NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 13, 2012

Dear Administrator:

The purpose of this letter is to further clarify the June 7, 2012 Dear Administrator Letter (DAL) which addressed recent changes to the Assisted Living Program (ALP) effective April 1, 2012.

Attached is a question and answer (Q & A) document in response to the frequently asked questions which have been posed regarding these changes to the ALP.

Questions related to the attached document should be addressed to the New York State Department of Health, Division of Long Term Care at ALPapplication@health.state.ny.us

Sincerely,

Mark Kissinger
Director, Division of Long Term Care
Office of Health Insurance Programs

Attachment

**Assisted Living Program Changes Questions & Answers:**

**1)** Q: Will counties be doing prior authorization?
A: No. As indicated in GIS 12 MA/017, the Local Department of Social Services' (LDSS) prior authorization (PA) is no longer required. Assisted Living Programs (ALPs) will notify the LDSS of new enrollments and the LDSS may conduct reviews at its discretion to assure that an individual is both Medicaid (MA) eligible and appropriately placed in the ALP. The LDSS is still responsible for notifying the ALP of any MA ineligibility or if it determines medical ineligibility.

**2)** Q: Is there a transition period or effective date for the ALP changes to stop prior authorization? Do rates have to be established and billing procedures need to be in place before the LDSS stops completing Prior Authorizations (PA) for the ALP services?
A: No, there is no transition period; the changes are effective immediately.

**3)** Q: Does the LDSS still have to authorize payment and complete the Principal Provider System (PPS) entry since there is no longer prior authorization?
A: Yes, the LDSS is still responsible for authorizing payment and completing the PPS entry. The ALP will continue to bill the same as in the past, in every way, *except* the need for the LDSS to prior authorize the ALP has been eliminated. There are no other changes to the billing.

**4)** Q: What if a particular ALP and county choose to prior review cases or not change the way paper work is submitted and reviewed? Should ALPs continue with the old process if their LDSS has still not changed their system?
A: As indicated in GIS 12 MA/017, the LDSS may conduct reviews at its discretion to assure an individual is both Medicaid eligible and appropriately placed in the ALP. The ALPs are now able to conduct assessments and the need for a LDSS PA has been eliminated. The county prior authorization authority was removed with the change in the state law.

**5)** Q: Will ALP programs have to routinely submit to the LDSS the names of clients admitted to/discharged from ALP services, including when a resident is discharged to a hospital, nursing home or has a temporary stays out of the facility?
A: As indicated in the GIS, ALPs will notify the LDSS of new ALP enrollments. The ALP is still obligated to notify the LDSS of any ALP admission/discharge, including discharge to a hospital, NH or any leave of absence, which may affect the status of an individual's MA coverage.

**6)** Q: Can ALPs now conduct assessments using the Patient Review Instrument (PRI)? What if the ALP does not have the staff trained for that?
A: Yes, ALPs are now able to conduct assessments (both initial and periodic) either directly or through contract with a CHHA or LTHHCP. Any RN completing the PRI must be PRI certified.

**7)** Q: Do the counties still have to provide letters of support for new facilities requesting to become ALPS and is the LDSS still required to contract with ALPS?
A: At this time, there are no changes regarding contracts. State law continues to require that an ALP application include, among other documents, a proposed contract with the LDSS Their policy is currently under review.

**8)** Q: How will the ALPs bill without a prior authorization number? Will the State issue a PA? Should anything be entered into the PA number section? Are there new forms or a contact to call if ALPs have a problem with billing?
A: No, the State will not issue a PA number. The ALP will continue to bill the same as in the past in every way except the need for a PA Number is eliminated. The contact for billing issues also remains

the Computer Sciences Corporation (CSC) as indicated in the ALP provider manual. In terms of MA claims, ALPs are advised that a PA number should not be included on the claim form; if a PA number is included on a claim form, an edit will occur that will prevent MA payment.

**9)** Q: Is there a standard form that the ALPs use to notify the LDSS that an individual has been/will be admitted to their ALP?
A: No, there is no standard form but the ALP remains responsible to notify the LDSS.

**10)** Q: Concerning the audit/reviews, if the LDSS finds the person no longer medically appropriate, the LDSS has to advise the ALP. What criteria should be used and what level of experience should the reviewer have? Is the determination reviewable in an Administrative Hearing?
A: The LDSS's prior authorization has been eliminated, but the criteria for Medicaid eligibility and medical appropriateness remains the same, along with Fair Hearing rights. In particular, the LDSS must send the Medicaid recipient a timely and adequate notice with the right to request a fair hearing with aid-continuing if the LDSS determines that an ALP participant is not eligible for the ALP.

**11)** Q: If the LDSS, at their discretion, conducts post ALP admission reviews/audits, is the reviewer required to be a RN?
A: No, criteria for a reviewer remain the same.

**12)** Q: What does the post admission audit consist of? Is there a special tool to use? Is there a minimum number of audits that need to be completed?
A: No, there is no special tool, nor minimum number of audits. As indicated in GIS 12 MA/017, any post admission audit/review is at the discretion of the LDSS.

**13)** Q: If we do not agree with the assessment, do we just call the toll free number or do we ask that the assessment be redone?
A: As indicated in GIS 12 MA/017, the LDSS is responsible for notifying the ALP of individuals they determine to be medically ineligible or no longer appropriate. The ALP is at financial risk for these individuals. The LDSS should try to resolve concerns with the ALP prior to contacting the OMIG regarding potential misuse of MA funds. As noted above in the response to question #10, the ALP participant is entitled to timely and adequate notice from the LDSS with the right to request a fair hearing with aid-continuing if the LDSS determines that the ALP participant in not eligible for the ALP.

**14)** Q: Has DOH issued a procedure for the ALPs to notify the LDSS of new admissions or does the LDSS decide what information is needed and how the ALP should notify the LDSS?
A: No, DOH has not issued a procedure for the ALPs to notify the LDSS. The LDSS may be notified of any ALP admission/discharge in much the same way as prior to the removal of the PA requirement.

**15)** Q: If the LDSS decides not to do post admission audits/reviews, does DOH do any kind of audit?
A: As indicated in the GIS, the LDSS may conduct reviews at its discretion to assure an individual is both Medicaid eligible and appropriately placed in the ALP. At this time, DOH is conducting post admission audits/reviews, however DOH retained the authority to do reviews at any time.

**16)** Q: If an ALP is part of a facility that also offers RHCF services, can a nurse from the RHCF complete the PRI for the ALP?
A: ALPs are able to conduct assessments directly or through contract with a CHHA, LTHHCP or other qualified providers. As indicated previously, any RN completing the PRI must be PRI certified.

**17)** Q: If the LDSS decides to audit cases and finds that a client is medically ineligible, should the LDSS refer its findings to SDOH or the OMIG?
A: The findings should be referred to the OMIG.

**18)** Q: If the ALP is no longer required to submit assessments to the LDSS, is the LDSS responsible for notifying the ALP of Medicaid ineligibility past admission?

A: Yes, as indicated in GIS 12 MA/017, subsequent to the LDSS post admission reviews/audits, the LDSS is responsible for notifying the ALP of any Medicaid ineligibility or if an individual is not medically appropriate.

**19)** Q: Will the paperwork requirements for new enrollees remain the same?
A: The prior authorization requirement by the district has been eliminated, but the assessment requirements of appropriateness for participation in the ALP have not changed.

**20)** Q: If a Medicaid client identification number (CIN) is not yet available (due to a pending status), will the name, date of birth and Social Security number be acceptable for the entry?
A: An individual must be approved eligible and have an *active* Medicaid CIN, NOT pending status, to be entered in the PPS in order for a provider to bill Medicaid.

**21)** Q: What is the process by which the ALP should notify the LDSS of an ALP admission and is there a time frame? Will the LDSS notify the ALP when an individual is entered in the PPS and what information will the LDSS require for a new resident admitted to the ALP in order to enter the resident into the PPS?
A: This process can be worked out between the ALP & LDSS and can be the same as prior to the recent changes. The ALP will continue to bill the same as in the past in every way except the need for PA is eliminated. There are no other changes.

**22)** Q: Should the ALP notify the LDSS of a person's RUG score, for LDSS records?
A: No, the ALP is not responsible for notifying the LDSS of RUG scores

**23)** Q: Does the ALP notify the State of the RUG score and any changes when the ALP bills or is there an additional notification process/requirement. Is eMedNY the portal for billing?
A: No, the ALP does not notify the State. The ALP will continue to bill the same as in the past in every way except the need for PA is eliminated. There are no other changes.

**24)** Q: In the past, ALPs have had problems with payment when the code has been changed by hospitals or nursing homes, and have asked the LDSS to resolve this problem. Is this still the process?
A: This is NOT the process. Changes to the PPS are made by the LDSS, not by any other entity.

**25)** Q: Will Medicaid spend downs still be handled by LDSS or will the system be able to identify spend downs? Will the ALP continue to work with the LDSS to resolve other financial issues?
A: Yes, the LDSS still handles MA spend downs and the ALP will continue to bill the same as in the past in every way *except* the need for the LDSS prior authorization has been eliminated. The ALP continues to be responsible to coordinate with the LDSS regarding MA eligibility criteria, both financial and medical.

**26)** Q: Will conflicts with "county of origin" for district of fiscal responsibility still be handled by LDSS or will the system automatically indentify the appropriate county?
A: County of origin and district of fiscal responsibility will still be handled by the LDSS.

**27)** Q: We understand the paperwork that is required by regulation every six months, or when there is a change in RUG score, must continue to be completed. We previously recertified the prior approval with LDSS. Do we have to notify LDSS or the State every six months or annually? Or would an ALP only notify LDSS or the State when an ALP resident is discharged?
A: The ALP is still obligated to notify the LDSS of any ALP admission/discharge, including discharge to a hospital, leave of absence or any leave which may affect the status of an individual's MA coverage.

**28)** Q: We request that the State consider providing training to give guidance to ALPs and LDSS, and to share questions and concerns.
A: Training will be considered in the future, once staff resources are identified.