NEW YORK STATE OF OPPORTUNITY. Department of Health

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Governor

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Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

March 15, 2022

DAL: #22-14
Subject: Reminder of Assisted Living Program Provider Responsibilities

Dear Administrator:

This correspondence is provided as a reminder for Administrators and Operators of Assisted Living Programs (ALPs) of specific compliance requirements as ALP providers. As there have been no policy changes, previous guidance remains in effect and ALP Administrators and Adult Care Facility Operators must continue to ensure compliance with all applicable rules, regulations, and participation requirements to which they are subject based on the facility's licensure and certification as well as the Medicaid provider conditions of participation. Please be reminded that policy updates are widely broadcast via the Health Commerce System and/or published in the Medicaid Update.

ALPs may bill only for services provided.

ALPs submit a fee-for-service claim to the Medicaid program and as such, claims are expected only when services are rendered to an eligible Medicaid-enrolled ALP participant with all record requirements met. Payments for ALP services must not be made when a participant is absent from the ALP or hospitalized. [Social Security Act §1902(a)(27); 18 NYCRR §§504.3(e) and 505.35(h)(7)].

The Medicaid billing system prevents payment of claims by both a hospital for an inpatient claim and the ALP for services rendered to the same Medicaid participant on the same calendar day. For clarification purposes:

- If no ALP services were provided to a qualified participant on a calendar day, then no Medicaid claim may be submitted by the ALP.

- If ALP services were provided to a qualified ALP participant on the same calendar day that the participant is transferred – but not admitted - to a hospital, then a Medicaid claim may be submitted by the ALP.

Please be reminded that, pursuant to previously provided guidance dated September 13, 2012, the ALP is obligated to notify the local department of social services of any participant leave that may affect the status of an ALP participant's Medicaid eligibility. Further, for the ALP to bill Medicaid, an ALP participant may only be out of the ALP for a total of ten (10) days per year, and not for more than two (2) consecutive days.

ALPs must maintain required documentation.

ALPs are required to maintain records to document the extent of services provided to Medicaid participants and that those services are performed by trained, qualified staff. [Social Security Act §1902(a)(27); 18 NYCRR §§494.6, 504.3, and 505.14.]

The clinical record must include the following at minimum: the Aide Supervisory Report, Aide Task Sheets, Plan of Care, Assisted Living Program Medical Evaluation, Assisted Living Program Interim Assessment, and case management notes. Documentation of a change would be made to one or more of the documents, depending on the nature of the change. Where the notation of a change, irrespective of its significance, is made in the clinical record should depend on the nature of the change with the understanding that it must be documented in one or more parts of the clinical record as necessary to ensure that all appropriate staff are accurately informed what steps must be taken to carry out orders and/or meet the resident's needs.

- Please be advised that often there are changes that need to be made to the Plan of Care that do not rise to the level of a significant change in condition or there is no change at all based on the post-assessment by the ALP nurse. Documentation is made in parts of the record appropriate to assure staff's ability to carry out the instructions.

ALPs must conduct timely and valid assessments, including nursing and social assessments.

ALP services must be provided in accordance with a completed Medical Evaluation and care plan based on an initial assessment of the participants' overall needs including those that are nursing, social, and functional in nature. This assessment must be completed within 30 days prior to initial admission, every six (6) months thereafter, and when requested by the participant's physician or when there is a change in condition.

A participant's simply having been sent to the hospital does not necessarily indicate a new UAS-NY assessment is required upon the participant's return to the ALP. There may be instances when an ALP participant is sent to the hospital, then held in observation status or admitted and returned to the ALP with no significant change in condition noted. In these instances, the ALP nurse will conduct and document an assessment to determine whether there is a change in condition and, if ultimately the assessment determines there is indeed no significant change in condition, then a new UAS-NY is not required. The ALP must, at minimum, document that some type of assessment was performed to evaluate whether a UAS-NY assessment is needed or if the care plan needs revision. To support completion of an assessment that results in no needed modifications, it is recommended that the assessment be documented in the case management notes and referenced by a brief care plan entry.

ALPs must ensure that assessments are completed, either directly or via contract, before beginning or continuing services for which payment will be made. [Reference: New York Social Services Law §461-l(2)(d)(iii); 18 NYCRR §§505.35(h) and 494.4(c), 494.4(h); and New York Department of Health Dear Administrator Letter 14-10: Revised ALP Medical Evaluation.]

ALPs may only provide services under a valid care plan.

For each ALP participant, the ALP must develop an Individualized Service Plan (ISP) and ensure that the participant's services are provided in accordance with the plan of care (commonly referred to as a "care plan"). [New York State Plan Amendment #09-0023-B; 18 NYCRR §§505.35(d) and 494.4(c)]

The care plan is established for each participant based on a professional assessment via the UAS-NY form prepared by the ALP nurse and ordered by the participant's physician or

equivalent. The UAS-NY helps catalogue the participant's pertinent diagnosis, prognosis, need for palliative care, mental status, frequency of each service to be provided, medications, treatments, diet regimen, functional limitations, and rehabilitation potential. The care plan is prepared by the ALP nurse in concert with the UAS-NY and in accordance with the evaluations of the nurse and the physicians or appropriate ordering equivalents.

ALPs must maintain appropriate policies and procedures.

ALPs must maintain written policies and procedures associated with conducting a UAS-NY Community Health Assessment and routinely review those policies and procedures with staff to ensure compliance with all applicable governing laws, regulations, and policies. Questions concerning the UAS-NY should be directed to the UAS-NY Support Desk at (518) 408-1021 or via email at uasny@health.ny.gov.

If you have any questions regarding this correspondence, please note the following contacts:

ALP Licensure:	acfcon@health.ny.gov
ALP Policy:	acfinfo@health.ny.gov
Home Care Policy, Licensure:	homecare@health.ny.gov
ALP Payment:	medicaid@health.ny.gov
ALP Home and Community Based Services Final Rule:	acfhcbs@health.ny.gov
UAS-NY Support Desk:	uasny@health.ny.gov

Sincerely,

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