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

Regulatory Review of Adult Day Services:

Final Report, 2014 Edition

December 2014

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REGULATORY REVIEW OF ADULT DAY SERVICES: Final Report, 2014 Edition

Janet O'Keeffe, Dr.PH, RN
Christine O'Keeffe, BA
Madhu Shrethra, BS

RTI International

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ACRONYMS

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

AAA	Area Agency on Aging
ACT	Alabama Community Transition
ADC	Adult Day Care
ADH	Adult Day Health
ADH-M	Adult Day Health Services-Mobile
ADHC	Adult Day Health Care
ADHS	Adult Day Health Services
ADL	Activity of Daily Living
ADP	Adult Day Program
ADS	Adult Day Services
AIDS	Acquired Immune Deficiency Syndrome
ALTCS	Arizona Long Term Care System
APD	Oregon Aging and People with Disabilities Division
ASA	Maine Assessing Services Agency
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BA	Bachelor of Arts
BS	Bachelor of Science
BSW	Bachelor of Social Work
CARES	Alabama Caregiver Assistance with Resources, Education, and Support
CCP	Illinois Community Care Program
CCSP	Georgia Community Care Services Program
CHOICE	Indiana Community and Home Options to Institutional Care for the Elderly and Disabled Program
CMA	Certified Medication Aide
CNA	Certified Nursing Assistant
COPE	Nevada Community Options for the Elderly
COPES	Washington State Community Options Program Entry System
CPR	Cardiovascular Pulmonary Resuscitation
CRMA	Certified Residential Medication Aide
DAAS	Arkansas Division of Aging and Adult Services
DADS	Texas Department of Aging and Disability Services
DAHS	Day Activities and Health Services
DAIL	Vermont Department of Disabilities, Aging and Independent Living

DAS	Georgia Division of Aging Services
DC	District of Columbia
DCOA	District of Columbia Office on Aging
DD	Developmental Disabilities
DHCFP	Nevada Department of Health Care Financing and Policy
DHEC	South Carolina Department of Health and Environmental Control
DHHS	Maine Department of Health and Human Services
	Nebraska Department of Health and Human Services
	New Hampshire Department of Health and Human Services
DHR	Alabama Department of Human Resources
DHS	Illinois Department of Human Services
	Oklahoma Department of Human Services
	Oregon Department of Human Services
	Tennessee Department of Human Services
DHSS	Delaware Department of Health and Social Services
	New Jersey Department of Health and Senior Services
DMAS	Virginia Department of Medical Assistance Services
DOA	Ohio Department on Aging
DOH	New Mexico Department of Health
	New York Department of Health
	Tennessee Department of Health
DPH	Massachusetts Department of Public Health
DSDS	Alaska Division of Senior and Disability Services
DSS	Virginia Department of Social Services
E&D	Elderly and Disabled Waiver
ECOP	Enhanced Community Options Program
EDCD	Elderly or Disabled Consumer-Direction Waiver
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
IDAPA	Idaho Administrative Procedure Act
IDD	Intellectual and Other Developmental Disabilities
IDOA	Illinois Department on Aging
LPN	Licensed Practical Nurse
LTSS	Long-Term Services and Supports
LVN	Licensed Vocational Nurse
MAT	Medication Administration Technician
MCO	Managed Care Organization
MDoA	Maryland Department of Aging
MLTC	Managed Long-Term Care
MLTSS	Managed Long-Term Services and Supports

OAA	Older Americans Act
ORS	Illinois Office of Rehabilitation Services
OSA	Michigan Office of Services to the Aging
PACE	Program of All-Inclusive Care for the Elderly
PASSPORT	Ohio Pre-Admission Screening System Providing Options and Resources Today waiver
PRN	Pro re nata (commonly used to mean "as needed" in Latin)
QExA	Hawaii QUEST Expanded Access
QSP	Qualified Service Providers
QUEST	Hawaii Medicaid program for elderly, blind or disabled individuals
RN	Registered Nurse
SADS	Social Adult Day Services Specialized Adult Day Services
SCA	Maine Service Coordination Agency
TAP	Texas The Alternatives Program
TB	Tuberculosis
VA	U.S. Department of Veterans Affairs

EXECUTIVE SUMMARY

Adult day services (ADS)--a non-residential service provided outside an individual's home for less than a full day--provides direct care to older adults and younger adults with physical disabilities. These services also meet caregivers' need for respite in order to work, fulfill other obligations, and recover from the demands of continuous caregiving. Many caregivers who use ADS are providing care to family members with dementia who need constant supervision to ensure their safety. By providing respite to unpaid caregivers, ADS can potentially delay or prevent nursing home placement.

This report provides information about each state's approach to regulating this key community service. Three ADS models are generally recognized: a social model; a health or medical model, which is sometimes combined with the social model; and a specialized model that provides services to meet the unique needs of individuals with a specific diagnosis, most often dementia.

The social model is designed for individuals who need supervision and activities but not extensive personal care and medical monitoring. The medical model provides more extensive personal care, medical monitoring, and rehabilitative services in addition to structured and stimulating activities.

States generally term these two models as ADS and adult day health services, and have more extensive requirements for the latter, particularly for nurse staffing. While some states license the models separately, others license providers to offer both models. The provision of health-related and medical services--particularly health monitoring, preventive health care, and ensuring the timely provision of primary care--can help to reduce health care costs.

While states vary in their approach to regulating ADS, all have some form of regulation and exercise oversight of ADS. About half require licensure, 11 require providers to meet certification standards, four require licensure for one ADS model and certification for another, and 13 use some other type of regulation, such as contractual requirements for providers receiving public funding. In over half the states, providers of Medicaid-funded ADS must meet additional Medicaid requirements.

Because ADS providers must meet Medicaid State Plan or waiver contracting requirements to furnish services to Medicaid beneficiaries--either in addition to or in lieu of state licensing or certification requirements--they are regulated at a level which allows them to furnish health-related and medical services, as well as long-term care services to elderly persons with a high level of nursing and medical needs.

For all these reasons, ADS are an important component of states' long-term care systems. Every state provides funding for these services through either the Medicaid State Plan or a waiver program and 24 states fund them through non-Medicaid programs as well. In 2012, 273,200 participants were enrolled in ADS centers.

INTRODUCTION

Adult day services (ADS)--a non-residential service provided outside an individual's home for less than a full day--is a key community service that provides direct care to participants and meets caregivers' need for respite in order to work, fulfill other obligations, and recover from the demands of continuous caregiving. In 2012, 273,200 participants were enrolled in ADS centers.[1]

States fund ADS as part of their long-term care systems, through both Medicaid and non-Medicaid programs. In addition to providing an important service to individuals with functional limitations, states fund these services because of their potential to delay or prevent nursing home placement, primarily by supporting informal caregiving. ADS can also reduce health care costs by providing health monitoring, preventive health care, and ensuring the timely provision of primary care, particularly for individuals at risk for incurring high medical costs.

States also cover day services for adults with intellectual and other developmental disabilities (IDD), which are regulated through the state and local systems that serve this population, and are not included in this report.[2] The report also does not include information about reimbursement rates, which vary according to the services ADS providers furnish, and thus are not comparable among states.[3]

In 2005, the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (HHS/ASPE), published the first national review of state regulation of ADS--including licensing, certification, and/or contractual requirements. Its purpose was to better understand the role that ADS can and do play in meeting the health and long-term care needs of older adults and working-age adults with physical disabilities, by examining key regulatory provisions--including required and optional services, and staffing and training requirements. This report updates the 2005 review.

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[1] In 2012, the average number of participants served daily in ADS centers was 185,300, which is smaller than the total enrollment because some participants did not attend each weekday. *Long-Term Care Services in the United States: 2013 Overview*. National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf.

[2] The majority of individuals with these disabilities are served through the IDD service system, which offers key services needed by this population, such as habilitation. Some ADS programs that serve elderly persons and working-age adults with physical disabilities also serve individuals with IDD if they can meet their needs.

[3] For information about Medicaid reimbursement rates, see Adult Day Services/Adult Day Health: Financial Viability and Scope of Services Provided Under Medicaid Waivers, at http://www.leadingage.org/uploadedFiles/Content/Members/Provider_Types/Adult_Day/Adult_Day_Services_Adult_Day_Health_Medicaid.pdf.

Terms, Definitions, and Language

Three major ADS models are generally recognized: a social model; a health/medical model, which is sometimes combined with the social model; and a specialized model.

The social model generally provides a secure environment, supervision, assistance with some activities of daily living (ADLs), and therapeutic activities aimed at helping participants to achieve optimal physical and mental functioning. The health or medical model provides many of the same services furnished in the social model and also medical, nursing, and rehabilitation services. Many programs combine both models.

Specialized models serve specific populations. For example, Colorado has a specialized services model called *specialized ADS center*, which provides intensive health supportive services for participants with a primary diagnosis of Alzheimer's disease or other dementias, multiple sclerosis, brain injury, chronic mental illness, or developmental disabilities, or for post-stroke participants who require extensive rehabilitative therapies.

States generally regulate one or two models of ADS programs--social and medical. Some states allow providers to offer both models in one program, called a combined model.

States use different terms for the three models; many use the terms *adult day care* (ADC) and *adult day health care* (ADHC) to distinguish the social from the medical model, but some states use the term adult day care for the medical model.[4] For example, New Hampshire licenses *adult day care* as a medical model and *adult day non-medical program services* as a social model. New Hampshire's Medicaid program covers ADC under its State Plan and a 1915(c) waiver program but calls the service *adult medical day services*.

To avoid confusion, this report uses the term *adult day services* as a generic term covering the social, medical, combined, and specialized models[5]--and the term *adult day health services* (ADHS) specifically for the medical model. When discussing each state, the report uses state-specific terms. States also use different terms for individuals served in ADS settings, such as client and recipient. This report uses the term *participant*.

Virtually all of the information in the individual state profiles is taken directly from states' statutes, regulations, and rules. However, because many states' provisions are written in "legalese," in many cases we have edited the language to ensure

[4] Louisiana is the only state that defines adult day care as a service only for persons with IDD. The state licenses only ADHC for the aged/disabled population.

[5] Adult day services is the term preferred and used by the National Adult Day Services Association, in part because the term "day care" is generally understood to be a service for children.

grammatically correct and consistent usage; to eliminate redundancy; to use scientifically accurate terms; and to ensure that the provisions are easily understood and comparable across states.

Data Collection and Methods

We conducted extensive Internet searches of state departments and offices of health, human services, and aging to locate licensing, certification, and any other regulatory requirements for ADS providers. We also conducted Internet searches to identify Medicaid and non-Medicaid programs that cover ADS and any requirements they have for ADS providers.

To ensure that the regulations found online were the most current and not undergoing revision, we contacted knowledgeable individuals in each state--either state provider representatives or state agency staff. At the start of this project, Arizona, Georgia and Massachusetts were in the process of revising their ADS regulations. Arizona approved its revised regulations during the study period, and Georgia and Massachusetts approved their revisions in 2015 and their profiles include information current as of May 2015. All of the other state profiles are current as of December 2014.

We asked state agency staff to review the regulatory profiles, but not all did. In more than half the states, representatives of state provider associations either reviewed the profiles and/or responded to requests for clarifications.

Most states' regulatory information was understandable, but occasionally, questions about undefined terms and the interpretation of ambiguous rules arose. In these instances, we contacted state regulatory and Medicaid agency staff for clarification. In all but three states we were able to obtain the answers sought.

The final section of each state profile includes the names and affiliations of individuals who provided information. A few profiles do not include the name of any state agency staff--either because those contacted did not respond or because the person who provided information changed jobs.

Organization of the Report

Section 1 of this report provides a brief overview of states' approaches to regulating ADS in selected areas--those included in each individual state's profile--and highlights similarities and differences among them. The selected areas include the state's general approach to regulation, inspection and monitoring; parameters for who can be served; required and optional services; provisions regarding medication; and staffing and training requirements.

Section 2 provides a profile for each state that describes its overall approach to regulating ADS providers, selected regulatory provisions, and Medicaid and other public funder requirements (if any).

1. OVERVIEW OF ADULT DAY SERVICES REGULATIONS

This section provides a brief overview of states' approaches to regulating ADS providers in key areas and highlights similarities and differences among them.

Licensing, Certification, and Other Requirements

The majority of states regulate ADS through licensure or certification.

- 26 states require licensure only;
- 10 states require certification only;
- 4 states require both licensure and certification; and
- 11 states do not require licensure or certification.

In the 11 states that do not require licensure or certification, ADS providers that serve only private pay participants are not regulated. Those that serve publicly-funded participants--through Medicaid and non-Medicaid programs--must meet the requirements of these programs and enter into some type of contract or agreement with the state agency that administers the programs. In four states that license and/or certify ADS programs, providers must meet additional requirements to receive reimbursement from publicly-funded programs.

Exhibit 1 indicates whether a state requires licensure, certification, or both, and/or some other type of contractual arrangement. In addition to licensing, certification, and other contractual requirements, ADS providers are required to comply with all applicable state, county, and local building regulations, zoning, fire, and health codes or ordinances.

EXHIBIT 1. State Approach to Regulation

State	Licensure Only	Certification Only	Licensure + Certification	Other Requirements
Alabama	---	---	---	X
Alaska	---	X	---	---
Arizona	X	---	---	---
Arkansas	X	---	---	---
California	---	---	X	---
Colorado	---	X	---	---
Connecticut	---	X	---	---
Delaware	X	---	---	---
District of Columbia	---	---	---	X
Florida	X	---	---	---
Georgia	X	---	---	X
Hawaii	X	---	---	---

EXHIBIT 1 (*continued*)				
State	**Licensure Only**	**Certification Only**	**Licensure + Certification**	**Other Requirements**
Idaho	---	---	---	X
Illinois	---	X	---	---
Indiana	---	---	---	X
Iowa	---	X	---	---
Kansas	X	---	---	---
Kentucky	---	---	X	---
Louisiana	X	---	---	---
Maine	X	---	---	---
Maryland	---	---	X	---
Massachusetts	X	---	---	X
Michigan	---	---	---	X
Minnesota	X	---	---	---
Mississippi	---	---	---	X
Missouri	X	---	---	---
Montana	X	---	---	---
Nebraska	X	---	---	---
Nevada	---	---	X	X
New Hampshire	X	---	---	---
New Jersey	X	---	---	X
New Mexico	X	---	---	---
New York	---	---	---	X
North Carolina	---	X	---	---
North Dakota	---	---	---	X
Ohio	---	X	---	---
Oklahoma	X	---	---	---
Oregon	---	X	---	X
Pennsylvania	X	---	---	---
Rhode Island	X	---	---	---
South Carolina	X	---	---	---
South Dakota	---	---	---	X
Tennessee	X	---	---	---
Texas	X	---	---	---
Utah	X	---	---	---
Vermont	---	X	---	---
Virginia	X	---	---	---
Washington	---	---	---	X
West Virginia	X	---	---	---
Wisconsin	---	X	---	---
Wyoming	X	---	---	---
TOTAL	**26**	**10**	**4**	**15**
--- = not applicable.				

Licensure

States have three basic approaches to licensure: (1) licensing a single model of ADS--social, medical, or combined; (2) licensing two models--generally ADS and ADHS--under a single licensing category; and (3) licensing two or more different models under two or more licensing categories.

States that license a social and medical or combined model under a single licensing category generally have some requirements that providers of both models must meet, and some that only the medical model providers must meet. For example, **Florida** licenses ADC centers and adult day health care (ADHC) is not a specific licensing category. However, if an ADC center chooses to be an ADHC provider, it must provide additional services, such as nursing and rehabilitative therapies, and meet related staffing requirements.

Very few states require a separate license to provide specialized services to specific populations. Florida requires a separate license to operate a Specialized Alzheimer's Services Adult Day Care Center, and Maine requires a separate license for ADHS and social ADS programs that want to operate a night program for persons with dementia. Other states that serve participants with special needs specify additional requirements in the regulations rather than requiring separate licenses.

Specific Requirements for Participants with Special Needs

Twenty-five states have specific requirements for providers that serve people with dementia, as shown in Exhibit 2. States' requirements may apply to any ADS program that serves people with dementia or only to programs that exclusively serve this population. Any additional requirements generally relate to staffing and training, such as requiring lower staff-to-participant ratios and dementia-specific training for all staff. For example, Michigan requires ADS programs to have no less than one staff person for each ten participants but requires dementia programs to have a minimum staff/volunteer/student-to-participant ratio of 1:3. Ten states have additional requirements for participants with other conditions, such as mental illness.

EXHIBIT 2. States with Provisions for ADS Centers Serving Participants with Special Needs

State	Dementia	Other
Alabama	---	---
Alaska	X	---
Arizona	---	---
Arkansas	X	---
California	X	X[1]
Colorado	---	X[2]
Connecticut	---	---
Delaware	X	X[3]
District of Columbia	---	---
Florida	X	---
Georgia	X	---
Hawaii	---	X[4]
Idaho	---	---
Illinois	---	---
Indiana	---	X[5]
Iowa	X	---
Kansas	X	---
Kentucky	X	---
Louisiana	X	---

EXHIBIT 2 (*continued*)		
State	**Dementia**	**Other**
Maine	X	X[6]
Maryland	---	---
Massachusetts	X	---
Michigan	X	---
Minnesota	X	---
Mississippi	---	---
Missouri	X	---
Montana	---	---
Nebraska	---	---
Nevada	X	---
New Hampshire	X	---
New Jersey	X	---
New Mexico	---	---
New York	---	X[7]
North Carolina	X	X[8]
North Dakota	---	---
Ohio	---	---
Oklahoma	---	---
Oregon	---	---
Pennsylvania	X	---
Rhode Island	X	X[9]
South Carolina	---	---
South Dakota	X	---
Tennessee	X	---
Texas	---	---
Utah	X	---
Vermont	---	---
Virginia	---	---
Washington	---	---
West Virginia	X	X[10]
Wisconsin	---	---
Wyoming	---	---
TOTAL	**25**	**10**

--- = not applicable.

1. Mental illness and traumatic brain injury.
2. Multiple sclerosis, brain injury, chronic mental illness, and stroke.
3. IDD and severe cognitive or physical disabilities.
4. Psychiatric illness.
5. Mild to severe cognitive impairments and high physical acuity needs.
6. Parkinson's disease.
7. HIV/AIDS.
8. Mental health disabilities, or other special needs, diseases, or conditions.
9. Mental health conditions or other special needs, diseases, or conditions.
10. Developmental disabilities, traumatic brain injury, mental illness, and HIV/AIDS.

Requirements for Co-Located ADS Providers

When ADS are co-located within other licensed settings such as nursing homes or assisted living facilities, states vary regarding licensure requirements. In **Tennessee**, if an ADC center is operated by a licensed facility such as a nursing home, the state may

determine that its licensing provisions adequately regulate the ADC center's program and that a separate ADS license is not needed. But an ADC program, regardless of its affiliation or location, must comply with the program content requirements as detailed in the rules.

North Dakota requires licensed hospitals, nursing facilities, and basic care facilities that provide ADC services to individuals who do not remain in the facility overnight to obtain approval from the Department of Health, which licenses these facilities, and to enroll as qualified service providers (QSPs) and meet QSP standards. In **West Virginia**, a medical ADC program maintained and operated by a nursing home, hospital or other licensed health care facility must comply with the standards in the medical ADC licensing rule and compliance must be evaluated independently from compliance with other licensure standards. Sharing of staff, space, physical facilities, and equipment may be permitted only if the requirements of each applicable rule are satisfied in full.

Certification

Ten states require ADS providers to be certified rather than licensed. In three states--Alaska, Iowa, and North Carolina--certification is equivalent to licensure and is required for all providers, regardless of payment source. In Iowa, in addition to certification, a program may be voluntarily accredited by the Department's designated accreditation entity, the Commission on Accreditation of Rehabilitation Facilities.

Seven of the ten states require only ADS programs that receive funding from Medicaid or other publicly-funded programs to be certified--Colorado, Connecticut, Illinois, Ohio, Oregon, Vermont, and Wisconsin. In most of these seven states, the agency that oversees the program providing funding--for example, the Medicaid agency--certifies programs using its own standards.

Connecticut is an exception. To be reimbursed through public programs, adult day centers must meet the Connecticut Association of Adult Day Centers standards for certification, developed in cooperation with the Connecticut Department of Social Services. An adult day center may provide one or both models of care--social and/or medical. If both, each model requires separate certification.

Licensure Plus Certification

Two states require licensure for one model and certification for another. **Kentucky** licenses ADHC (medical model) and certifies ADC (social model). **Maryland** licenses ADC and medical day care but certifies a small social ADC program offered by the Maryland Department of Aging called Senior Center Plus. Providers must meet certification requirements for zoning and planning and Medicaid standards if serving waiver participants.

Two states require licensure for all providers and additional certification for Medicaid providers serving individuals in specific programs. **California** requires certification for licensed ADHC centers to become a Medi-Cal provider of Community-Based Adult Services in its managed care program. (Medi-Cal is the name of California's Medicaid program.) **Nevada** requires licensed Medicaid providers serving participants in the 1915(i) State Plan program to also be certified. In addition to meeting Medicaid's ADS-specific requirement, providers must meet the State Plan program's general provider qualifications and Medicaid program requirements.

Other Requirements

Eleven states do not license or certify ADS providers that serve only private pay participants. However, all of these states require ADS providers who wish to serve participants in publicly-funded programs to enter into official, most often contractual, agreements with the state agencies that administer these programs and to meet program requirements. Some of these states' contracting requirements are as detailed and exacting as other states' licensing or certification provisions.

For example, New York has two types of ADS programs: social ADS and ADHC. Providers of the social model serving Medicaid waiver participants and Medicaid managed long-term care participants must meet New York State Office for the Aging requirements. ADHC programs must be approved by the New York State Department of Health through New York's Certificate of Need Process and must comply with state rules and regulations governing this service.

Idaho's approach is somewhat different. ADC programs serving participants in the Commission on Aging Senior Services Program, must operate under guidelines established by the Idaho Commission on Aging that are in accordance with the standards developed by the National Council on Aging, National Institute on Adult Day Care (now known as the National Adult Day Services Association).

Four states that require licensure, certification, or both, also have other contracting requirements for certain programs. **Massachusetts** requires all providers of ADHS to be licensed, but providers of supportive day services and dementia day services do not require licensure. To be reimbursed through non-Medicaid public programs they must be operated in accordance with program standards issued by the Executive Office of Elder Affairs. Providers must agree to meet the standards as part of their provider agreement.

Oregon has operational standards, which ADS programs comply with on a voluntary basis. However, all ADS providers are required to register their programs on a registry administered by the Department of Human Services, Aging and People with Disabilities Division. When registering, providers are required to indicate on a checklist the extent to which they are voluntarily complying with the standards.

In **Nevada**, the Department of Human Resources Division for Aging Services funds ADS through grants to licensed providers who, in addition to licensure, must also comply with additional service specifications. Similarly, in **New Jersey**, the Department of Health and Senior Services administers a solely state-funded ADS program for persons with Alzheimer's disease, dementia, or memory disorders. The Department enters into letters of agreement with social ADC agencies and licensed ADHS providers, who must comply with the rules for this program.

Inspection and Monitoring

Regardless of how a state regulates ADS, ADS providers must comply with all applicable federal, state, departmental, or local statutes, laws, ordinances, rules, and regulations (e.g., fire safety, environmental, and food service requirements). Thus, providers may undergo multiple inspections in addition to the one conducted by the state licensing, certifying, or contracting entity.[6] Generally, these inspections must occur before the inspection for licensing or certification.

For example, **Tennessee**'s Department of Human Services requires the receipt of approvals from all relevant entities prior to conducting a pre-licensure inspection. Additionally, Tennessee requires that all ADS facilities be inspected and approved annually by an environmentalist of the Tennessee Department of Health (or a local health department), or receive annual approval as another licensed facility, such as a nursing home or an assisted living facility.

The inspection and monitoring provisions presented below are in addition to health, safety, fire, and other environmental requirements.

Most of the 40 states that require licensure or certification require inspections prior to initial licensure and generally prior to license renewal. Most also stipulate that unannounced visits will be made either at specified intervals or at any time to ensure compliance with rules or to investigate complaints.

In the states that license or certify ADS providers, the frequency of inspections varies, as the examples that follow demonstrate.

- **Alaska** conducts an on-site inspection as part of the initial certification process. Initial certification is for 1 year and renewal certification is for 2 years. An additional on-site visit is conducted during the certification period.

- **Kansas** conducts at least one unannounced inspection of each ADC facility within 15 months of any prior inspection. An additional site visit is conducted every 15 months to ensure that a facility complies with construction standards.

[6] Wyoming conducts joint inspections when administratively feasible and appropriate.

- **Nebraska** conducts inspections prior to and following licensure and may conduct an on-site inspection any time it deems necessary. Each year, it conducts an inspection of up to 25 percent of ADS providers based on a random sample. In addition, it conducts focused inspections in response to complaints and incidents, or when 5 years have passed without an inspection.

- **North Carolina** conducts a precertification inspection. To ensure compliance with certification standards, ADS programs are recertified annually in addition to monthly monitoring of compliance by county departments of social services. ADHS programs receive additional monitoring at least quarterly by county departments of health.

- **Oregon** inspects and monitors only those ADS programs contracting with Medicaid. The initial certification for a 2-year period requires an on-site inspection. Recertification requires a self-assessment demonstrating that the program continues to meet the certification standards as well as an on-site inspection. Unannounced on-site certification reviews may be conducted at any time.

- **Wyoming** conducts initial and annual renewal on-site licensure evaluation surveys and may also conduct an on-site inspection at any time at its discretion, for example, in response to a complaint.

- **Virginia** issues initial licenses and renewals for an ADC center for periods of up to 3 successive years. ADC centers issued a license for a period of 6 months are inspected at least twice during the 6-month period, and at least one of these inspections is unannounced. ADC centers issued a license for a period of 1 year are inspected at least three times each year, and at least two of these inspections are unannounced. ADC centers issued a license for a period of 2 years are inspected at least twice each year, and at least one of those inspections is unannounced. For any ADC center issued a 3-year license, an unannounced inspection must be conducted each year.

In the states that do not require licensure or certification, inspections and other monitoring requirements are the purview of the state agencies that contract with ADS providers to serve participants in publicly-funded programs. As in states that require licensure and/or certification, states vary in the frequency of their inspections.

- **Indiana**'s Division of Aging conducts an on-site inspection before an ADS provider is included as a provider in one or more of its programs. On-site inspections are conducted every 3 years thereafter. Indiana's Medicaid agency also conducts surveys to ensure compliance with program requirements every 3 years.

- **Mississippi**'s Department of Human Services monitors ADS programs three times a year and at least every 6 months. Area Agencies on Aging (AAA) monitor

and evaluate local service providers for their efficiency and effectiveness in delivering services. Medicaid waiver program staff conduct an on-site visit after an application is approved and before a provider number is issued. Site visits are conducted at least every 2 years.

- **New York**'s State Office for the Aging and local AAA are responsible for the oversight of social ADS programs that they fund, and they monitor them on a regular basis. If funded under a managed care contract, the managed care entity monitors providers to ensure that they comply with state requirements. The state Department of Health surveys ADHC programs (which are offered only by nursing facilities), which may or may not coincide with the nursing home survey.

- **Texas**'s Department of Aging and Disability Services may monitor providers in its Day Activity and Health Services program. The Health and Human Services Commission--which oversees Texas Star+Plus, a managed care program--does not have specific inspection and monitoring requirements for day activity and health services. However, the Texas Star+Plus managed care organizations (MCOs) may have their own inspection and monitoring requirements, which can vary.

Internal Evaluations

Many states require ADS providers to have an internal evaluation process, which can include annual evaluations, utilization reviews, participant satisfaction surveys, and participant improvement, or care plan audits. States generally require that any evaluation involve the governing body and advisory board (if any), multidisciplinary staff, participants and their family members/caregivers, and other relevant entities.

For example, **Washington** requires ADS centers to develop a quality improvement plan, with specific measurable objectives, designed to meet the requirements of any licensing agency, funding source, or regulations, as well as professional standards. The center's administrator must develop policies and procedures for monitoring program quality and determining further action needed to address identified problems.

Alaska requires each ADS program to conduct an internal evaluation of its operation and services at least annually. The evaluation must include: (1) a review of the extent to which the program assisted participants and their families and caregivers; (2) measurement of the achievement of goals and objectives; (3) outcome measures as designed by the state agency; (4) an assessment of the program's cost-effectiveness; (5) an assessment of the relationship of the program to the rest of the community service network; and (6) recommendations for improvement, corrective action of problem areas, and future program directions.

Parameters for Who Can Be Served

A primary purpose of regulating ADS 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 who can be served in ADS settings.

State definitions of ADS usually include general statements about the type of individuals that ADS providers may or may not admit or retain. In addition, virtually all states have provisions related to involuntary discharge, which generally give providers discretion to determine whether they can meet an individual's needs. Examples of such general statements follow.

- Providers may serve only individuals whose needs can be met by the ADS center within its certification category.

- Individuals may not be admitted or retained if the provider cannot meet their needs.

- Participants can be involuntarily discharged when their condition presents an immediate and serious risk to their or others' health, safety, or welfare.

- The licensee may not admit individuals requiring ongoing or extensive nursing care nor admit or retain individuals requiring a level of service that the center is not licensed to provide or does not provide.

- Providers may not serve individuals who have communicable diseases that constitute a danger to other participants.

Some states have additional specific provisions regarding the types or level of functional or health needs that should preclude admission and retention. For example, **South Carolina** prohibits the admission or retention of individuals who are confined to a bed, whether because of a physical or mental condition, as well as those whose needs exceed the resources outlined in the regulations.

Kansas prohibits providers from admitting persons in need of specialized services for mental illness unless they are under the care of a physician and unless they can provide appropriate treatment can be provided. Although Kansas allows providers to define the target population they wish to serve, they are not allowed to admit individuals with the following conditions, unless their negotiated service agreement includes resources to meet their needs:

- Incontinence and an inability to participate in its management;
- Immobility;
- Requires a two-person transfer;

- Behavior symptoms that are not manageable; or
- A clinical condition that requires the use of physical restraints.

Michigan allows ADS providers to serve individuals who require assistance with ADLs and regular supervision in order to live in their own home or the home of a relative; are capable of leaving their residence, with assistance, to receive services; and need intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that would likely lead to institutionalization.

Michigan's providers of dementia ADC may serve individuals who have a diagnosis of Alzheimer's disease or another type of dementia; do not have an acute medical illness; have significant impairments in cognition, communication, and ADLs; are responsive to redirection and other supportive verbal interventions when angry, anxious, lost, or upset; and may require one or more of the following: (1) modifications in environmental cues, communication approach, and task breakdown to enhance comprehension and participation in identified activities; (2) supervision to maintain personal safety; and (3) hands-on assistance to perform toileting, grooming, hygiene, and bathing.

Many states allow ADS providers considerable flexibility in determining who they will and will not serve. For example, **Virginia** requires ADC centers to develop a written statement of the purpose and scope of the services to be provided, and a description of adults who will be accepted into the program as well as those whom the program cannot serve. The center may admit only individuals who meet its admission criteria.

However, if providers choose to serve individuals with specialized needs, they generally will have to meet specific staffing requirements. For example, if an ADS program wants to admit individuals with skilled nursing needs, then it must employ licensed nursing staff who are immediately available on site to meet those needs. Providers who choose to serve only persons who do not have medical and nursing needs are not required to employ or contract with licensed nurses.

Pennsylvania prohibits the admission of individuals who are bedfast; have a communicable disease; have emotional or behavioral disorders; are habitually addicted to alcohol or drugs and, as a consequence of the addiction, are disruptive in a group setting; or do not need the activities and services provided in an ADS center and need referral to other, more appropriate programs, such as a senior center or nutrition site.

Providers are allowed to involuntarily discharge participants for one or more of the following reasons: (1) a participant experiences a sudden change in level of functioning that the center determines to be a threat to the participant or others; (2) a participant is not capable of being transported to the center; (3) a participant does not have a functional impairment and is not in need of the structured program of activities or services offered by the center; or (4) a participant no longer meets the admission criteria.

Generally, states permit medical models--ADHS--to serve individuals with nursing and medical needs. However, most states do not have explicit provisions for determining who may be served in ADHS programs. **New York** is an exception, defining an ADHC participant as someone: (1) who is not a resident of a nursing home; is functionally impaired and not homebound; requires supervision and monitoring, and preventive, diagnostic, therapeutic, rehabilitative or palliative care or services, but does not require continuous 24-hour-a-day inpatient care and services; (2) whose assessed social and health care needs can be met satisfactorily in whole or in part by the delivery of appropriate services in the community setting; and (3) who has been admitted to an ADHC program based on an authorized practitioner's order and the ADHC program's interdisciplinary comprehensive assessment.

If ADHC providers serve Medicaid waiver program participants--who must meet a state's nursing home level of care criteria--then they can most likely serve a population with extensive ADL and nursing needs. Nursing home level of care criteria, however, vary among states, sometimes markedly. Thus, an individual who meets the criteria in one state may not meet it in another and so the characteristics of waiver program participants served in ADHS programs in one state may be very different from those in another state.

In most states, the parameters for who can be served are set indirectly through provisions regarding mandatory and optional services, and mandatory staffing. For example, if the regulations state that ADS providers may furnish skilled nursing services and require registered nurse (RN) staffing, one can infer that individuals who need these services can be served.

Required and Optional Services

ADS programs provide socialization, social activities, nutrition services, and supervision to ensure safety. They also monitor participants' health and functioning at a basic level to determine whether the program can continue to meet participants' health and functional needs. In addition to these core services, our review focused on whether states considered the following services to be mandatory or optional:

- ADL assistance;
- Health education and counseling;
- Health monitoring;
- Medication administration;
- Nursing services;
- Physical, occupational, and speech therapy;
- Skilled nursing services;
- Social services; and
- Transportation.

Most states' licensing, certification, or contractual requirements identify a range of services that ADS providers must and may offer. Many of these services are self-explanatory, for example, ADL assistance, physical, occupational and speech therapy, and transportation. But many states do not define health education and counseling, health monitoring, nursing and skilled nursing services, and social services. When they do, the definitions are not always consistent across states.

To determine whether a state required or permitted ADS providers to offer these services, we reviewed states' definitions of these services and used the following definitions, which incorporate the most common services mentioned in states' statutes, regulations, and rules. We used the following definitions to determine whether each state considered the service mandatory or optional:

- ***Health Education and Counseling*** comprise teaching good health and safety practices and self-management of health conditions, encouraging self-care, and counseling regarding health conditions and health care. Some states consider these services to be nursing services. In these cases, we indicated that both were either required or optional.

- ***Health Monitoring*** comprises health screening; monitoring of participants' general health and medical status, including daily checking of vital signs, hygiene, and general functioning; checking weight and dental health; and taking appropriate action when there is a change in condition, including immediately reporting changes to the participants' caregiver, physician, RN, or other health professional involved in their care.

- ***Nursing Services*** are generally defined as health or health-related services, such as routine skin care; simple dressing changes; medical screening emphasizing prevention and continuity of care, which includes routine blood pressure checks or blood glucose diabetic maintenance checks; and supervision of health services provided by program aides.

- ***Skilled Nursing Services*** are those that must be provided by an RN or a licensed practical nurse/licensed vocational nurse (LPN/LVN) under the supervision of an RN according to the requirements of states' Nurse Practice Acts. Most states that require or allow ADS providers to furnish skilled nursing services define them explicitly but some states do not. For example, **New Jersey** defines skilled nursing services by providing examples of such services that can only be provided by an RN or an LPN, including, but not limited to: (1) medication administration, pacemaker checks, or the monitoring of urinary output, unstable blood glucose, or unstable blood pressure that requires physician and or advanced practice nurse intervention; (2) wound treatment; (3) stasis ulcer treatment; (4) intravenous or intramuscular injection; and (5) nasogastric or gastrostomy tube feeding.

Washington defines skilled nursing services generally as medically necessary services provided directly or indirectly by an RN under physician supervision, or by an LPN under physician or RN supervision, that a licensed nurse acting within the scope of practice can provide or supervise. Skilled nursing services include the initial assessment of applicants for ADS and development of the nursing plan of care. They also include: (1) skilled care and assessment of an unstable or unpredictable acute or chronic medical condition; (2) skilled nursing tasks (such as medication administration, wound care, inserting or irrigating a catheter); (3) training or teaching participants or their caregivers to manage self-care for newly diagnosed, acute, or episodic medical conditions (such as self-administration of an injection and caring for a colostomy, and disease self-management); and (4) evaluation and management of a plan of care when skilled nursing oversight is needed to ensure that complex non-skilled care is achieving its purpose.

Some states consider medication administration to be a nursing service and other states consider it a skilled nursing service. We assessed medication administration as a distinct service. Provisions regarding medications are discussed in detail in the next section.

- ***Social Services*** comprise: (1) a social and psychosocial assessment of individuals' formal and informal support systems and mental and emotional status; (2) discharge planning; (3) activities to ensure participants' access to appropriate resources and supplemental services if needed to meet special needs; (4) referrals for persons not appropriate for ADS; and (5) individual and group counseling for participants and their families and caregivers, generally by a licensed social worker or other professional staff.

State Variation

States vary considerably regarding which services they require or allow ADS providers to furnish. Section 2 of this report includes specific information about required and optional services for ADS and ADHS providers in each state.

In contrast to the social model of care, states generally require providers of the medical model--ADHS--to furnish skilled nursing services, medication administration, and rehabilitation therapies.

Some states do not list specific services as either required or optional, but other provisions suggest that they are at least optional, and in such instances, we counted them as such. For example, **Arizona** does not list transportation as a required or optional service, but a provision regarding reimbursement for transportation implies that the service is offered by at least some ADS providers. In **Hawaii**, the regulations do not list transportation as a required or optional service but require that transportation be addressed in participants' individualized care plans.

Often, provisions regarding mandatory and optional services are included in sections of the regulations that do not relate specifically to services. For example, provisions regarding medications sometimes were found in rules regarding the physical environment, with references to how medications must be stored.

Other states indicate required services by including them in the definition of ADS. For example, Maine defines ADHS as a program that provides health monitoring and personal care services in addition to a group program of care, therapeutic activities, and supervision. Therapeutic activities are defined as restorative activities designed to maintain or improve the quality of life or delay skill deterioration. Examples of therapeutic activities include those aimed at improving or maintaining gross motor activities, social activities, sensory enhancement activities, crafts, outdoor activities, spiritual activities, and extensive ADL assistance.

Provisions Regarding Medications

Virtually all states require providers to have written policies for medication management and administration, which must be in accordance with applicable state laws, including each state's Nurse Practice Act.

Most states make a clear distinction between providing assistance to participants who administer their own medications (i.e., assistance with self-administration) and administering medications. Many states require providers of the social model to provide assistance with self-administration and providers of the medical model to administer medications. But there are exceptions. When medication administration is either a required or optional service, regulations generally state that the service must comply with applicable state laws.

Provisions regarding medication administration are closely related to staffing requirements. For example, **New Jersey** requires ADHS to provide medication administration and defines this service as a procedure in which a prescribed medication is given to a participant by an authorized person in accordance with all laws and rules governing such procedures. ADHS providers are required to hire an RN, who must not perform the functions of any other position while functioning as the director of nursing services.

Assistance with Self-Administration versus Medication Administration

Most states' provisions related to assistance with self-administration of medications include provisions for determining whether a participant is capable of self-medication. For example, **Virginia**'s rules state that unless it is contrary to an ADC program's policy, participants may take their own medication if a physician has deemed them capable of doing so and has given written authorization for them to self-administer medications.

Texas requires that licensed nurses ascertain on a monthly basis whether participants who are self-administering their medications continue to be capable of self-administration. If participants cannot--or choose not to--self-administer their medications, Texas requires that they be administered by a person who holds a current license under state law that authorizes the licensee to administer medications.

To be considered capable of self-administration of medications, **Pennsylvania** requires that a participant be able to identify the medication, acknowledge the amount of medication to be taken and the schedule for taking it, remember to take the medication on schedule with infrequent reminders from staff persons, and obtain medication from its container without assistance or with minimal assistance.

A major difference among states is that some define *assistance with* medication administration to include activities that other states define as medication administration. The component--*pouring the prescribed dosage according to the medication profile record*--is considered by those states to be an integral part of medication administration --not assistance with self-administration. For example, **New Jersey** defines medication administration as a procedure that includes *removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container)*, verifying it with the prescriber's orders, giving the individual dose to the participant, seeing that the participant takes it, and recording the required information, including the method of administration.

Texas defines assistance with self-medication to include, but not be limited to: (1) reminders to take medications at the prescribed time; (2) opening containers or packages and replacing lids; (3) *pouring prescribed dosage according to the medication profile record (emphasis added)*; (4) returning medications to the proper locked areas; (5) obtaining medications from a pharmacy; and (6) listing on an individual participant's medication profile record the medication name, strength, dosage, amount received, directions for use, route of administration, prescription number, pharmacy name, and the date each medication was issued by the pharmacy.

Wyoming defines administering medicine to encompass reading the label, opening the container of medicine, *removing the prescribed dosage*, and giving it to the person for whom it is prescribed. Persons authorized to administer medicine under the Act include licensed physicians, RNs, LPNs, and physicians' assistants.

Tennessee's definition of self-administration does not include removal of the medication dose from the container, but requires the person assisting *to check the self-administered dose against the dosage shown on the prescription and reassure participants that they are taking the correct dosage*, which in effect, requires the staff person to ensure that the correct dosage is being taken. The regulations are silent on what should be done if the self-administered dose is not the same as the prescribed dose.

In **Wisconsin**, if an adult day center employs an RN, she may set up and label medications and delegate responsibility for administering them to ADS staff. She may also delegate medication setup and labeling to an LPN.

Licensed Personnel versus Unlicensed Personnel

Most likely reflecting differences in State Nurse Practice Acts, states vary regarding provisions about who is authorized to administer medications.

Vermont requires ADS centers to provide medication management under the supervision of an RN or an LPN under an RN's direction. Further, the state requires that all staff responsible for medication administration be licensed by the state to administer medications or successfully complete the most current medication training program developed by the state and the Board of Nursing. They must also complete the current approved refresher course every 3 years.

If a participant requires medication administration, unlicensed staff may administer medications under certain conditions--for example, if there is a physician's written order on file and an RN, or an LPN under the direction of an RN has delegated administration of specific medications to designated staff for designated participants. **Vermont** is one of just a few states with provisions addressing PRN (as needed) medications, stating that the use of PRN medications is prohibited unless certain conditions exist: (1) a participant is capable of determining when the medication is needed; (2) a licensed health care professional administers the medication; or (3) the participant's physician has provided detailed written or documented verbal instructions.

Other states have much less exacting standards for medication administration by unlicensed personnel. For example, **New Hampshire** requires that personnel who are not otherwise licensed practitioners, nurses, or medication nursing assistants, and who assist a participant with self-administration or administration of medication through nurse delegation, must complete, at a minimum, only a 4-hour medication supervision education program covering both prescription and non-prescription medication. The program must include the following:

- Infection control and proper hand washing techniques.
- The "five rights" of medication administration (the right participant, the right medication, the right dose, at the right time, and through the right route).
- Documentation requirements.
- General categories of medications such as anti-hypertensives or antibiotics.

- Desired effects and potential side effects of medications.

- Medication precautions and interactions.

Staff Requirements

States require ADS providers to employ specific types of staff. Virtually all states require the hiring of a director who will be responsible for the day-to-day operation and management of the facility. However, some states require the director to be a full-time position, whereas others allow one person to hold the director position and another position. For example, **Texas** requires a director, an activities director, a facility nurse (RN or LVN), an RN nurse consultant (for 4 hours per week) if an LVN is hired, a dietician consultant (at least 4 hours per month), and attendants (i.e., direct care workers). One person is permitted to fill two of the first three staff positions--if he or she has the required qualifications--but not all three positions.

In addition to a director, the type of staff required depends in large part on the services that an ADS program is required to offer. As states vary considerably regarding required and optional services, they also vary regarding staffing.

For example, **New York** requires ADHC programs--which provide a high level of medical and nursing care--to have a director, a full-time RN, a social worker, a certified nursing assistant, a physical therapist, an occupational therapist, a dietitian, a pharmacist consultant, and a medical director. The ADHC program is also required to employ or contract with speech therapists.

Louisiana requires ADHC programs to hire a full-time director, an RN (full-time or part-time), a program manager, a social services designee/social worker, and direct service workers (the last three are called key positions). They must also designate one staff member who is employed at least 10 hours per week as a food service supervisor.

Louisiana's staffing requirements--like those of a few other states--differ depending on licensed capacity. Programs with a licensed capacity of 16-30 participants must employ at least two full-time persons or full-time equivalents to fulfill key staff requirements. Those with more than 30 participants must employ at least three full-time persons or full-time equivalents to fill key staff positions.

Some states' regulations specify that only a director needs to be hired and allow providers the flexibility to determine the type and number of staff needed to meet participants' needs.

Licensed Nurses

A major difference between staffing requirements for the social and medical models is that the latter are generally required to have licensed nurses available in

some capacity--as full-time or part-time employees or as consultants. Because most states require staffing consistent with participants' needs, if an ADS provider is required to furnish services that only licensed nurses can provide (or sometimes delegate), then they must hire or contract with a licensed nurse.

In some states, the licensing regulations do not require that licensed nurses be hired, but Medicaid requirements for providers serving waiver program participants do. For example, in **South Carolina**, Medicaid requires ADHC providers serving waiver program participants to have an RN on staff to provide nursing services, which include observing participants' functional level and noting changes; supervising medication administration; and coordinating treatment plans with physicians, therapists, and other involved service delivery agencies.

Although many states require that licensed nurses be employed or under contract, the number of hours they must work varies considerably: from 8 hours a month, to 8 hours per day, or whenever participants are present, with many variations in between. In **Virginia**, for example, an ADHC provider must have an RN at the program a minimum of 8 hours each month, or more, depending on the number of participants in attendance and according to their medical and nursing needs. Although an RN does not need to be employed full-time, he or she must be available, either in person or by telephone, to the center's participants and staff during all times that the center is in operation.

ADHS programs in **Massachusetts** must provide nursing coverage on-site for at least 6 hours per day for programs with a licensed capacity of 35 or fewer participants, and at least 8 hours per day for programs with a capacity of 36 or more participants. Programs must increase licensed nursing staff by 4 hours for each additional 1-12 participants attending the program.

In **North Carolina**, adult day health (ADH) centers must have a health care coordinator to organize the delivery of health care services and participate in direct care, who must be either an RN or LPN. If the health care coordinator is an LPN, an RN must provide supervision consistent with the Nursing Practice Act, and on-site supervision by the RN must occur no less frequently than every 2 weeks.

Staffing Ratios

All but six states require minimum direct staff-to-participant ratios. As shown in Exhibit 3, mandatory staff ratios range between 1:4 and 1:10 with the majority of states requiring ratios of 1:6 or 1:8. Some states have more than one required staff-to-participant ratio, requiring different ratios for different types of ADS; some have different ratios for Medicaid providers, and some require different ratios for participants with a high level of need or those with dementia. (For more detailed information about staff-to-participant ratios, consult the individual state profiles in Section 2.)

EXHIBIT 3. Staff-to-Participant Ratios, by State							
State	**1:4**	**1:5**	**1:6**	**1:7**	**1:8**	**1:9**	**1:10**
Alabama	---	---	---	---	---	---	X
Alaska	X	---	---	---	X	---	---
Arizona	---	---	---	---	---	---	---
Arkansas	---	X	---	---	X	---	---
California	---	---	---	---	X	---	---
Colorado	---	---	---	---	X	---	---
Connecticut	---	---	---	X	---	---	---
Delaware	X	---	---	---	X	---	---
District of Columbia	---	---	X	---	---	---	---
Florida	---	---	X	---	---	---	---
Georgia	X	---	---	---	X	---	---
Hawaii	---	---	X	---	---	---	---
Idaho	---	---	X	---	---	---	---
Illinois	---	---	X	---	---	---	---
Indiana	X	---	X	---	X	---	---
Iowa	---	---	---	---	---	---	---
Kansas	---	---	---	---	---	---	---
Kentucky	---	X	---	---	---	---	---
Louisiana	---	---	---	---	---	X	---
Maine	---	---	X	---	---	---	---
Maryland	---	---	---	X	X	---	---
Massachusetts	X	---	X	---	X	---	---
Michigan[1]	---	---	---	---	---	---	X
Minnesota	---	X	---	---	X	---	---
Mississippi	X	X	X	X	X	X	X
Missouri	---	---	---	---	X	---	---
Montana	---	---	---	---	---	---	---
Nebraska	---	---	---	---	---	---	---
Nevada	---	---	---	---	---	---	---
New Hampshire	---	---	---	---	X	---	---
New Jersey	---	X	---	---	---	X	---
New Mexico	---	X	---	---	---	---	---
New York	---	---	---	X	---	---	---
North Carolina	---	X	X	---	X	---	---
North Dakota	---	---	---	---	X	---	---
Ohio	---	---	X	---	---	---	---
Oklahoma	X	---	---	---	X	---	---
Oregon	X	---	X	---	---	---	---
Pennsylvania	---	---	---	X	---	---	---
Rhode Island	---	---	X	---	---	X	---
South Carolina	---	---	---	---	X	---	---
South Dakota	X	---	X	---	---	---	---
Tennessee	---	---	---	---	X	---	---
Texas	---	---	---	---	X	---	---
Utah	---	---	X	---	X	---	---
Vermont	---	---	---	X	---	---	---
Virginia	---	---	X	---	---	---	---
Washington	---	---	X	---	---	---	---
West Virginia	---	---	X	---	---	---	---
Wisconsin	---	---	X	---	---	---	---
Wyoming	---	---	X	---	---	---	---
TOTAL	**9**	**7**	**20**	**6**	**20**	**4**	**3**

--- = not applicable.

1. Dementia ADC programs must have a minimum staff/volunteer/student-to-participant ratio of 1:3.

For example, **Indiana** recognizes three levels of care in ADS programs and requires different ratios for each. *Basic (level 1)*: the staff-to-participant ratio must be a minimum of 1:8. *Enhanced (level 2)*: the staff-to-participant ratio must be a minimum of 1:6. *Intensive (level 3)*: the staff-to-participant ratio must be a minimum of 1:4.

Many states give providers the flexibility to determine the ratio beyond the minimum required. For example, **Vermont** requires a minimum direct services staff-to-participant ratio of 1:7 but allows providers to determine how much the staff-to-participant ratio must be adjusted as the number of participants with functional or cognitive impairments or the severity of the impairment increases.

Wisconsin requires a minimum of one staff person for each eight non-severely impaired participants and a minimum of one staff person for each four severely impaired participants at the ADS site, but the state does not provide guidelines for determining what constitutes severe impairment.

Virginia requires an ADHC center to employ sufficient interdisciplinary staff to adequately meet the participants' health, maintenance, and safety needs. The center must provide at least two staff members awake and on duty at all times when there are Medicaid waiver participants in attendance, and maintain a minimum staff-to-participant ratio of at least 1:6 (waiver and other participants). However, The Virginia Department of Medical Assistance Services (DMAS) reserves the right to require an ADHC center to employ additional staff if, on review, DMAS staff find evidence of unmet participant needs.

States with minimum staff-to-participant ratios define which workers are to be counted in determining the ratio. For example, **Minnesota**'s regulations state that only those employees whose primary duties, as defined in their job descriptions, are to work directly with participants by providing care, supervision, and assistance in achieving care plan objectives must be counted as staff members in calculating the staff-to-participant ratio.

The six states without minimum staff-to-participant ratios allow providers to determine the number of staff to employ. **Nebraska** requires only that ADHC programs maintain a ratio of direct care staff member to participants sufficient to ensure that participants' needs are met. **Arizona** requires that sufficient staff be present on an ADHC facility's premises when participants are present, and they must have the qualifications, skills, and knowledge necessary to: (1) provide the services in the ADHC facility's scope of services; (2) meet participant's needs; and (3) ensure participants' health and safety.

Although **Hawaii** requires ADC programs to have a staff-to-participant ratio of 1:6, it does not have a minimum ratio for ADH programs. Instead, it requires a sufficient number of employees qualified and competent to provide the services for which the center is licensed; and a sufficient number of aides to perform necessary duties.

Other Staffing Requirements

Virtually all states require that a minimum of one or more staff members be available when participants are present and that at least one staff member with current certification in cardiovascular pulmonary resuscitation (CPR) be present at all times during the hours of operation. Other states additionally require that at least one staff person certified in the provision of first-aid also be present during the hours of operation.

Virtually all states also have provisions regarding the use of volunteers, requiring them to have the same qualifications, orientation, and training as regular staff; and requiring their supervision by a paid staff member. States also address the specific conditions that must be met for volunteers to be counted in the staff-to-participant ratio. In **Virginia**, for example, volunteers may be counted only if both of the following criteria are met: (1) they have the same qualifications as compensated employees and meet the same training requirements; and (2) for each volunteer, at least one compensated employee is also counted in the staff-to-participant ratio.

A few states restrict the use of volunteers. For example, in **Mississippi**, volunteers may not be used in place of required staff, and they can be used only on a periodic and temporary basis.

Training Requirements

Virtually all states have requirements for orientation and initial training for workers. For example, prior to assuming job responsibilities, **Delaware** requires all personnel to receive training in fire safety; first-aid; emergency procedures; infection control; and special needs of the elderly and persons with cognitive or other disabilities, including the specific needs of the participants being served.

States vary somewhat regarding required training topics. **West Virginia** requires that training include, at a minimum: (1) emergency procedures and disaster plans; (2) the center's policies and procedures; (3) participants' rights; (4) confidentiality; (5) abuse prevention and reporting requirements; (6) complaint procedures; (7) specialty care based on individualized participants' needs and service plans; (8) the provision of group and individual participant activities; (9) infection control; and (10) needs of the elderly and disability populations.

Wyoming requires that before assuming job responsibilities or within 1 week of hire, all staff persons must receive an orientation that includes training specific to the staff person's assigned responsibilities, as well as training on more general topics, including: (1) the purposes of the ADC facility; (2) state procedures for addressing abuse and neglect; (3) confidentiality of personal information; (4) employee responsibilities; (5) capabilities and special needs of the elderly and disabled; (6) the facility activity schedule; and (7) record-keeping responsibilities. Additionally, all staff persons must be trained in the appropriate procedures for handling emergencies before

job responsibilities are assumed, including--at least--fire, illness, or injury, and lost or missing person emergencies.

Some states require that all employees have current first-aid and CPR training; most require that at least one staff trained in first-aid and CPR be on duty at all times.

Some states, such as **Mississippi**, do not specify topics that need to be covered, stating only that all staff and volunteers who have contact with and responsibility for special populations should receive specific training in serving that population.

Many states require specific training about dementia. Some states require training about dementia only for ADS providers who present themselves as providing special services for this population. For example, **Minnesota** requires ADS centers that serve persons with Alzheimer's disease and other dementias to ensure that the direct care staff and their supervisors are trained in dementia care. Required topics include: (1) an explanation of Alzheimer's disease and other dementias; (2) ADL assistance; (3) problem solving with challenging behaviors; and (4) communication skills.

Iowa requires that all personnel employed by or contracting with a dementia-specific program receive a minimum of 8 hours of dementia-specific education and training prior to--or within 30 days of--employment or the beginning date of the contract. The dementia-specific education or training must include, at a minimum, the following topics: (1) an explanation of Alzheimer's disease and other types of dementias; (2) the program's specialized dementia care philosophy and program; (3) skills for communicating with persons with dementia; (4) skills for communicating with family and friends of persons with dementia; (5) an explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the caregiving role, and family dynamics; (6) the importance of planned and spontaneous activities; (7) skills in providing assistance with ADLs; (8) the importance of the care plan and social history information; (9) skills in working with challenging participants; (10) techniques for simplifying, cueing, and redirecting; and (11) staff support and stress reduction.

Other states require dementia training for all ADS providers, as in **West Virginia**, which requires at least 2 hours of training on Alzheimer's disease and other dementias that includes: (1) basic understanding about Alzheimer's disease and other dementias; (2) communication approaches and techniques for use when interacting with persons with Alzheimer's disease or other dementias; (3) prevention and management of problem behaviors; and (4) activities and programming appropriate for persons with dementia.

Amount of Training Required

States vary considerably regarding the amount of staff training required. Wyoming requires that all staff primarily responsible for the direct care of participants attend at least *8 hours* of staff development activities annually, which must consist of in-service training programs, workshops, or conferences related to ADC or gerontology, provided

that both subject areas are addressed during the year. In contrast, **Texas** requires *18 hours* of initial training, and **Minnesota** requires ADS centers to provide all employees with *20 hours* of orientation within the first 40 hours of employment at the center. Minnesota also requires at least *4 hours* of supervised orientation before employees work directly with center participants and a minimum of *8 hours* in-service training annually in areas related to the care of center participants, including the provision of medication assistance.

Virginia requires *24 hours* of initial training, but allows it to be provided through self-study of material provided by the ADS center, as well as formal lectures, observation, supervised practice, and audiovisual training. Staff who are primarily responsible for the direct care of the participants must attend annually at least *8 additional hours* of staff development activities that must consist of in-service training programs, workshops, or conferences relevant to the needs of the population served. These staff development activities must be in addition to first-aid, CPR, or orientation training.

Delaware requires the most hours: aide orientation and training must include at least *40 hours* of instruction and a supervised practicum in body mechanics.

Several states require the director of an ADS center to obtain continuing education annually: 8 hours in **West Virginia**, 12 hours in **Texas**, and 24 hours in **Virginia**.

Public Funding of Adult Day Services

Exhibit 4 shows the public funding sources for ADS in each state. As can be seen, with the exception of West Virginia and the District of Columbia, all states cover ADS under their Medicaid programs, and 24 cover ADS under at least one non-Medicaid program--generally funded by a combination of state general revenues, Older Americans Act funds, and Social Services Block Grant funds (listed as “non-Medicaid programs” in Exhibit 4).

States have several options for covering ADS under their Medicaid programs. The majority--40 states--use the 1915(c) waiver authority for the aged/disabled populations; 14 states use a managed care authority; nine offer it under the Medicaid State Plan; one state uses the State Plan (i) authority, and one uses the State Plan (k) authority.

Medicaid requires ADS providers to meet all state regulatory requirements and some states require them to meet additional requirements. California, for example, licenses ADHC centers as health facilities but to be a Medi-Cal provider, a licensed ADHC center must also be certified by the California Department on Aging as a Community-Based Adult Services center.

EXHIBIT 4. Public Funding for ADS as of October 2014						
State	**State Plan**	**1915(i) State Plan**	**1915(k) State Plan**	**1915(c) Waiver**	**Managed Care Waiver**	**Non-Medicaid Program**
Alabama	---	---	---	X	---	---
Alaska	---	---	---	X	---	---
Arizona	---	---	---	---	X	---
Arkansas	---	---	---	X	---	---
California[1]	---	---	---	---	X	---
Colorado	---	---	---	X	---	X
Connecticut	---	---	---	X	---	X
Delaware	---	---	---	X	X	---
District of Columbia	---	---	---	---	---	---
Florida	---	---	---	X	X	X
Georgia	---	---	---	X	---	X
Hawaii	---	---	---	---	X	X
Idaho	---	---	---	X	---	---
Illinois	---	---	---	X	---	---
Indiana	---	---	---	X	---	---
Iowa	---	---	---	X	---	---
Kansas	---	---	---	X	---	X
Kentucky	---	---	---	X	---	---
Louisiana	---	---	---	X	---	---
Maine	X	---	---	X	---	X
Maryland	X	---	---	X	---	X
Massachusetts	X	---	---	X	---	X
Michigan	---	---	---	X	---	X
Minnesota	---	---	---	X	X	X
Mississippi	---	---	---	X	---	---
Missouri	---	---	---	X	---	---
Montana	---	---	---	X	---	---
Nebraska	---	---	---	X	---	---
Nevada	---	X	---	X	---	X
New Hampshire	X	---	---	X	---	---
New Jersey	X	---	---	---	X	X
New Mexico	---	---	---	---	X	X
New York	X	---	---	X	X	---
North Carolina	---	---	---	X	---	X
North Dakota	---	---	---	X	---	X
Ohio	---	---	---	X	---	X
Oklahoma	---	---	---	X	---	X
Oregon	---	---	X	---	---	X
Pennsylvania	---	---	---	X	---	X
Rhode Island	X	---	---	---	---	---
South Carolina	---	---	---	X	---	---
South Dakota	---	---	---	X	---	X
Tennessee	---	---	---	---	X	---
Texas	X[2]	---	---	X	X	---
Utah	---	---	---	X	---	---
Vermont	X	---	---	---	X	---
Virginia	---	---	---	X	---	---
Washington	---	---	---	X	X	X
West Virginia	---	---	---	---	---	X
Wisconsin	---	---	---	X	X	---
Wyoming	---	---	---	X	---	X
TOTALS	**9**	**1**	**1**	**40**	**14**	**24**

--- = not applicable.

1. In 2011, ADHC services were eliminated as an optional Medi-Cal State Plan benefit. A class action lawsuit challenged the elimination, and a Settlement Agreement was reached in March 2012. On April 1, 2012, Community-Based Adult Services became a mandated “Long-Term Services and Supports” benefit within California’s 1115 Medi-Cal waiver program.
2. Most State Plan participants receive day activity and health services in the state’s 1115 managed care waiver program, but individuals who are not mandatory enrollees in managed care, and individuals who for various reasons do not consistently remain eligible for Medicaid, continue to be served in the State Plan.

Medicaid Managed Long-Term Care

The last 10 years have seen an increase in the number of states providing long-term services and supports (LTSS) through risk-based managed care arrangements outside of the Program of All-Inclusive Care for the Elderly (PACE) programs. In 2004, eight states were operating managed care programs that covered some LTSS outside of PACE programs with 105,000 enrollees. In September 2014, 21 states had such programs and the projected number of enrollees was 1,170,000.[7]

As shown in Exhibit 4, 14 states cover ADS through some form of managed care program. Managed care arrangements may alter traditional Medicaid contracting requirements. For example, Florida covers ADHC covered in the state's Medicaid Managed Long-Term Care Program, which has replaced six 1915(c) waiver programs that formerly served the aged/disabled populations. Licensed ADHC providers do not have to become a Medicaid-contracted provider if they contract directly with one of the state's MCOs. Managed long-term care plans may limit the providers in their networks based on credentials, quality indicators, and price, but they must include a minimum number of providers of all covered services.

Conclusion

In sum, while states vary somewhat in their approach, all have some form of regulation and exercise oversight of ADS. States generally distinguish between ADS and ADHS, with the latter having more extensive requirements for nurse staffing.

Only West Virginia and the District of Columbia do not use Medicaid to fund ADS. In the states that cover ADS under Medicaid--either through the State Plan or a waiver program--providers who want to be reimbursed by Medicaid must meet Medicaid contracting requirements. Depending on whether a state licenses, certifies, or otherwise regulates ADS providers, Medicaid requirements may be more prescriptive, particularly for providers who are serving participants in waiver programs who meet nursing home level of care criteria.

ADS are a key community-based service that enables individuals with long-term care needs--including significantly impaired nursing home eligible participants--to remain at home or living with family. To the extent that ADS--both the social and health models--enable informal caregivers to continue providing care in the home, institutionalization can be prevented or delayed. Additionally, ADS that provide basic preventive and primary health care may prevent more costly illnesses.

[7] Saucier, P. *Truven Health Analytics data presented at the American Health Insurance Plans National Conference on Medicaid*, Washington, DC, October 1, 2014.

REGULATORY REVIEW OF ADULT DAY SERVICES: FINAL REPORT, 2014 EDITION

The continuation of this report (the state profiles) is available at http://aspe.hhs.gov/daltcp/reports/2014/adultday14-2.pdf.

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

REGULATORY REVIEW OF ADULT DAY SERVICES: FINAL REPORT, 2014 EDITION

Files Available for This Report

FULL REPORT

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2014/adultday14es.cfm
HTML	http://aspe.hhs.gov/daltcp/reports/2014/adultday14.cfm
PDF	http://aspe.hhs.gov/daltcp/reports/2014/adultday14.pdf

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.]

Alabama	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-AL.pdf
Alaska	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-AKpdf
Arizona	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-AZpdf
Arkansas	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-AR.pdf
California	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-CA.pdf
Colorado	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-CO.pdf
Connecticut	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-CT.pdf
Delaware	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-DE.pdf
District of Columbia	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-DC.pdf
Florida	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-FL.pdf
Georgia	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-GA.pdf
Hawaii	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-HI.pdf
Idaho	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-ID.pdf
Illinois	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-IL.pdf
Indiana	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-IN.pdf
Iowa	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-IA.pdf
Kansas	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-KS.pdf
Kentucky	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-KY.pdf
Louisiana	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-LA.pdf

Maine	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-ME.pdf
Maryland	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MD.pdf
Massachusetts	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MA.pdf
Michigan	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MI.pdf
Minnesota	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MN.pdf
Mississippi	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MS.pdf
Missouri	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MO.pdf
Montana	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-MT.pdf
Nebraska	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NE.pdf
New Hampshire	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NH.pdf
New Jersey	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NJ.pdf
New Mexico	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NM.pdf
New York	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NY.pdf
Nevada	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NV.pdf
North Carolina	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-NC.pdf
North Dakota	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-ND.pdf
Ohio	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-OH.pdf
Oklahoma	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-OK.pdf
Oregon	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-OR.pdf
Pennsylvania	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-PA.pdf
Rhode Island	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-RI.pdf
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South Dakota	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-SD.pdf
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West Virginia	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-WV.pdf
Wisconsin	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-WI.pdf
Wyoming	http://aspe.hhs.gov/daltcp/reports/2014/adultday14-WY.pdf