Assisted Living Waiver Questions

Submitted by HOPE, November, 2008

Responses prepared by Division of Aging Staff

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1. Should a facility so desire, can a specific (smaller) number of total beds within a licensed residential facility apply to participate in the Medicaid Waiver program, or must the entire licensed residential facility apply? For example if there is a 20 bed residential facility, can application be made for only 10 of those beds to participate in the Medicaid Waiver program?

Response: The facility does not have to enroll all of its apartments/units (beds) in the waiver program. The provider may participate to whatever extent they choose.

2. If a smaller number is acceptable, must there be designated beds/rooms to be used for the program or can the rooms "float" due to vacancy as long as the total number of waiver residents remains consistent?

Response: The apartments/rooms do not have to be designated. If there are any apartments/rooms that do not meet the requirements of the rules, they cannot be used for waiver clients.

3. Once the facility is approved for the program, what would the criteria be for admission into the community? Does each facility have the right to deny admission? Also, should the facility need to terminate the residency.... what is the right of the landlord and what is the right of the resident?

Response: The person must meet NF level of care—Levels 1-3—and be Medicaid eligible. They cannot meet skilled level of care (405 IAC 1-3-1).

The facility is not required to accept a client.

The facility must follow the criteria for transfer and discharge as prescribed in Rule 5 (IAC 16.2-5-1.2 (r).

4. If a facility application was approved for 10 beds out of 20......would the facility be able to go back and asked for approval on the other 10? If so, is there a timeframe?

Response: Yes, subsequent approval for additional apartments/units is allowed and there is no timeframe.

5. If a facility is new to the program, who is their resource for questions regarding billing questions?

Response: You may contact the Division of Aging or EDS. If the company is doing the billing, EDS will send a field representative to your facility to assist in setting up the process. If the facility tells the Division of Aging at the time of application to the program, they can schedule a field representative to come to your facility. A map of the EDS field reps is attached. The supervisor of waiver operations would be the appropriate person to contact for any questions

not answered by review of the waiver application packet. The current Supervisor of Waiver Operations is Susan Waschevski at 317-232-7148.

6. Some facilities that have converted from non-licensed residential to licensed residential/waiver were accustomed to charging a "damage deposit" upon residency, as the apartments are often damaged while occupied. Is this practice no longer acceptable if a participant in the waiver program?

Response: No, you cannot require any payment other than Medicaid per diem and the Room and Board component.

7. For a facility that has private pay and the waiver program, it would appear that services provided may differ in some areas, thus separate addendums to the admission agreement may be necessary. For example, for the private pay resident, there may be a base rate for room and board, but additional charges for additional services rendered; whereas, those services would be included in the daily rate paid by the waiver program. Are you aware if this is how facilities are addressing this variance in services/charges?

Response: After meeting the basic requirements of the rule for licensure (410 IAC 16.2-5) and the Assisted Living Medicaid Waiver Service rules (460 IAC 8) the provider would be considered in compliance. If you have other services that are available to private pay clients or to Waiver clients whose family or other individuals may choose to purchase them, that is acceptable.

8. If a resident is out of the building for 1 or more days and holds the apartment, can you charge the level care fee for those days?

Response: No, Medicaid cannot be billed the level of care fee for days away from the facility. Room and Board fees may be paid monthly and, unless the person dies or otherwise vacates the room, those fees do not have to be refunded to the client for occasional days away from the AL. The persons' Room and Board payment is paid monthly and continues to be required for as long as the person inhabits or maintains belongings in the unit.

9. Who determines the level of service? The nurse or AAA case manager?

Response: The case manager, in combination with the facility staff and the client.

10. Does the $52 personal money need to be in separate accounts for each resident, or one account and facility keeps track of funds for each resident? Will the same rules regarding residential licensure/resident funds apply?

Response: Rule 5 applies. 410 IAC 16.2-5-1.2 (t)

11. What kind of documentation will be reviewed in an audit for Nursing, Resident Services Assistant or office staff?

Response: The contractor for quality assurance (currently Liberty of Indiana) does a survey or audit that is consumer focused and will be looking at services from the client's perspective. They would look to assure that appropriate level of care is in place, the plan of care meets the client's needs and will be asking the resident their level of satisfaction. Other components of the

"survey" are completed by the Indiana State Department of Health in their licensure surveys and are not audited by the Division of Aging or their contractors.

12. Can medications be left in the resident rooms (locked) if self administering or only requiring medication reminders, or must they be maintained in a medication room?

Response: 410 IAC 16.2-5-6 (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.

13. Is there a minimum score a resident must have to be approved for placement under the waiver program? For instance; 1 resident scored a 0. At this time he is private pay. He will need to apply for Medicaid in about 2 months. Will Medicaid allow him to stay in this unit with a 0 score?

Response: The person *must* meet Nursing Facility level of care. The assumption would be that, if they do, they will score at least 1.

14. Is it acceptable to have one nurse responsible for waiver rooms and comprehensive halls at the same time? Both halls are under one roof but separated by locked doors.

Response: The facility must meet the requirements for residential licensure staffing. (410 IAC 16.2-5-1.4). There are no additional staffing requirements prescribed in the AL Medicaid waiver rules.

15. Do we need a report sheet and does staff attend morning meetings?

Response: This is not addressed in either residential licensure rules or assisted living waiver rules. Facility policy would apply.

16. Do we need documentation of making rounds?

Response: This is not addressed in either residential licensure rules or assisted living waiver rules. Facility policy would apply.

17. Any special considerations for residents owning and using personal vehicles?

Response: This is not addressed in either residential licensure rules or assisted living waiver rules. Facility policy would apply. The waiver does not disallow someone from owning one (1) personal vehicle.

18. What is the facility's responsibility for transportation (i.e., M.D. appointments, grocery, activities in community etc)? Can they attend activities on the comprehensive unit or do they need different activity plans?

Response: The facility must meet the activity requirements at 410 IAC 16.2-5-7.1. This is the only provision in either rule that addresses the issue. 7.1 (b) requires the facility to provide and/or coordinate scheduled transportation to community based activities.

19. Do you have to have a Health Facility Administrator (HFA) over the Medicaid waiver beds? This is a stand-alone building.

Response: Yes. The residential licensure rules require each facility to have a licensed health facility administrator. In the future there will be a license category for Residential Care Administrator (RCA) but that is not yet available. Unlicensed assisted living facilities are not permitted to participate in the waiver program.

20. Can you be over a comprehensive care facility as an HFA and be over a Medicaid waiver wing if it is a wing in the same building?

Response: Yes, as long as the "waiver wing" is part of a licensed residential facility.

21. Can a nurse/QMA from the comprehensive facility set up meds and take them to a resident in the residential/Medicaid waiver wing?

Response: The facility must follow the Personnel requirements at 410 IAC 16.2-5-1.4. This includes such provisions as providing staff in number and qualifications to meet the needs of the residents. More specifically, if 50 or more residents of the facility regularly receive residential nursing services or administration of medications, or both, at least one nursing staff person shall be *on site* at all times.

22. Can a facility that has just been issued a provisional license bill for Medicaid ALF wavier services or must the facility wait until full licensure is granted?

Response: A provisional license is one that is given to a newly licensed facility until they have been operating for one year. Since they meet licensure requirements, a residential facility with a provisional license may participate in the Medicaid waiver program.

23. Can an eligible Medicaid waiver facility be paid for services retroactive to the date of admission, or is the facility paid for services it renders from the date the waiver resident is determined to be eligible by FSSA? As you will recall, in long term care, when a Medicaid pending resident is admitted, services rendered are paid for by FSSA retroactive from the date of admission, while eligibility is being determined.

Response: The Division of Aging is hoping to implement the retroactive payment component in the near future.

24. Rule 8 defines the service plan (Section 2—Definitions) at (32) as *" a written plan for services to be provided by the provider, developed by the provider, the recipient, and others, if appropriate, on behalf of the recipient, consistent with the services needed to ensure the health and welfare of the recipient. It is a detailed description of the capabilities, needs, choices, measurable goals, and if applicable the measurable goals and managed risk issues, and documents the specific duties to be performed for the recipient, including who will perform the task, when, and the frequency of each task based on the individual's assessed needs and*

preferences." At (28) in Definitions, it states, the *"plan of care" means the written plan developed by the interdisciplinary team, on which the recipient's case manager documents the proposed Medicaid waiver services, the Medicaid state plan services, as well as other medical services and special services and informal community supports that are needed by the recipient to ensure the health and welfare of the recipient"* How involved will the Case Manager be in the development of the service plan? How frequently will he/she visit to ensure timely compliance?

Response: The **Plan of Care** that Rule 8 (28) is referencing is the Waiver Plan of Care/Cost Comparison budget that the waiver case manager enters into the state case management data base. The interdisciplinary team consists of the case manager, waiver recipient and anyone else the recipient chooses to provide input. The Plan of Care is signed by the waiver recipient and the case manager. The Notice of Action is issued from the services indicated on the Plan of Care.

The **Service Plan**, Rule 8 (32) is formulated by the provider and developed in collaboration with the provider, recipient and anyone else the recipient chooses. The provider, recipient and case manager all sign the service plan. The provider is responsible for maintaining the service plan. The Case Manager is required to visit every 90 days at a minimum.

25. Section 6 (c) states, *"The initial plan of care must be approved by the office of Medicaid policy and planning prior to the initiation of assisted living Medicaid waiver services. It must be updated at least every ninety (90) days and annually or when the recipient experiences a significant change."* How will approval be gained by the office of Medicaid prior to admission/services?

Response: The Plan of Care referred to is the waiver plan of care/cost comparison budget (CCB) that the case manager submits to the Division of Aging (operating agency for OMPP) through the state case management data base. The approval is issued via the Notice of Action. This is part of the process the DA is working on now in hopes of being able to speed up the process.

26. The residential rule describes the evaluation/service plan in Section 2 (a) *as "initiated prior to admission and updated at least semi-annually and upon a known substantial change in the resident's condition, or more often at the resident's or facility's request."* As the facility participating in the waiver program must be a licensed residential facility, the facility must either review all service plans at least every 90 days, or differentiate between those who are participants of the waiver program versus those who are not, as the residential service plan review is less frequent than the review required by the waiver program. Would you agree?

Response: Yes.

27. Section 6 (g) (3) states, *"supports the negotiated risk; which includes the recipient's right to take responsibility for the risks associated with decision making."* Section 9 (a) - (f) then addresses the content of a negotiated risk plan, which is drafted "*if deemed appropriate and determined to be necessary by a recipient's interdisciplinary team."* Does the office view the negotiated risk plan as a document separate from the service plan, or might the negotiated risk be incorporated into the service plan?

Response: It could (and should) be incorporated into the service plan.

28. *Section 6 (h) states, "If requested by a recipient, the provider will assist a recipient and a recipient's case manager in obtaining, arranging, and coordinating services outlined in the recipient's plan of care that are not assisted living Medicaid waiver services"* Is it anticipated that the costs of such services be met by the resident or family member?

Response: They can be met by either of the above or by the facility per facility policy/practice.

29. Section 7 (b) states, *"The impairment level assessment tool for assisted living Medicaid waiver services will be based on the point system definition designated on the level of service assessment form and will be documented on forms prescribed by the division."* Please clarify the completion and use of this tool. For example, do both the facility and case manager complete the tool? Or, does the facility complete the tool and the case manager then reviews the tool for accuracy? Some facilities have utilized this tool as their service plan. Is this acceptable?

Response: The Level of Service assessment will be entered into Insite by the case manager but the answers to the questions should be done with input from the case manager, assisted living staff and participant to verify agreement on the level of services being provided. The level of service assessment can be changed if the provider and case manager determine that it does not accurately represent the needs of the client.

30. Section 8 (d) (3) states the service plan is signed and approved by *(D) the case manager.* Will the case manager be on-site at the time of review or will the service plan be faxed or forwarded for review and signature?

Response: The rule does not specify that the case manager be on-site at the time the service plan is reviewed.

31. Applicants to the program are provided a copy of the "Indiana Assisted Living Service Survey Tool" (a 4-page document dated 8/6/2007) to be completed by an FSSA Inspector or FSSA designee. How often can the facility anticipate visits for such inspection?

Response: That document is used primarily for entry into the program. The Division of Aging relies on ISDH for compliance with the licensure rule requirements done by ISDH on average of every 12 months. (The quality assurance surveys described in question 11 are performed randomly (by consumer) but you should expect that each waiver client will be visited at least annually. Depending upon reporting of incidents or complaints required by the waiver, the Division of Aging or its contractors could visit at other times).

12-5-2008