MARYLAND

Citation Assisted living programs: Title 10.07.14

General Approach and Recent Developments

Significant revisions to the regulations are expected to be final in 2007. Several bills were enacted into law. Chapter 452 (2006) requires that ALPs have an emergency electrical power generator on the premises by October 2009. Chapter 356 (2006) requires a uniform assisted living disclosure statement which is posted on the Department of Health and Mental Hygiene website. The disclosure describes the purpose of the statement, what is assisted living, where to find the licensing regulations, facility contact information, sources of payment accepted, levels of care, what is a resident agreement, services provider, criteria for discharge or transfer, staff training requirements, staffing patterns and where to file a complaint. Another law makes operating or owning an unlicensed facility a felony.

The opening section of the rules state that the purpose of the chapter is to set minimum, reasonable standards for licensure of ALPs that are intended to maximize independence and promote the principles of individuality, personal dignity, freedom of choice, and fairness for all individuals residing in ALPs.

ALP rules were revised in 2002 to clarify medication administration requirements and to add disclosure provisions for facilities serving residents with Alzheimer's disease. The HCBS waiver has been expanded to include all ALFs.

The uniform assessment tool was revised in 2003. The previous tool did not adequately assess and determine a LOC for people with behavior problems and dementia. As a result, more residents are likely to be assigned to Level III.

Adult Foster Care

The ALP regulations apply to small facilities that might be considered AFCHs.

Web Address	Content
http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.htm	Rules
http://www.mdoa.state.md.us/alintro.html	Guide
http://www.dhmh.state.md.us/ohcq/alforum/home.htm	Provider
http://dhmh.state.md.us/ohcq/licensee_directory/licensee_directory.htm	List
http://dhmh.state.md.us/ohcq/alforms/alforms.htm	Forms
http://dhmh.state.md.us/ohcq/alforms/al_disclosure.pdf	Disclosure form

Supply						
Category	2007		2004		2002*	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living programs	1,366	20,093	1,248	17,148	2,000	14,273
* The figures included in the 2002 report were based on estimates as the state converted from its previous regulatory structure to one that consolidated several different categories.						

Definition

An ALP is "a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof to meet the needs of residents who are unable to perform, or who need assistance in performing, the ADLs or IADLs in a way that promotes optimum dignity and independence for the residents." The term "assisted living program" may not be used in advertising unless the facility is licensed.

Unit Requirements

Programs licensed after the effective date of the regulations must provide a minimum of 80 square feet of functional space for single occupancy and 120 square feet for double occupancy rooms. No more than two residents may share a room. Facilities previously licensed as domiciliary care homes must provide a minimum of 70 and 120 square feet for single and double occupancy, respectively. Buildings with one to eight occupants must have one toilet for every four occupants and larger buildings must also have at least one toilet on each floor. Showers/baths must be available for every eight occupants.

Admission/Retention Policy

Facilities are licensed by the level of impairment of residents. Residents are assigned to a level based on an assessment score. The assessment includes 12 questions that cover medical illnesses/conditions and additional questions covering cognitive and psychiatric conditions, treatment requirements, medication management, ADL assistance, risk factor management, and management of problematic behaviors.

In general, programs may not serve anyone who, at the time of admission, requires more than intermittent nursing care; treatment of Stage III or IV skin ulcers; ventilator services; skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; treatment for an active reportable communicable disease; or treatment for a disease or condition which requires more than contact isolation. Residents may not be admitted if they are a danger to self or others and the danger cannot be eliminated through appropriate treatment modalities or if they are at risk for health or safety complications which cannot be adequately managed.

A program may request a waiver to care for residents with needs that exceed the licensure level. It must demonstrate that it can meet the resident's needs and others will not be jeopardized.

Waivers for Level I and Level II programs may not be granted for more than 50% of the licensed bed capacity. Level III programs may not receive waivers for more than 20% of capacity or 20 beds, whichever is less.

Nursing Home Admission Policy

Nursing home care is covered when an individual requires health-related services provided on a daily basis by or under the supervision of a nurse due to medical, cognitive or physical disability. The need for intermittent, part-time services does not qualify (for example, home health nursing), nor does the need for unlicensed care (e.g., personal care) even if care is needed full-time. There is some overlap in how the term intermittent nursing care is applied under the licensing and Medicaid LOC policies.

Services

Before move-in, the assisted living manager determines whether the resident may be admitted and whether the resident's needs can be met by the program based on an assessment and an examination by a health care professional. A functional assessment is completed within 30 days of admission that includes: level of functioning in ADLs; level of support and intervention needed, including any special equipment and supplies required to compensate for the individual's deficits in ADLs; current physical or psychological symptoms requiring monitoring, support, or other intervention by the ALP; capacity for making personal and health care-related decisions; presence of disruptive behaviors, or behaviors which present a risk to the health and safety of the resident or others; and specified social factors.

Services include three meals in a common dining area, special diets, personal care, laundry, housekeeping, social and spiritual activities, and medication management. The program must facilitate access to health care and social services (social work, rehabilitation, home health, skilled nursing, physician services, oral health, counseling, psychiatric care, and others).

Dietary

Three meals a day and snacks that are well-balanced, palatable, varied, properly prepared, and of sufficient quantity and quality to meet daily nutritional needs are required. As part of the licensing process, facilities submit a four week menu cycle with documentation by a licensed nutritionist or licensed dietician that the menus are nutritionally adequate. Special diets as ordered by a physician or needed by the resident must be provided.

Agreements

Agreements must include a clear and complete reflection of commitments and actual practices and a recommendation for review by an attorney. The agreement includes: the LOC for which the facility is licensed; the LOC needed by the resident; a statement that describes that a resident may be discharged if the LOC increases and a waiver is not approved; a list of services provided and not provided; complaint/grievance procedure; occupancy provisions (i.e., room assignment, relocation, change in roommate, transfer policy, availability of locks for storage); the staff's right to enter a room (if any); resident rights; bed hold policy; admission and discharge policy; obligations of all parties for arranging for and overseeing medical care and monitoring health status.

The agreements must also include financial information that includes: obligations for payment; handling finances; purchase of rental equipment; arranging and contracting for services not provided by the facility; durable medical equipment; and disposition of resident property upon discharge or death. Also included are the rate structure for the service package, fee-for-service rates; notification of changes; third-party payments; person responsible for payment; procedures if the resident is no longer able to pay; and terms governing refunds. If the resident's needs change significantly, the agreement must be amended.

Provisions for Serving People with Dementia

Programs with an ASCU or program must complete the department's disclosure form that describes: a statement of philosophy or mission; staff training and staff job titles, including the number of hours of dementia-specific training provided annually for all staff by job classification and a summary of training content; admission procedures, including screening criteria; assessment and care planning protocol, including criteria to be used that would trigger a reassessment of the resident's status before the customary six month review; staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program; 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; the program's fee or fee structure for services provided by the ASCU or program as part of the disclosure form required by the regulation; discharge criteria and procedures; and any services, training, or other procedures that are over and above those that are provided in the existing ALP.

Medication Administration

Aides who have passed required training may administer medications. Untrained aides may assist with self-administration. Management must arrange for quarterly, on-site reviews of medications by a RN, authorized prescriber, or licensed pharmacist for each resident who self-administers medications.

Public Financing

The state administers an HCBS waiver and a state-funded program that serves beneficiaries age 50 and older in residential settings. A waiver amendment included assisted living services as part of a broad package of services available to people 50 years of age or older in their own or in residential settings. Amendments to the waiver raised eligibility to 300% of the federal SSI benefit. Room and board, paid by the resident, is capped at $420 a month. Medicaid pays the lesser of the provider's usual and customary charge or $55.74 a day for Assisted Living Level II services ($41.81 if the resident receives medical day care services) and $70.31 a day for Level III services ($52.73 if the resident receives medical day care services). The Level I licensing LOC does not qualify for the Medicaid waiver. Non-SSI beneficiaries are allowed a PNA of $64 and all additional income is applied to the cost of care. SSI beneficiaries retain SSI benefits above the amount paid for rent and do not pay toward the cost of services. The Medicaid waiver program served 1,798 beneficiaries in 975 facilities, up from 1,473 beneficiaries in 763 facilities in 2004.

Additional payments are available for assistive equipment. Medicaid will pay the actual costs and payment is capped at $1,000 per participant for 12 months. Medicaid will pay 67% of the costs of environmental modifications (the provider pays 33%), up to a maximum of $3,000 per participant. Exceptions to the maximum are allowed at the discretion of the Department on Aging.

The state-subsidized Senior Assisted Living Group Home Subsidy program provides access to assisted living in small group homes which are licensed by the Department of Health and Mental Hygiene for 4-16 residents. The subsidy supports the cost of services provided in assisted living, including meals, personal care and 24-hour supervision for elderly residents who are frail and unable to live independently.

The program served 300 participants in 2007 and 350 in 2004. Participants with incomes no greater than 60% of the statewide median income and assets no greater than $11,000 for a single person and $14,000 for a couple apply their income (less a $64 needs allowance) toward the cost of care. State-funded subsidies may cover the difference between the participant's contribution and the monthly fee, up to a maximum of $650 a month.

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

Medicaid Participation						
	2007		2004		2002	
	Facilities	Participation	Facilities	Participation	Facilities	Participation
Medicaid	975	1,798	763	1,473	362	730
State	300	528	NR	350	259	520

Medicaid Payment Rates (2007)		
	Level II	Level III
Services	$1,672/20.66	$2,109.30
Room and board	$420	$420
Total	$2,092.20	$2,529.30
Assistive equipment add-on	up to $1,000	up to $1,000

Staffing

Based on the number of residents to be served and their needs, the facility develops a staffing plan that identifies the type and number of staff needed to provide the services required. The staffing plan includes on-site staff sufficient in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the residents. A staff member must be present when a resident is in the facility.

Programs must have staff capacity to deliver the care for which they are licensed (see table below). Facilities contracting with Medicaid must have one staff member for every eight residents during daytime hours.

Training

Administrators. After January 2006, assisted living managers of programs with five or more beds must complete a management training course approved by the Department that includes 80 hours of course work and an examination and may include not more than 25 hours of Internet, correspondence courses, tapes or other methods that do not require direct interaction between faculty and participants. The curriculum must cover the philosophy of assisted living; the aging process and its impact; assessment and LOC waivers; serving planning; clinical management; admission and discharge criteria; nutrition and food safety; dementia, mental health and behavior management; end of life care; management and operations; emergency planning; quality assistance and the survey process. Managers must complete 20 hours of annual training.

Staff must receive initial and on-going training program to ensure that residents receive services that are consistent with their needs and generally accepted standards of care for the specific conditions of those residents to whom staff will provide services. Staff must receive initial and on-going training in: fire and life safety; infection control, including standard precautions; basic food safety; basic first aid; emergency disaster plans; and individual job requirements as appropriate to their job.

Staff must have knowledge in: health and psycho-social needs of the population served as appropriate to their job responsibilities; resident assessment process; use of service plans; and resident rights.

If job duties involve the provision of personal care services, staff must have knowledge in cuing, coaching, and providing assistance with ADLs. Staff working with people with cognitive impairments and mental illness must have training in a series of areas related to the population served.

Facilities participating in the Medicaid waiver: staff must complete eight hours of training on medication administration and pass a performance test.

Background Check

Applicants must document any felony conviction of the applicant, assisted living manager, or household member (in small, owner-occupied facilities). Management must conduct either a criminal history records check or a criminal background check consistent with §19-1901 et seq. Annotated Code of Maryland.

Monitoring

Under the law, the Department of Health and Mental Hygiene may delegate monitoring and inspection of programs to the Office on Aging and the Department of Human Resources or to local health departments through an interagency agreement. Survey findings and plans of correction must be posted in the facility.

Fees

$25 a year for programs monitored by the Department of Human Resources or the Department on Aging; $100 a year for programs inspected and monitored by the Department of Health and Mental Hygiene. Programs with 16 beds or more pay $100 a year plus $6 for each bed over 15. Fees will be increased under the pending regulations.

Maryland Level-of-Care Differences -- Staff Capacities			
Area	**Level I -- Low (0-25)**	**Level II -- Moderate (26-60)**	**Level III -- High (61+)**
Health and wellness	Ability to recognize the cause and risks associated with a resident's health condition once these factors are identified by a health care professional. Provide occasional assistance in accessing and coordinating health services and interventions.	Ability to recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition. Provide or ensure access to necessary health services and interventions	Ability to recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition. Provide or ensure on-going access to coordination of comprehensive health services and interventions
Functional	Provide occasional supervision, assistance, support, set up, or reminders with some but not all ADLs.	Provide or ensure substantial support with some, but not all, ADLs or minimal supports with any number of ADLs.	Provide or ensure comprehensive support as frequently as needed to compensate for any number of ADLs.
Medication and treatment	Ability to assist with self-administration of medications or coordinate access to necessary medications and treatments.	Provide or ensure assistance with self-administration of medications or administer necessary medications and treatments, including monitoring their effects.	Provide or ensure assistance with self-administration of medications or administer necessary medications and treatments, including monitoring or arranging for monitoring the effects of complex medication and treatment regimens.
Behavioral	Monitor and provide uncomplicated intervention to manage occasional behaviors that are likely to disrupt or harm the resident or others.	Monitor and provide or ensure intervention to manage frequent behaviors which are likely to disrupt or harm the resident or others.	Monitor and provide or ensure on-going therapeutic intervention or intensive supervision to manage chronic behaviors which are likely to disrupt or harm the resident or others.
Psycho-logical	Monitor and manage occasional psychological episodes or fluctuations that require uncomplicated intervention or support.	Monitor and manage frequent psychological episodes or fluctuations that may require limited skilled interpretation or prompt intervention or support.	Monitor and manage a variety of psychological episodes involving active symptoms, condition changes, or significant risks that may require some skilled interpretation or immediate interventions.
Social and recreational	Occasional assistance in accessing social and recreational services	Ability to provide or ensure on-going assistance in accessing social and recreational services.	Provide or ensure on-going access to comprehensive social and recreational services.

RESIDENTIAL CARE AND ASSISTED LIVING COMPENDIUM: 2007

Files Available for This Report

REPORT INTRODUCTION (*including Cover, Table of Contents, Acknowledgments, and Acronyms*)

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom.pdf

SECTION 1. Overview of Residential Care and Assisted Living Policy

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.pdf

SECTION 2. Comparison of State Policies

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.pdf

SECTION 3. State Summaries

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.pdf

Each state's summary can also be viewed separately at:

Alabama	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAL.pdf
Alaska	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAK.pdf
Arizona	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAZ.pdf
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Idaho	http://aspe.hhs.gov/daltcp/reports/2007/07alcomID.pdf
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