formulate interventions to address those problems and to evaluate if the planned interventions were successful.

6. Therapeutic social and recreational programming

An activity program shall be designed to meet the individual needs of each resident and shall provide activities appropriate to residents with dementia daily. This program shall be individualized and properly implemented, followed, and reviewed as changes are needed. Residents who have wandering behaviors shall have an activity program to address these behaviors. There shall be a minimum of 20 hours of planned programming each week, not to include activities of daily living; at least one hour must be one-on-one.

There shall be a designated employee responsible for managing or coordinating the structured activities program. This employee shall be on-site in the special care unit at least 20 hours a week, shall maintain personal interaction with the residents and familiarity with their needs and interests, and shall meet at least one of the following qualifications:

(a) Be a qualified therapeutic recreation specialist;
(b) Be eligible for certification as a therapeutic recreation specialist or an activities professional by a recognized accrediting body;
(c) Be a qualified occupational therapist or an occupational therapy assistant; or
(d) Prior to or within six months of employment, have successfully completed 40 hours of DSS training in adult group activities and in recognizing and assessing the activity needs of residents.

DMAS Administrative Costs

Because of the need to monitor this Waiver and the increased quality oversight required by CMS if this Waiver is implemented, DMAS is requesting funding for one full-time staff position (Medicaid Facilities Inspector) to perform utilization reviews provided through this Waiver. DMAS will review all facilities providing services in this Waiver. All utilization reviews will be performed at least annually and will be performed on-site. These utilization reviews will be coordinated with DSS to avoid overlapping reviews.

Timeframe for Implementation

In order for this Waiver to become a reality, DMAS must complete several tasks. They are :

- DMAS must first complete a Home and Community-Based Care Waiver application and submit it to CMS. This is in process.
- While waiting for approval from CMS, DMAS must develop emergency regulations; which are to become effective in the spring of 2005.
- Computer programming must be completed in order to enroll participants in the Waiver.
- A provider manual must be written and providers must be enrolled and trained.

- Preadmission screening teams must be trained and
- An effective date of enrollment in the Waiver is expected to be spring, 2005.

Appendix A

2004 Appropriation Act, Item 326.SS

1. The Department of Medical Assistance Services shall develop, in conjunction with affected constituents, a Waiver pursuant to §1915(c) of the Social Security Act (42 U.S.C. 1396n) from the Centers for Medicaid and Medicare Services to establish a Home and Community-Based Care Waiver for persons with Alzheimer's disease and related dementias ("Alzheimer's/Dementia Assisted Living Waiver"). The Alzheimer's/Dementia Assisted Living Waiver shall be for those individuals who meet the functional criteria for admission to a nursing facility, who have a diagnosis of Alzheimer's disease or a related dementia, and who are eligible to receive an Auxiliary Grant. The Waiver enrollment for the first year of such program shall be limited to an enrollment of 200 individuals who choose to move to an assisted living facility.

2. Out of this appropriation, $1,327,550 from the general fund and $1,327,550 from nongeneral funds in the first year and $1,855,050 from the general fund and $1,855,050 from nongeneral funds in the second year shall be shall be provided for the implementation of the Alzheimer's/Dementia Assisted Living Waiver. The Department of Medical Assistance Services must also receive a Waiver pursuant to §1915(c) of the Social Security Act from the Centers for Medicare and Medicaid Services to establish such program. The Waiver proposal described herein shall be developed and presented to the Governor and the Chairman of the Joint Commission on Health Care by October 1, 2004, in order that the fiscal impact of such Waiver can be considered during the development of the 2005-2006 budget. The agency shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act.

APPENDIX B

Additional information on the AG Program

The local department of social services in the locality where the individual resides determines eligibility for the AG program. The city or county within the state where the person last lived outside of an institution or adult family care home determines residence for AG eligibility. If residency cannot be determined, residency is where the individual is living at the time of the application. To be eligible for the AG program, an individual must meet all of the following:

- Be 65 years of age or older or be 18 years of age and blind or disabled;
- Reside in a licensed ALF or approved AFC home;
- Be a citizen of the United States or an alien who meets specified criteria;
- Non-exempted income less than the sum of the AG rate plus the personal needs allowance;
- Have non-exempted resources less than $2,000 for one person or $3,000 for a couple; and
- Have been assessed and determined to need residential care or assisted living care.[7]

The Auxiliary Grant covers room and board and maintenance and care. The AG rate includes:

- Provision of a furnished room in a facility that meets applicable building and fire safety codes;
- Housekeeping services based on the needs of the resident;
- Meals and snacks, including extra portions and special diets;
- Clean bed linens and towels as needed by the residents and at least once a week;
- Minimal assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence;
- Medication administration as required by licensing regulations including insulin injections;

- Provision of generic personal toiletries including soap and toilet paper;

- Minimal assistance with the following: care of personal possessions, care of personal funds if requested by the recipient and residence policy allows it; use of telephone, arranging transportation, obtaining necessary personal items and clothing, making and keeping appointments, and correspondence;

- Securing health care and transportation when needed for medical treatment;

- Providing social and recreational activities as required by licensing regulations; and

- General supervision for safety.[7]

APPENDIX C

§ 32.1-330. Preadmission screening required.

All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Woodrow Wilson Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals.

(1984, c. 781; 1990, c. 716; 2003, c. 480.)

APPENDIX D

22VAC40-71-150, F

Assisted living facilities shall not admit or retain individuals with any of the following conditions or care needs:

1. Ventilator dependency;

2. Dermal ulcers III and IV except those stage III ulcers which are determined by an independent physician to be healing, as permitted in subsection G of this section;

3. Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a health care professional licensed in Virginia as permitted in subsection H or subsection I of this section;

4. Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold;

5. Psychotropic medications without appropriate diagnosis and treatment plans;

6. Nasogastric tubes;

7. Gastric tubes except when the individual is capable of independently feeding himself and caring for the tube or as permitted in subsection I of this section;

8. Individuals presenting an imminent physical threat or danger to self or others;

9. Individuals requiring continuous licensed nursing care;

10. Individuals whose physician certifies that placement are no longer appropriate;

11. Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance;

12. Individuals whose health care needs cannot be met in the specific assisted living facility as determined by the facility.

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7. Virginia. Department of Social Services. Long-Term Care and Prevention Services, 2003 Program Report. Richmond: State of Virginia, 2003.

Additional Resources

Alabama. Department of Public Health. Specialty Care Assisted Living Facilities Rules. July 2004

Harris, Patricia. Telephone Interview. 10 August 2004 – 13 August 2004.