April 26, 1994

Dear Interested Party:

Enclosed please find a copy of recently asked questions and answers concerning the Assisted Living Program (ALP). The list was developed from questions received from potential ALP operators and other interested parties.

We expect that more questions will arise as the program develops and is closer to implementation. Please continue to forward them to us. Questions related specifically to a Certified Home Health Agency, a Licensed Home Care Services Agency or a Long Term Care Home Health Program should be referred to the Department of Health's Bureau of Home Health Care Services at (518) 473-6473. Questions pertaining to Medical Assistance program requirements and billing should be referred to the Department's Division of Health and Long Term Care at (518) 473-5563 or 473-5569; general ALP questions should be referred to the Office of Housing and Adult Services at (518) 432-2991.

Sincerely,

/s/
Peter R. Brest
Associate Commissioner
Office of Housing and Adult Services

Attachment

4/26/94

Assisted Living Program (ALP)

The following compilation of questions and answers was developed in response to frequently asked questions about the ALP. The Department of Social Services (the Department) regulations cited in 18 NYCRR are from Adult Care Facility (ACF) regulations Parts 485 - 488, and 494 and Medical Assistance (MA) regulations Part 500. The Department of Health (DOH) regulations cited in 10 NYCRR are from Parts 765 - 767 and apply to Licensed Home Care Services Agencies (LHCSA) only. Questions related specifically to a Certified Home Health Agency (CHHA), a Licensed Home Care Services Agency (LHCSA) or a Long Term Care Home Health Program (LTCHHP) should be referred to the DOH's Bureau of Home Health Care Services at (518) 473-6473. Questions pertaining to MA program requirements and billing should be referred to the Departments Division of Health and Long Term Care (DHLTC) at (518) 473-5563 or 473-5569; general ALP questions should be referred to the Office of Housing and Adult Services (OHAS) at (518) 432-2991.

1. Q. Are there guidelines or models for the required contracts with CHHAs and LTHHCPs?

   A. There are no models for these contracts. The required services that must be provided to ALP residents by CHHA or LTHHCP employees are contained in Department regulations [18 NYCRR 494.3(b)]. ALP and CHHA operators should negotiate mutually acceptable rates for ALP services. Since a particular component of service provision need not be identified, it may not be necessary to use the type and unit of service now used for billing.

2. Q. When an ALP serves residents from contiguous counties will a contract be required with the local social services districts of each county?

   A. No. A contract is required only with the local social services district of the county in which the ALP is physically located.

3. Q. Are there guidelines or models for the required contract(s) with a nursing facility?

   A. There are no models for these contracts, but the operator must document that a written agreement has been entered with, at least, one nursing facility for the transfer of eligible individuals who are no longer appropriate for retention in the ALP.

4. Q. Will a contingently approved ALP operator be permitted to reduce the number of ALP beds contingently granted?

   A. Yes. The relinquished beds will return to the need pool.

5. Q. Will a contingently approved ALP operator be permitted to reduce the percent of individuals receiving public benefits to be served by the ALP as stated by the applicant in the application?

   A. No. Contingent approval of the application was based upon the applicant's statement that a specified percentage of ALP residents would be in receipt of public benefits. Any subsequent change will not be permitted because it would have affected the applicant's original ranking in the competitive batch.

6. Q. Will the Department develop forms for the reporting and tracking of ALP expenses?

   A. Department staff are revising the DSS-2963 Adult Home Annual Financial Report and the DSS 3061 Enriched Housing Annual Financial Report to accommodate the reporting of ALP financial data. Under the revised format, ALP related revenues and expenses will be reported separately from ACF revenues and expenses on the same form. ALP-only operators will also use these financial reporting forms. The new report forms will be available for the 1994 reporting year. Those ACF operators who will also be licensed as ALP providers should have their financial records organized now so that ALP related financial information can be identified separately from adult home or enriched housing program financial data.

7. Q. Is separate billing by the CHHA or LTHHCP for completion of the required resident assessments allowed?

   A. Reimbursement for nursing services, including completion of nursing assessments, is included in the MA home care services rate and, therefore, cannot be billed as a separate service by the CHHA or LTHHCP for ALP residents. A CHHA or LTHHCP, however, may bill MA for completion of the initial nursing assessment which takes place prior to the MA recipient becoming an ALP resident.

8. Q. When must an approved ALP meet the number or percent of residents who are privately paying or are in receipt of public benefits which was stated on the application?

   A. An ALP must meet the mix of private pay residents and those in receipt of public benefits, which was stated on the application, within 18 months of opening.

9. Q. Must a list of all ALP residents be maintained at the facility?

   A. Yes. The ALP must maintain a current roster of all ALP residents which identifies their payer status. This roster will serve to verify that the ALP is complying with its commitment to serve a specified number of public pay individuals.

10. Q. When will the capitated MA rate be paid?

    A. If no claim-filing errors are made by the ALP, payment on remittance statements will be made within 30 days of their receipt by Computer Science Corporation (CSC), the State's Medicaid fiscal intermediary.

11. Q. What billing forms, practices and procedures are required for MA payment?

    A. All of this information is contained in the MMIS ALP Provider's Manual. Approved ALP operators will be provided a copy by the Department prior to program implementation.

12. Q. Will an ALP receive Medicaid reimbursement for the period during which the MA recipient is hospitalized, is the resident of a nursing facility or a rehabilitation center?

    A. No. Reimbursement for Medicaid funded home care services will not be paid to an ALP for the period during which the recipient is an in-patient in a hospital, a nursing facility or rehabilitation center.

13. Q. Will an ALP receive Medicaid reimbursement when the MA recipient is temporarily absent from the facility?

    A. MA payments will continue to be made to the ALP when an MA eligible resident is absent from the ALP for a period not to exceed two days in order to visit friends or relatives under the following conditions:

    - 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 two (2) days duration for any single absence;
    - the ALP obtains prior authorization from the fiscally responsible social services district if the recipient's total days of absence exceeds 18 days in a 12 month period;
    - 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 on a form to be developed by the Department. A copy of the form must be maintained in the resident's record and included in transfer records. In addition to documenting absences, this form must be used to document the prior authorization of the social services district.

14. Q. If the income of an ALP resident is not sufficient to cover the costs of residing in an ALP but is too high to be eligible for Supplemental Security Income (SSI) or MA, will the resident be able to spend down to the MA level each month?

    A. It may be possible for the resident to become MA eligible with a spend down. In determining eligibility for a spend down, however, the local department of social services will compute a budget using the SSI level II benefit including the personal needs allowance and the amount disregarded by the Social Security Administration (SSA) as the basis for the non-medical portion of the costs.

15. Q. How long will a hospitalized recipient of SSI continue to receive Level II benefits?

    A. Receipt of SSI is governed by Federal standards and requirements and questions relating to an individual's case should be addressed to the nearest office of the SSA. Generally, SSI benefits are not interrupted when the recipient has been in the facility at least one day of the month. SSA has a procedure to continue benefits when it is expected that the hospitalized individual will return to the facility within three (3) months and payment is required to hold the bed. (ACF Informational Letter No. 28, December 19, 1988, more fully details the continuation of SSI benefits to temporarily institutionalized residents.)

16. Q. Will inspections by the Department and the DOH be conducted simultaneously?

    A. The Department and the DOH plan to conduct a joint pre-opening inspection. All other inspections, such as surveys and complaint investigations, will be coordinated but not necessarily jointly conducted.

17. Q. Will Department inspectors be given access to the home care agency's records and staff and DOH inspectors to non-home care agency records and staff?

    A. Yes. Inspectors for the Department and the DOH will have complete access to all staff, records, files and space of the adult home or enriched housing program and the home care agency whether inspections are conducted simultaneously or independently. Both departments are required to maintain the confidentiality of the information reviewed or obtained. Additionally, the local social services district, in accordance with the provisions of the ALP model contract, has access to the ALP's records.

18. Q. Is an operator able to designate different beds for ALP residents or must the beds remain the same?

    A. Specific beds need not be designated for ALP use only but the operator always must have available the number of beds designated on its certificate for ALP residents. Therefore, if an adult care facility is approved for 20 ALP beds but has only 18 ALP residents, there must be two more beds available for ALP residents. (The only exception to this is during a 12 month phase in schedule when the ALP capacity is gradually increasing from a lesser start-up capacity to full capacity.)

19. Q. How long must an ALP operator retain records?

    A. Records pertaining to an individual ALP resident must be kept for not less than six years after the death of the resident or termination of the admission agreement. All other records must be kept for seven years.

20. Q. In an ALP, what is the time period for written confirmation of a physician's medical order?

    A. For ALP residents, a physician's medical order, including one by telephone, must be signed by the physician within 14 days of the order.

21. Q. What requirements must an ALP operator meet for the confidentiality of HIV and AIDS-related information?

    A. An ALP operator must comply with 18 NYCRR Section 485.11(g)(1)-(15) assuring the confidentiality of HIV and AIDS-related information. The operator must also comply with 10 NYCRR Section 766.3(l)(2)(c)(iii) requiring assurances for the protection of confidentiality for those involved in reported exposures in the ALP's HIV policy/procedure.

22. Q. What requirements must an ALP operator meet for the protection of individuals from the transmission of infectious diseases, such as, HIV, tuberculosis and hepatitis?

    A. An ALP operator must comply with 10 NYCRR Sections 766.3(l)(1)(i)-(v) and (2)(i)-(iii) requiring that a program is implemented and enforced for the prevention of circumstances which could result in an employee or resident becoming exposed to significant risk body substances which could put them at significant risk of infection during the provision of services.

    ALP operators must enforce generally accepted practices of infection control and need to review all pertinent ACF Informational Letters distributed by the Department on HIV including # 34, August 30, 1989, Updated Information on HIV Infection and AIDS containing information on universal

precautions. Other Informational Letters for review pertaining to HIV include #14, June 26, 1986, Information on AIDS, # 7-92, August 3, 1992, Updated OSHA Instructions on Bloodborne Pathogens and # 5-93, May 26, 1993, Model Exposure Control Plan and OSHA Consultation Services.

23. Q. Will one set of Residents' Rights for ALP residents be developed that meet the requirements of both the Department and the DOH?

A. Below is a revised list of Residents' Rights that will apply in an ALP. This list meets the requirements of both Departments.

(1) Each operator must adopt a statement of the rights and responsibilities of residents, and must treat each resident in accord with the principles contained in the statement.

(2) A copy of the statement of rights issued by the department must be provided to each resident.

(3) A copy of the statement of rights issued by the department must be posted in a conspicuous location in a public area of the facility.

(4) At a minimum, the operator must afford each resident the following rights and protections:

(i) to receive courteous, fair and respectful care and treatment, and not be physically, mentally or emotionally abused or neglected in any manner;

(ii) to exercise his or her civil rights and religious liberties, and to make personal decisions, including the choice of physician, and to have the assistance and encouragement of the operator in exercising these rights and liberties;

(iii) to have private written and verbal communications or visits with anyone of his or her choice, or to deny or end such communications or visits;

(iv) to send and receive mail or any correspondence unopened and without interception or interference;

(v) to present grievances and complaints including those related to care and services and recommend changes in policies and services on his/her behalf, or the behalf of other residents, to the administrator, facility staff, the Department of Social Services, the Department of Health, other government officials or any other parties without fear of interference, coercion, discrimination or reprisal. This extends to the resident's designee, as well. If not satisfied with the results of the complaint investigation,

the resident or his/her designee shall have the right to appeal the outcome to the Department of Social Services or the Department of Health, as appropriate.

(vi) to join other residents or individuals inside or outside the facility to work for improvement in resident care;

(vii) to confidential treatment of personal, social financial and health records;

(viii) to have privacy in treatment and in caring for personal needs;

(ix) to receive a written statement (admission agreement) of the services regularly provided by the facility operator, those additional services which will be provided if the resident needs or asks for them and the charges (if any) for these additional services;

(x) to manage his or her own financial affairs;

(xi) to not be coerced or required to perform the work of staff members or contractual work; and if the resident works, to receive fair compensation from the operator of the facility;

(xii) to have security for any personal possessions if stored by the operator;

(xiii) to have recorded on the facility's accident or incident report the resident's version of the events leading up to the accident or incident; and

(xiv) to object if the operator terminates the admission agreement against the resident's will.

(xv) to refuse treatment after being fully informed of and understanding the consequences of such actions, unless such refusal causes, or is likely to cause, in the judgment of a physician, life threatening danger to the resident or others.

24. Q. What information or forms must be sent when a resident is being transferred to a hospital?

A. ALPs must retain in the resident's record and send to the hospital all information the emergency room or admitting staff need to know about the resident. In adult homes and enriched housing programs this is contained, for the most part, on the Personal Data Sheet (DSS 2949) and the Medical Evaluation (DSS 3122). The operator must assure that hospitals receive this same

information when ALP residents are transferred. This can be accomplished by sending copies of pertinent sections of the ALP Assessment Form including the Identifying Information (DSS 4449 B), the Medical Evaluation (DSS 4449 C 1-4) and the Nursing/Functional/Social Assessment (DSS 4449 D 1-3). An operator may also develop his or her own transfer form and submit it to the Department's Regional Office for approval.

25. Q. What grievance and complaint procedure must an ALP operator follow?

A. An ALP operator must develop and institute a resident complaint system based on 10 NYCRR Section 766.1(j)(1)-(3). It must include:

(1) documentation of receipt, investigation and resolution of any complaint, including the maintenance of a complaint log indicating the dates of receipt and resolution of all complaints received;

(2) review of each complaint with a written response to all written complaints and to oral complaints, if requested by the individuals making the oral complaint, explaining the complaint investigation findings and the decisions rendered to date by the agency within 15 days of receipt of such complaint; and

(3) an appeals process with review by a member or committee of the governing authority within 30 days of receipt of the appeal.

26. Q. What standards for clinical supervision of direct care staff, i.e., home health and personal care aides, must an ALP operator follow?

A. An ALP operator must follow the standards of clinical supervision found in 10 NYCRR Section 767.5(a)-(d) for all staff providing health care services, including all personal care.

27. Q. What standards for employee orientation must an ALP operator follow?

A. An ALP operator must follow the standards for orientation found in 18 NYCRR Section 487.9 (a)(3) and (5), 488.9(a)(2) and 10 NYCRR Section 766.3(i) and (l)(1)(iii) for all employees. This will assure that employees receive orientation to:

- o the characteristics and needs of the population;
- o discussion of the residents' rights and the facility's rules and regulations for residents;
- o discussion of the duties and responsibilities of all staff;
- o discussion of the general duties and responsibilities of the individual(s) being trained;

- o discussion relative to the specific duties and tasks to be performed;
- o training in emergency procedures;
- o the policies and procedures of the the home care services agency operation;
- o the use of protective equipment;
- o preventive practices; and
- o circumstances which represent a significant risk for all employees whose job-related tasks involve, or may involve, exposure to significant risk body substances.

28. Q. What standards for in-service training must an ALP operator follow?

A. All direct care ALP employees must participate in twelve (12) hours of in-service training per year. The DOH standards in 10 NYCRR 766.3(i)(1) and (1)(iii) and the Department standards in 18 NYCRR 487.9(a)(4) and (5) and 487.9(g)(4) for adult homes pertain. Pursuant to 10 NYCRR, training topics must include: the use of protective equipment, preventive practices and circumstances which represent a significant risk for all employees whose job-related tasks involve, or may involve, exposure to significant risk body substances.

29. Q. What standards must an ALP operator follow for employee health status?

A. Both 18 NYCRR 487.9(a)(8), 488.9(a)(5) and 10 NYCRR 766.3(i)(1)-(2) for employee health status require documentation that the employee is free from any health impairment that is of potential risk to the resident or may interfere with the performance of the employee's duties.

Additionally, in accordance with the DOH requirements, any ALP employee who provides direct patient contact, must demonstrate rubella immunization. For those employees, a record shall be maintained of immunization to rubella, consistent with good medical practice, except that women of childbearing age shall have a screening test approved by the DOH to be followed by immunization as appropriate.

All ALP employees must have a ppd (Mantoux) test within 30 days prior to employment and no less frequently than every two years after employment begins, unless waived by the Department based on a physician's statement that the test is contraindicated.

30. Q. Do ALP employees need to wear any identification?

A. ALP direct care staff must display proper and current identification which must at least include their name and title.

31. Q. Does a minimum number of staff, including night staff, need to be on duty in an ALP?

    A. The minimum number of staff on duty is determined by the needs of the residents. Minimum numbers of night staff on duty must be able to safely and adequately meet the needs of the residents and must also meet the requirements in 18 NYCRR 487.9(f)(6) if the ALP is located in an adult home. The assignment of more staff on duty is determined by the needs of the residents. Additionally, the facility's emergency and disaster plan must consider these needs, the number of staff on duty and the location of ALP beds in the facility in the event of an emergency evacuation.

    Section 767.5(a)(b)(c) of 10 NYCRR requires that the ALP operator ensures that for health care services sufficient numbers of appropriately trained and oriented supervisory staff are available, i.e., able to be reached by phone.

32. Q. What standards for emergency and disaster planning must an ALP operator follow?

    A. An ALP operator must follow the standards contained in 18 NYCRR 487.12 and 488.12. Operators of already certified ACFs must review their existing emergency and disaster plans and update, as necessary, to assure that they provide for the needs of all residents in all circumstances.