



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF AGING AND COMMUNITY SERVICES
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Commissioner

DATE: February 11, 2011

NUMBER: 2011-4, VII-2

TYPE: Policy Memorandum

SUPERSEDES: 2004-5, VIII-1,
Provider Manual

SUBJECT: Disclosure of Assisted Living
Facilities' Medicaid Policies

DISTRIBUTION CODE: IX a, c, d,
e, f, g, i

EFFECTIVE: Immediately

APPLICABILITY: Assisted Living Facilities

BACKGROUND: This policy was originally issued in August 2004 to address the many problems that occurred because of the inconsistent application of Assisted Living Medicaid policies. Consumers had expressed confusion and frustration with their lack of understanding of the different responses they received from various Assisted Living providers. At that time, in the interest of helping facilities clarify their policies regarding the Medicaid Waiver, the Health Care Association of New Jersey, the New Jersey Association of Homes and Services for the Aging (renamed LeadingAge New Jersey), and the Division of Aging and Community Services in the Department of Health and Senior Services met and agreed upon the policy.

PURPOSE: The Department of Health and Senior Services has decided to reissue this policy with minor clarifications, clearer instructions, and updates to approved Medicaid Waiver processes. The intent is to reinforce the implementation of this policy in a consistent and effective manner statewide.

POLICY: Each facility remains responsible for creating a Medicaid full-disclosure handout to be included in the information package given to prospective residents during the marketing phase. In addition, this handout must be given to all current residents of its facility. The Department has identified the topics that must be addressed in all Medicaid Disclosures and has also created a standard 'Eligibility Criteria Sheet' to be attached to every Medicaid Disclosure distributed. Each facility will create the handout according to its own policies and protocols.

As facilities modify their Medicaid Disclosure handouts now and in the future, they must fax a copy of the handout to the Division of Aging and Community Services at 609-943-4981.

JUSTIFICATION:

Centers for Medicare and Medicaid Services

Global Options for Long Term Care (GO) is the 1915 (c) HCBS Medicaid Waiver, approved by the federal Centers for Medicare and Medicaid Services (CMS), and operated by the New Jersey Department of Health and Senior Services. One of the waiver services covered by GO is assisted living. Assuring quality standards and the health and welfare of participants are fundamental statutory and regulatory requirements for the administration of a Medicaid Waiver program. As part of the CMS review criteria for a Waiver, a State must identify safeguards regarding participant access and eligibility. These safeguards must include "full disclosure to participants and assuring that participants are supported in exercising their right to free choice of providers." "In order to effectively exercise this right, participants should have ready access to accessible information about the qualified waiver providers that are available to furnish the services..."

NJ Medicaid Approved Providers

The Provider Agreement between the NJ Division of Medical Assistance and Health Services and the approved Medicaid Provider states that the provider agrees to comply with all applicable State and Federal laws, policies, rules, and regulations promulgated pursuant thereto.

NJ Standards for Licensure for Assisted Living - NJAC 8:36

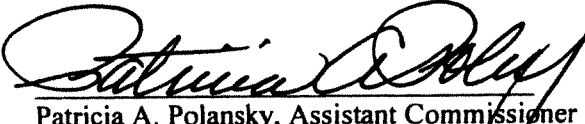
Per 8:36-6.2 Financial arrangements and full disclosure:

- (a) The facility shall disclose in the admission agreement the service it will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the residence..." and
- (b) Concerning financial arrangements, the facility shall:
 - 5. Provide the resident with information about obtaining financial assistance available from third-party payors and/or other payors and referral systems for resident financial assistance.

Per 8:36-5.1 Types of services provided to residents:

- (h) In accordance with N.J.S.A. 26:2H-12.16 et seq., a new assisted living residence or comprehensive personal care home licensed on or after September 1, 2001, shall attain a level of occupancy by Medicaid-eligible persons of at least 10 percent of its total bed complement within three years of licensure and shall maintain this level of Medicaid occupancy thereafter.

At this time, there is not one standard Medicaid Disclosure Handout to be utilized by all assisted living facilities statewide. All facilities, however, are required to and responsible for creating a Disclosure that encompasses all of the components included in the attached guidance.



Patricia A. Polansky, Assistant Commissioner
Division of Aging and Community Services

MEDICAID DISCLOSURE HANDOUT TOPICS

THE FOLLOWING TOPICS AND CONSIDERATIONS MUST BE INCLUDED TO ENSURE FULL DISCLOSURE:

Medicaid Waiver Eligibility Criteria

- The Department of Health and Senior Services' has developed a standard **Eligibility Criteria Information Sheet** that is to be attached directly to every assisted living facility's Medicaid Disclosure Policy Handout.
- In general, the Medicaid Disclosure should acknowledge that participation in the Global Options for Long-Term Care (GO) Medicaid Waiver is not guaranteed for all applicants. Applicants must meet all eligibility requirements and enrollment criteria.
- A GO applicant, within the target population, must be determined to be both financially and clinically eligible. Spending down to the income and resource limit for Medicaid does not in and of itself guarantee eligibility for the Global Options for Long-Term Care (GO) Medicaid Waiver.
- Applicants must also be determined to meet the Nursing Facility Level of Care in NJ. Including this topic in the Medicaid Disclosure will open the door for conversation with the prospective/current resident and their family about what they will do if the applicant is found ineligible for Medicaid.
 - Enrollment on the GO Medicaid Waiver is not retroactive.
 - Clinical eligibility is not assumed, determined retrospectively, or back-dated to coincide with a financial eligibility or a facility admission date.
- Moreover, the Medicaid Disclosure can acknowledge that both financial and clinical eligibility are re-evaluated at least annually once program enrollment is established. If at any time, a participant is no longer eligible, he or she will be disenrolled from the GO Medicaid Waiver program. If GO Medicaid Waiver program disenrollment occurs, what are the expectations of the Assisted Living (AL) provider?

Responsibilities of all parties when spend down occurs

- Who is responsible for tracking the resident's spend down?
 - Is the individual, or a specific family member/representative, responsible for notifying a designee of the assisted living when he or she is within 3-6 months of spend down?
- At what point will the Assisted Living facility verify that the resident is aware of his or her need to contact the County Welfare Agency to apply for a Medicaid financial eligibility determination?
- Upon what notification (and from whom) will the Assisted Living facility then exercise its responsibility to complete and fax the AL/AFC Referral Form to the Office of Community Choice Options (OCCO) to request a clinical eligibility determination?
 - The processing of the AL/AFC Referral alone does not constitute enrollment on the GO Medicaid Waiver nor does it guarantee residency for the applicant at the referring AL/AFC facility. It does, however, aid in a more timely application process and notify the Medicaid applicant if, in fact, he or she meets the established eligibility criteria.

Accepting the individual on the Waiver

- Does the Assisted Living expect a resident to pay privately for a certain number of years before accepting him or her on the GO Medicaid Waiver? If so, how many years?
- Will the Assisted Living facility accept the resident as a Medicaid beneficiary as soon as he or she is approved for the Waiver? If not, at what point does the Assisted Living facility notify the resident? Not accepting the resident as a Medicaid beneficiary as soon as he or she is approved for the Waiver limits him or her from accessing Medicaid as their health insurer. Applicants can not enroll in the Medicaid Waiver until they are residing in an Assisted Living facility that agrees to accept them as Medicaid beneficiaries.
- GO participants, are only enrolled in the Waiver if they are within the target population, when both **financial** and **clinical** eligibility have been established, and when the participant has been admitted to/accepted by the Medicaid provider Assisted Living/Adult Family Care.

Direct admission of Waiver participants from the community

- Does the Assisted Living reserve Medicaid beds only for those who have paid privately first? Again, after what period of time?
- Does the Assisted Living admit residents directly from the community who are applying for the GO Medicaid Waiver or those already enrolled on the GO Medicaid Waiver program?

Waiver participants in dementia units

- Will the Assisted Living accept Medicaid reimbursement for residents who are located in a specialized Alzheimer's or Dementia Unit?
- Medicaid reimbursement is payment in full and services can not be supplemented by third parties for advanced level of care needs.

Internal wait lists

- It is the Department of Health and Senior Services conclusion that if the assisted living facility has not yet attained 'a level of occupancy by Medicaid-eligible persons of at least 10 percent of its total bed complement' as stipulated in accordance with N.J.S.A. 26:2H-12.16 et seq., and per 8:36-5.1(h), when a resident(s) is considered 'Medicaid-eligible' that person(s), if applicable, would not be subject to remain on an assisted living facility's internal wait list for Medicaid enrollment. An internal wait list would go into effect once the mandated Medicaid complement is met.
- Has the Assisted Living facility determined the certain number of Medicaid beneficiaries that it can accept at any one time? If so, if someone is approved for the Waiver, and the facility is at its target number, how is that situation handled? Again, not accepting the person on the Waiver is in effect denying the person insurance coverage for all other expenses that Medicaid would customarily pay. Since the person is financially eligible for Medicaid they have limited income and resources leaving them unable to pay privately until you have a Medicaid vacancy.
- What are the expectations regarding payment during this time? Who will pay the Assisted Living facility? How?
- What if there is no one available or with the means to pay? Will the person be discharged?
- Is there a maximum amount of time that someone could be on an Internal Wait List?
- Explain how a person is placed on your Internal Wait List. If placement is on a case by case basis, this must be stated.

Financial requirements from the time resident spends down/applies for Medicaid until the time he or she is enrolled in the Waiver

- Medicaid is NOT responsible for paying for assisted living services (reimbursing an assisted living facility) for any services rendered before the applicant was enrolled on the GO Medicaid Waiver.
 - The facility must be very clear, and residents/families must be made aware, about who is responsible for paying for services until the applicant is enrolled on the Waiver.
- Again, a GO applicant, within the target population, is only enrolled in the Medicaid Waiver when both **financial** and **clinical** eligibility have been established and when the participant has been admitted to/accepted by the Medicaid provider facility/program.
- If necessary, a recipient of Supplemental Security Income may apply to the Social Security Administration (SSA) for an enhanced state supplement to pay for Room and Board (meals and housekeeping) at the Medicaid rate and have a PNA, whether he or she is on the waiver. The enhanced state supplement, through the Social Security Administration, can not however pay for the cost of assisted living services.
- The Assisted Living facility may stipulate conditions in the Medicaid Disclosure whether it will handle the resident's funds, become Representative Payee or if it will expect the participant/representative to do this activity?

Accommodations for Waiver participants

- Will Medicaid beneficiaries be required by the Assisted Living facility to reside in a shared room?
- Will Medicaid beneficiaries be required by the Assisted Living facility to reside in a private bedroom with shared bathroom and common area, or will they reside in a private bedroom and bath with a shared kitchen and common area?
- Will Medicaid beneficiaries be asked to relocate to another location?

Room & Board (R & B) Supplementation for a Room Upgrade

- Does the Assisted Living facility, through review of the Division of Aging and Community Services, accept Room & Board Supplementation from a third party on behalf of a Medicaid beneficiary?

Consequences of non-payment of the Room and Board fee, Cost Share, or R & B Supplementation

- What are the consequences if a Medicaid beneficiary does not pay the Assisted Living for his or her designated Room & Board fee or Cost-Share amount?
- What are the consequences if the designated third-party payer does not pay the Assisted Living for the authorized Room & Board Supplementation amount?
- What is the time frame for payment?
- Will a 30-day eviction notice be given, in what circumstances?
- Will the resident be moved to a shared room, in what circumstances?

Holding the room during an absence

- An Assisted Living facility must hold a Medicaid beneficiary's unit until the end of the month in which the person was transferred to a hospital/nursing facility, however, after that, how does the facility determine whether the person is capable of returning to the Assisted Living?
- Can the Assisted Living still meet the beneficiaries care needs? If so, how does the Assisted Living facility determine how many months it can hold the unit?
- The Assisted Living facility can collect the Room & Board fee and any R & B Supplementation during a leave of absence, but can not bill the per diem/cost of services to Medicaid or charge for service costs to the Medicaid beneficiary or a Third Party representative during a leave of absence. If the AL facility does collect R & B for the month, it is equivalent to collecting that month's rent and the room/unit should be held for the person for that month.

Restrictions on absences from facility for non-medical reasons (elective/have control over)

- There is no per diem payment for days when the beneficiary is out of the Assisted Living facility, and as a result, there may be the potential hardship for a facility if there is a preponderance of Medicaid Waiver residents out of the facility at the same time.
- Assisted Living facilities typically determine a specific number of days a month/year that it can have the resident out of the facility for non-medical reasons.

Time frame for removing belongings

- If it has been determined that the person will not return to the Assisted Living facility, how long is the Medicaid beneficiary, or his or her family, given to remove personal belongings, in the event of:
 - Death, institutionalization, return to a private residence.

SIGNATURES:

All Medicaid Disclosures are to be signed and dated by the Assisted Living (AL) resident, his or her family member/representative, and by a representative of the Assisted Living facility (including name and title). The resident's signature may be the mark of an X as performed by the resident.

The Department of Health and Senior Services' **Eligibility Criteria Information Sheet**, as attached to the facility's Medicaid Disclosure Policy Handout, is to be signed and dated by the AL resident and a representative of the AL facility.

Copies of the signed handout are to be given to the individual applicant/resident and his or her family member/representative and one shall be retained by the Assisted Living facility. A copy of the signed handout is to be given to the applicable Medicaid Waiver care management site upon request.

Securing all signatures is a vital component of the Medicaid Disclosure Handout. It is one way of documenting the attestation that each party is aware of his or her responsibilities with regard to important issues such as, but not limited to, spend down notification, payment for continued residency, referral and access to Medicaid screening determinations, and eligibility requirements for enrollment on the Medicaid Waiver program.



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February 11, 2011

Re: Eligibility Criteria Information Sheet for the Global Options for Long-Term Care Medicaid Waiver

Dear Assisted Living Administrator:

In an effort to ensure that both assisted living providers and Medicaid applicants are fully informed of eligibility and enrollment criteria, the Division of Aging and Community Services is reissuing the enclosed advisement regarding the Global Options for Long-Term Care (GO) Medicaid Waiver program's target population, eligibility criteria and enrollment standards. Assisted Living remains a covered service that GO participants may receive, however, the Division is aware that some families and individuals seeking admission to assisted living facilities are told that once they have exhausted their financial resources, they can automatically continue their stay in the residence as GO Medicaid Waiver participants. Applicants are often unaware that there is a clinical eligibility criterion, in addition to the financial eligibility, both of which must be met in order to qualify for the Medicaid Waiver. When individuals have spent down their resources and discover that they are ineligible for the Waiver, they are frustrated and angry.

Furthermore, the GO Waiver is designed to target the Aged and Disabled population – specifically those individuals age 65 and over, and those individuals between the ages of 21-64 who have been determined physically disabled. Targeting criteria approved by the Centers for Medicare and Medicaid Services (CMS) states that individuals between the ages of 21 and 64 with chronic mental illness, mental retardation or developmental disability are *ineligible* for GO Waiver enrollment.

As a Medicaid provider, should your facility agree to admit someone for residency who is not within this target population, you are advised that if that resident later applies for Medicaid coverage through the Global Options Waiver it is possible that he or she will be found ineligible for enrollment despite satisfying the financial and clinical requirements, and as a result there will be no payment to your facility from Medicaid. Please review this GO Medicaid Waiver policy with your Marketing staff to avoid inappropriate referrals and ensure complete understanding of GO program eligibility criteria and operational standards.

Finally, to help prevent future misunderstandings regarding GO Medicaid Waiver eligibility, for those interested in relocating to your facility or already residing there, you are directed to attach the enclosed 'Eligibility Criteria Information Sheet' directly to your facility's Medicaid Disclosure Policy handout.

Thank you. Your cooperation in this matter is greatly appreciated.

Sincerely,

Patricia A. Polansky, Assistant Commissioner
Division of Aging and Community Services

Enclosure

c: Nancy Day
Margaret Vilaro
OCCO Field Office Managers
Nancy Field
Aging and Disability Resource Centers
DACS County Liaisons
AAA Directors, Care Coordinators and Care Management Supervisors



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**ELIGIBILITY CRITERIA INFORMATION SHEET
FOR THE GLOBAL OPTIONS FOR LONG-TERM CARE (GO) MEDICAID WAIVER**

Global Options for Long-Term Care is a 1915(c) Medicaid Waiver program in New Jersey approved by the Federal Centers for Medicare and Medicaid Services (CMS). It is specially designed and targeted for the Aged and Disabled population, specifically those individuals age 65+ and those physically disabled between the ages of 21 - 64. Individuals between the ages of 21 and 64 who are chronically mentally ill, mentally retarded or developmentally disabled are ineligible for GO Waiver enrollment.

Any GO applicant, including those interested in residing in an Assisted Living (AL), must be determined both financially and clinically eligible in order to participate. The fact that applicants have spent down their resources and are within Medicaid's financial limit does not automatically make them eligible for the GO Waiver. Applicants must also meet clinical requirements related to their health status and functional abilities.

FOR MORE INFORMATION ON FINANCIAL ELIGIBILITY CRITERIA CONTACT THE COUNTY WELFARE AGENCY.

Professional staff designated by the N.J. Department of Health and Senior Services (DHSS) perform level of care evaluations for all GO Medicaid Waiver applicants. This professional determines the Waiver applicant's clinical eligibility by conducting a comprehensive care needs assessment which demonstrates whether or not the applicant requires the basic nursing facility level of care as described in state regulation N.J.A.C.8:85-2.1.

FOR MORE INFORMATION ON CLINICAL ELIGIBILITY CRITERIA CONTACT THE DHSS REGIONAL OFFICE OF COMMUNITY CHOICE OPTIONS.

Again, the Target Population established for the GO Waiver includes: Individuals age 65 and over, or those between the ages of 21-64 who are determined physically disabled.

Targeting criteria approved by CMS further states that: Individuals between the ages of 21 and 64 who are chronically mentally ill, mentally retarded or developmentally disabled are ineligible for GO Waiver enrollment.

AL PROVIDER STAFF (NAME):	SIGNATURE: X	DATE:
AL RESIDENT AND/OR REPRESENTATIVE (NAME):	SIGNATURE: X	DATE: