Agenda

- Highlight key issues that are critical to the operation of the ALP
- Reference Dear Administrator letters and old directives, some of which are not available on the HCS
- Review changes not reflected in regulation
Prior Authorization by Local District

• Medicaid Redesign Team (MRT) recommendations eliminated requirement for Local Department of Social Services’ (LDSS) prior authorization for admitting residents

• LDSS may conduct reviews at its discretion regarding appropriateness, and is still responsible for notifying the ALP of any MA ineligibility or if it determines medical ineligibility.

• ALPs must notify the LDSS of admission/discharge, including discharge to a hospital, NH or any leave of absence, which may affect the status of an individual's MA coverage

  • See Dear Administrator: Clarification to ALP changes (ALP Q&As) September 13, 2012
ALP Conducting Assessment

• Also from MRT, ALPs can conduct assessments (UAS), both initial and periodic, either directly or through contract with a Certified Home Health Agency (CHHA) or Long Term Home Health Care Program (LTHHCP)
• Mechanism for ALP to be reimbursed for preadmission assessment still under CMS review
• Also, nothing prohibits use of a contracted; appropriately certified nurse to conduct assessment
• Regulations not yet updated. See:
  • Dear Administrator: Clarification to ALP changes (ALP Q&As) September 13, 2012
  • Changes to ALP as the Result of MRT Recommendations (Notice to Providers), June 7, 2012
45 Day Reassessment

- Legislation was passed eliminating requirement, however regulations were not updated

  - See: DAL: 00-14: Elimination of 45-day Reassessment, January 22, 2001
Uniform Assessment System (UAS) NY

- UAS replaces PRI as assessment tool (regulations are not updated to reflect this change)
- UAS provides both RUG score and Nursing Facility Level of Care (NFLOC) score
- Use RUG score cross walk, see *UAS-NY Implementation: Implications for ALP Billing, NYSDOH Presentation, March 6, 2013*
  - NFLOC score indicates program options
- All UAS training is online
- UAS is a lengthy assessment for applicant/resident
  - Training and assessment are significant time commitment
  - Consideration in conducting assessment directly or using subcontractor
- Review ALP UAS Question and Answer Document, April 11, 2014
- UAS-NY Support Desk: uasny@health.ny.gov or 518-408-1021
UAS

In the ALP, the UAS replaces:

• Hospital/Community Patient Review Instrument (PRI) Screen
• DSS-4449B Identifying Information
• DSS-4449D Nursing/Functional/Social Assessment
• *DSS-4449C The Medical Evaluation will be partially replaced by the UAS-NY. The physician’s section has been substantially shortened.
  – The revised Medical Evaluation and Physician Orders form (DSS-4449C) will be used to document any new diagnosis or medications not previously documented in the UAS-NY.
  – The physician must also certify that the UAS-NY was reviewed and accurately reflects the resident’s medical and mental health conditions.
  – During the six month ALP reassessment, the UAS-NY will be updated by the assessor and sent to the resident’s physician who will complete the Medical Evaluation and Physician Orders DSS-4449C form and sign the physician certification.
  – See DAL: 13-13: Revised ALP Medical Evaluation (DSS-4449C), June 18, 2013
UAS

• UAS is for Medicaid eligible people (including those who have applied for Medicaid)

• Non-Medicaid eligible people must sign DOH 5032 to have information submitted into system (UAS)

• If the person declines, use predecessor tool (PRI)
UAS NFLOC Score Below 5

- DOH acknowledges ALP residents sometimes score better once receiving the benefit and support of the program.
- However, low NFLOC score upon application indicates not appropriate for ALP
- Individuals seeking admission to the ALP, who have a NFLOC below 5, are not permitted to be served by ALP. These individuals should be counseled and directed to other appropriate home and community-based Medicaid long term care program options.
- **Note that the UAS is being reviewed to determine if changes need to be made to better reflect needs related to cognitive impairment.**
Existing Enrollees: Individuals currently enrolled in ALP, who have a NFLOC below 5, **may continue to be enrolled in ALP if:**

- there is a physician order, based on a physical examination that indicates appropriateness for continuation in the program.
- the individual has no home or residence to return to upon discharge from the ALP. **OR**
- in the absence of continued coverage under the ALP the person would reasonably be expected to meet the NFLOC requirement within the next six months. This determination would be based on the presence of the following criteria:
  - History of numerous hospitalizations and/or trips to the emergency room, and the ability of ALP to avert hospitalization and/or emergency room use through medical management.
  - Complex medical conditions and care management needs requiring continuous clinical oversight by the multidisciplinary team for the participant to remain medically stable.
  - Psychiatric diagnoses and behaviors requiring constant intervention by ALP. In the absence of support and services, the participant would not likely be able to complete activities of daily living and comply with medical regimen for chronic disease.
- See DAL: 15-08: ALP Eligibility and the UAS, June 18, 2015
Change in Contracting Requirements

Additional MRT changes not reflected in regulation:

- ALPs can contract with Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCP) and other qualified providers for services included in the ALP Medicaid capitated rate
- ALPs may contract with a number of qualified providers to ensure appropriate services to residents, not just a single CHHA/LTHHCP
  - NHs cannot provide the service using their staff, but can provide services through outpatient services
  - Can contract with outpatient therapy company
  - Can contract with multiple entities, as opposed to just one CHHA/LTHHCP
- See:
  - ALP Changes under NY State Medicaid Program GIS (Notice to Districts), June 7, 2012
  - Changes to ALP as the Result of MRT Recommendations (Notice to Providers), June 7, 2012
ALP Medical Evaluation

• The ALP Medical Evaluation is considered medical orders for service
• The evaluation must be signed by a physician
  – OMIG audit criteria
  – Less flexibility than other ACF/AL settings
• The Medical Evaluation and the UAS- NY are to be completed prior to admission as they are the evaluation/assessment tools utilized to determine ALP eligibility
Retention of People Who are Chairfast

Change in legislation, not reflected in regulation. If ALP wants to admit or retain residents who are chairfast:

• the ALP must be equipped and staffed to meet the needs of the resident;
• the resident’s physician must approve of the placement;
• the resident must have a stable medical condition; and,
• the resident must be able, with direction, to take action sufficient to assure self-preservation in an emergency.
• ALPs must inform DOH if planning to retain chairfast residents.
• Other retention standards remain; resident is ineligible if
  – in need of continual nursing or medical care;
  – chronically bedfast; or
  – cognitively, physically or medically impaired to such a degree that his or her safety would be endangered.
  – See: DAL: 14-07: Change in Legislation to Enable the Retention of People Who are Chairfast, Oct. 31, 2014
Role of Nurse

- Despite the fact that you must have a home care component for an ALP, the ALP LHCSA nurse does not provide skilled nursing services to ALP residents. The regulations point to the CHHA or LTHHCP for the provision of nursing and other skilled services.

- Q&A permits the LHCSA RN to provide short term skilled nursing services in an emergent situation when the CHHA nurse is unavailable. The services may be provided until the CHHA nurse is available, and the LHCSA RN must notify the CHHA. The CHHA must provided any needed follow up.
  - See ALP Question and Answer Document, January 19 2001
Medicare Maximization

• Services included in the ALP Medicaid rate are:
  – personal care services which are reimbursable under title XIX of the Federal Social Security Act;
  – home health aide services;
  – personal emergency response services;
  – nursing services;
  – physical therapy;
  – occupational therapy;
  – speech therapy;
  – medical supplies and equipment not requiring prior authorization; and
  – adult day health care in a program approved by the Commissioner of Health.

• Many of those services are provided by a CHHA, LTHHCP or other qualified provider
• Medicare is maximized for those services, when applicable
  – Implications for Medicaid-only ALP resident
  – Implications for some services not covered by Medicare (maintenance services)

  – See ALP Question and Answer Document, October, 4, 1994
DME and Supplies

• The ALP Medicaid payment covers the provision of medical supplies and equipment not requiring prior approval

• DME providers may only submit claims for a Medicaid eligible ALP participant for DME items requiring prior approval

• See Medicaid Update DME Clarification, March 2007

• Procedure codes that require prior approval are underlined in the DME fee schedule, available at http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Fee_Schedule_2006.pdf
DME and Supplies

- Confusion about what ALP is responsible for
  - Different terms contribute to confusion
  - The process for approval, authorization, etc. for DME and supplies can change, which impacts inclusion in the ALP rate
  - Confusion about what is considered DME and supplies; for ex. hearing aids

- Hearing aids and their repairs are *not* considered DME or medical supplies, and are not captured within the services paid for within the ALP Medicaid rate. They should be billed to the ALP participant’s individual Medicaid benefit.

- Hearing aid batteries (V5266) are an example of medical supplies that *are* included in the ALP’s rate.

- **ALP providers should consult DME fee schedule when there is a question**
  - See Medicaid Update. Vol. 31, Number 3, March 2015, article: *The Billing of Hearing Aids and Repairs for Assisted Living Program Participants*, pg. 9
Medicaid Percentage Commitment

• The ALP can serve private pay people, as well as Medicaid eligible people.

• DOH has required ALP applicants to identify the percentage of ALP beds you have that will be for Medicaid eligible residents. DOH expects you to maintain that commitment.
  – Failure to fulfill commitment can result in potential enforcement action, suspension or limitation of operating certificate, rescission of ALP approval

• Historically, DOH has indicated it would permit 18 months to meet Medicaid percentage commitment, however the Department may stipulate different timeframe (See ALP Question and Answer Document, October, 4, 1994)
Temporary Absence from the ALP: Medicaid

• No “Medicaid bed hold” in the ALP
• Provision for ALP to get paid by Medicaid during a short term absence while visiting friends and relatives, if certain conditions are met
• Note: ALP will not receive any Medicaid reimbursement for a resident who is away from the facility for more than two days. If the resident is absent for more than two days, the ALP will not receive reimbursement for any days of the absence.
Temporary Absence from the ALP: Medicaid

Medicaid reimbursement will only be made if the absence is no more than two days in duration and the following conditions are met:

• The recipient has resided in the ALP for at least 30 days
• The recipient’s physician has approved the absence in writing
• The ALP assures that the recipient’s health care needs will be met during the absence,
• The visit is limited to 2 days duration for any single absence,
• The ALP obtains prior authorization from the financially responsible social services district if the recipient total days of absence exceeds 18 days in a 12 month period (NOTE this was reduced to 10 days in a 12 month period; see GIS 10 OLTC/008, Nov. 9, 2010)
• The ALP is fiscally responsible for the provision of any home care services included in the MA rate which are required by the recipient during the absence which the family members or friends are unwilling to provide, and;
• The ALP documents all absences using Department form

— See ALP Question and Answer Document, April 25, 1996
Temporary Absence from the ALP: SSI

• Supplemental Security Income (SSI) Congregate Care Level 3 payment can continue when someone is temporarily institutionalized.

• If the resident has been in the facility at least one day in the month, SSA has a procedure to continue benefits when it is expected that the hospitalized individual will return to the facility within 3 months and payment is required to hold the bed.

• Physician must indicate the person is expected to return within 90 days.

  – See Social Security Administration POMS SI 00520.140 Temporary Institutionalization (TI) Benefits, October 21, 2013
Hospice and the ALP

• Medicaid eligible person cannot be in both Hospice and the ALP
• When a Medicaid resident in an ALP elects hospice services, the ALP must discharge the resident and designate the recipient’s bed as an AH or EHP bed
  – If not 100% ALP, you may designate another ACF beds as an ALP bed
  – If the ALP is full or does not have any AH or EHP beds, the resident’s bed may be temporarily designated as a non-ALP bed
• The hospice patient does not physically move to another room/bed
• The ALP must notify the district of fiscal responsibility of the recipient’s date of transfer from the ALP to a non-ALP bed
• Medicaid payment for ALP services ends on the date of the resident’s transfer to a non-ALP bed
• The resident will continue to make room and board payment to the adult care facility in accordance with the terms of the resident agreement
  – See 02 OMM/ADM-6: Hospice and the ALP, November 22, 2002
Flu Mask Regulation

- Home care component of ALP (LHCSA) must follow “flu mask regulation”
- Does *not* apply to ACF staff/ALP staff not under your home care agency
- Regulations require:
  - documentation of the influenza vaccination status of all personnel to which the regulations apply each year; and,
  - unvaccinated personnel must wear a surgical mask at all time while in areas where patients or residents may be present during periods that the Commissioner of Health determines that the influenza is prevalent

Federal Home and Community Based Settings Rule

- Federal rule applies to all home and community based services (HCBS) provided under a federal HCBS Medicaid waiver
- State has until March 2019 to come into compliance with rule
- When ALP transitions into managed care/managed long term care, rule will apply to ALP
- Various requirements including characteristics of setting, person centered planning, choice, access to greater community, access to food, access to visitors
- Under discussion in DOH ACF regulatory reform workgroup
  - How requirements will be applied
  - How CMS guidance will be incorporated
  - What settings the regulations apply to
Federal Home and Community Based Settings Rule

• Challenges:
  – Orientation towards younger, disabled population
  – ALP beds in a dementia unit
  – Heightened scrutiny
    • ALPs located in the same building as a nursing home
    • ALPs that otherwise isolate residents from the broader community

• CMS Page on Federal HCBS settings rule:

• New York State HCBS Settings Rule page:
Tools and Resources

- LeadingAge NY Assisted Living Program Reference Library (handout)
- New York State Department of Health Assisted Living page: [https://www.health.ny.gov/facilities/assisted_living/](https://www.health.ny.gov/facilities/assisted_living/)
- Current Dear Administrator letters and required reports available on Health Commerce System
Questions???

Contact:
Diane Darbyshire

ddarbyshire@leadingagency.org
Phone: 518-867-8828
www.leadingagency.org