NEW YORK STATE
MEDICAID PROGRAM

ASSISTED LIVING PROGRAM (ALP)
MANUAL

POLICY GUIDELINES

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Section I – Scope of Services

Home Care Services

Home care services that are covered under the daily Medicaid rate, and for which no additional separate billing can be made, in the Assisted Living Program (ALP) include:

- Title XIX Personal Care Services;
- Home Health Aide Services;
- Personal Emergency Response Services (PERS);
- Nursing Services;
- Physical Therapy;
- Occupational Therapy;
- Speech Therapy;
- Medical supplies and equipment not requiring prior approval; and
- Adult day health care in a program approved by the Commissioner of Health.

In addition to the provision of any of these needed home care services, the ALP is responsible for the overall case management of individuals participating in the program.

Case Management

Case management functions that are the responsibility of the ALP include, but are not limited to, the following:

- Receiving the initial referral for the assisted living program, providing information to the applicant about the program, assisting the applicant, when appropriate, in completing an MA application and forwarding the application to the social services district in which the ALP is located;
- Assisting the applicant to obtain a physician's order when the applicant or the applicant's representative is unable to do so;
- Completing the applicant's social assessment on forms approved by the Department;

- Completing or arranging for completion of the nursing assessment which includes the Patient Review Instrument (PRI) or its successor, and other tools approved by the Department;
- Determining the Resource Utilization Group (RUG) category of the individual based upon the assessments and physician's order;
- Forwarding to the social services district for their review the completed nursing and social assessments, RUG category determination and physician's order form;
- Providing or arranging for the delivery of ALP services;
- Allowing the individual access to his/her written case records;
- Establishing linkages to services provided by other community agencies, providing information about these services to MA recipients and establishing criteria for referring MA recipients to these services;
- Achieving, to the maximum extent possible, economic efficiencies, including, but not limited to, using shared aides consistent with the ALP's staffing standards; and
- Arranging for the reduction or discontinuance of an MA recipient's services when the ALP reassesses the recipient and determines that the recipient's services must be reduced or discontinued.

Request for Admission to an Assisted Living Program

A request for an assessment for admission into the ALP will be made directly to the ALP. The ALP must complete an initial screening to determine that an individual is appropriate for participation. Following the initial screening, the ALP must complete, or arrange for completion of, a nursing assessment which includes the PRI, or its successor, and other tools approved by the Department.

A social/functional assessment must also be completed by the administrator of the ALP after the individual is determined appropriate for the ALP.

> This must be completed *prior* to his/her admission to the ALP to determine if the individual's physical, supervisory, and psychosocial needs can be supported by the ALP.

If the individual is determined appropriate for the ALP, based on the review of the physician's order, nursing and social assessment and mental health assessment, if deemed necessary, the ALP will make a RUG category determination.

A copy of the assessments and respective RUG category determination is then forwarded for review by the ALP to the local department of social services (LDSS) in which the ALP is located.

Responsibilities of the LDSS

Upon receipt of the ALP's assessment and RUG category determination, the LDSS in which the ALP is located must:

- Complete an initial review of the MA eligibility of the individual.

  When determining eligibility, the LDSS must adhere to existing regulations and requirements regarding districts of fiscal responsibility. The LDSS of fiscal responsibility is responsible for determining MA eligibility for an applicant.

  If not the district of fiscal responsibility, the LDSS in which the ALP is located must forward the Medicaid application and any documentation to the district of fiscal responsibility.

- Determine the applicant's LDSS of fiscal responsibility pursuant to State regulations at 18 NYCRR 505.35 (i):

  - For individuals who are MA eligible at the time of admission to the ALP, the district that is fiscally responsible for the individual immediately prior to his or her admission to the ALP will retain fiscal responsibility for the individual; and

  - For non-MA eligible individuals admitted to the ALP who later become MA eligible, the district in which the individual resided immediately prior to his or her admission to the ALP is the fiscally responsible district.

- Review the assessments and RUG category determination and within 10 working days of the LDSS' receipt of this documentation and the ALP's request for prior authorization of MA funded home care services for the applicant/recipient (A/R), take one of the following actions:

  - Agree with the ALP's determination and authorize payment for six months from date of admission to the ALP. If not the district of fiscal responsibility, forward the assessments and RUG category determination to the fiscally responsible district for prior authorization; or

  - Conduct its own assessment and based upon the findings of the assessment agree with the ALP's assessment and authorize payment for six months from date of admission. If not the district of fiscal responsibility, forward the assessments and RUG category determination to the fiscally responsible district for prior authorization; or

- Conduct its own assessment and based upon those findings disagree with the ALP's assessment. The district where the ALP is located must then forward both the district's and the ALP's assessment to the local professional director (LPD) or designee, for review and final determination of the appropriate payment.

  This determination must be made within 5 working days of the LPD's or designee's receipt of the request for review.

  If not the LDSS of fiscal responsibility, forward final determination with the assessments and RUG category determination to the fiscally responsible district for prior authorization.

Note: When the LDSS' and the ALP's assessment disagree, an agreement may be reached by sharing information or conducting a joint assessment.

The LDSS of fiscal responsibility makes the MA eligibility determination and provides the applicant with the Notice of Decision and Fair Hearing rights associated with the determination.

If the LDSS of fiscal responsibility makes an adverse decision regarding a recipient's access to ALP services, the LDSS of fiscal responsibility is responsible for notifying the recipient in writing and affording the recipient Fair Hearing rights.

Consequently, notice and Fair Hearing rights will only be afforded in the following two circumstances:

- When an ALP accepts an MA recipient for admission, the district's assessment disagrees with the ALP's assessment and the local professional director upholds the district's decision, the district must send a denial notice and afford the recipient fair hearing rights.

- When an ALP determines to reauthorize an ALP participant and the district disagrees with the ALP's assessment and the local professional director upholds the district's decision, the district must send a discontinuance notice and afford the recipient fair hearing and aid-continuing rights.

Prior Authorization

Prior authorization from the LDSS is required for the provision of the home care services portion of the ALP.

Formal notification of eligibility for ALP services from the district of fiscal responsibility is required prior to initiation of service delivery.

Reassessment/Reauthorization Procedures

The ALP must reassess the individual's appropriateness for the ALP *every six months from the date of the individual's admission to the ALP*.

If the individual's condition changes during the authorization or reauthorization period so that the RUG category also changes, a new assessment must be completed by the ALP and submitted to the district.

Qualification/Requirements of the ALP as a Personal Care Provider Agency

In order to be eligible to provide Medicaid-funded Personal Care Services in the Assisted Living Program, the ALP must be licensed or certified by the New York State Department of Health (NYSDOH) as a home care agency.

Additionally, the ALP must have either a NYSDOH approved Home Health Aide training plan or a NYSDOH approved Personal Care Aide training plan.

Section II - Record-Keeping Requirements

Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid recipients.

Providers must furnish information regarding any payment claimed to authorized officials upon request of the State Medicaid Program or the local department of social services.

For medical facilities subject to inspection and licensing requirements provided in Article 28 of the Public Health Law, the State Hospital Code contains specific details concerning content and maintenance of medical records.

Practitioners providing diagnostic and treatment services must keep medical records on each recipient. Records include:

- Recipient identification (name, sex, age, etc.);
- Conditions or reasons for which care is provided;
- Nature and extent of services provided;
- Type of services ordered or recommended for the recipient to be provided by another practitioner or facility;
- The dates of service provided and ordered.

The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program.

For auditing purposes, records on recipients must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant.

Basis of Payment

Payment for services provided to eligible MA recipients by the ALP is made through two funding mechanisms:

- The residential component is paid by the resident to the ALP at the SSI Congregate Care Level II rate established by the Department or at a private pay rate established by the ALP if the resident is ineligible for SSI.
- As stipulated in the model contract provided by the Department in the ALP Administrative Directive, the ALP may not charge more than the SSI Congregate

Care Level II rate for the residential component to a resident in receipt of MA funded home care services.

- The home care services component is paid through the district's prior authorization of the appropriate RUG category. This daily rate is equal to 50% of the amount that would be expended for an individual patient within the same RUG category in a residential health care facility located in the same district as the ALP.

Payment for home care services provided to a recipient in an ALP will be authorized by the LDSS. The rate codes and corresponding reimbursement rates to be used when prior authorizing MA home care services will be made available through the social services district.

No payment for MA funded home care services may be made to the ALP while the recipient is receiving residential health care facility services or inpatient hospital services.

MA payment will continue to be made to the ALP when an MA eligible resident is absent from the ALP for a 24 hour period or more in order to visit friends or relatives under the following conditions:

- The recipient has resided in the ALP for at least thirty (30) days;
- A statement is obtained from the recipient's physician approving of the absence;
- The ALP can assure that the recipient's health care needs can be met during his or her absence;
- The visit is limited to two (2) days duration for any single absence;
- The ALP will obtain prior authorization from the fiscally responsible district if the recipient's total days of absence exceed eighteen (18) days in a twelve (12) month period;
- While the recipient is absent from the ALP, the ALP is fiscally responsible for the provision of any home care services included in the MA home care services rate which are required by the recipient during his/her absence and which the family member or friend is unable or unwilling to provide.

The ALP must document all absences on forms provided by the Department.

Section III – Definitions

For the purpose of the Medicaid program and as used in this Manual, certain terms are defined as follows:

Assisted Living Program (ALP)

An entity established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator.

Certified Home Health Agency (CHHA)

A home care services agency which possesses a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law, or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the Public Health Law which is authorized under Article 36 to provide a Long Term Care Program.

Long Term Home Health Care Program (LTHHCP)

A coordinated plan of care and services provided at home to invalid, infirm, or disabled persons who are medically eligible for placement for an extended period of time in a hospital or residential health care facility (skilled nursing facility or health related facility).

The program shall be provided in the person's home, an adult care facility other than a shelter for adults, or in the home of a responsible relative or other responsible adult.

A LTHHCP is authorized by the Commissioner of the New York State Department of Health to provide long term home health care only.

The following institutional types and agencies can apply to become a LTHHCP:

- A certified home health agency; or
- A residential health care facility or hospital.

Adult Home

A home established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator.

Enriched Housing Program

An enriched housing program (EHP) is an entity established and operated for the purpose of providing long term residential care to five or more adults, primarily persons age sixty-five or older in community integrated settings resembling independent housing units.

The program provides or arranges for the provision of room, and provides board, housekeeping, personal care and supervision.

Licensed Home Care Services Agency (LHCSA)

A voluntary non-profit or proprietary home care agency licensed by the New York State Department of Health to provide directly or through contract, personal care, home health aide or nursing services.