STATE OF NEW YORK
DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 02 OMM/ADM-6

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: November 22, 2002

SUBJECT: Provision of Hospice Care in Adult Care Facilities and Assisted Living Programs

SUGGESTED DISTRIBUTION:
Home Care Services Staff
Medical Assistance Staff
Adult Services Staff
Director of Social Services
Family-Type Home Coordinators
Staff Development Coordinators

CONTACT PERSON:
Bureau of Local District Support
Upstate: (518) 474-8216
NYC: (212) 268-6855
Department of Health Area Offices

ATTACHMENTS:
Attachment A Transfer Form (Available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
92 ADM-15 94 ADM-9 01 LCM-3		360-6.6(a) 485-490	10 NYCRR Part 790-794 10NYCRR Sec. 86		DAS Facility Info. Letter 22 Fac. Dir. 3-90 & 6-91

I. PURPOSE

The purpose of this directive is to clarify policies regarding the provision of Medicare and Title XIX Medicaid Hospice Care in Adult Care Facilities (ACFs) and Assisted Living Programs(ALPs) and to identify the process that must be followed in order to enable Medicaid recipients residing in ALPs to receive hospice services.

II. BACKGROUND

Hospice is defined as a coordinated program of home and inpatient care which treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration. Hospices provide palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stage of illness, and during dying and bereavement. To be a hospice patient, the individual must be diagnosed by a physician as terminally ill, that is, having six months or less to live. A patient must choose to elect hospice services.

Hospice care may be provided in a terminally ill individual's home, the home of a relative or friend, a free-standing hospice, a nursing facility, an Intermediate Care Facility for the Developmentally Disabled (ICF-DD), or a general hospital. A terminally ill individual's home includes an adult care facility such as an adult home or a family type home, a foster home for a child or an adult; and other types of living arrangements as specified in 18 NYCRR Part 360-6.6.

Hospices may not admit residents of adult homes or enriched housing programs unless all of the hospice residents' needs can be met without impairing the capacity of the adult home or enriched housing program operator to meet the needs of non-hospice residents.

An ALP is defined as an entity established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator. The ALP is intended to serve residents whose needs can be met in a less restrictive and lower cost residential setting. An ALP must possess a valid operating certificate as an adult home or enriched housing program and must be either a Licensed Home Care Services Agency, a Certified Home Health Agency or a Long Term Home Health Care Program.

To date Medicaid policy has precluded the delivery of hospice in ALPs because hospice services and many ALP services were duplicative.

This directive provides a process that enables an ALP resident who has chosen hospice care to receive such care by temporarily converting the ALP bed to an Adult Home (AH) or Enriched Housing Program (EHP) bed. The use of the Retention Standards Waiver Program to waive certain retention criteria for residents who chose to enter hospice is also explained.

III. PROGRAM IMPLICATIONS

In order for a Medicaid resident of ALP to receive hospice services, the ALP resident must be discharged from the ALP and his/her ALP bed converted to an AH or EHP Program bed.

IV. REQUIRED ACTIONS

The procedures contained in Section IV. A-C of this directive must be followed so that ALP residents, who elect to do so, may receive hospice services.

A. Actions Required by the Assisted Living Program/Adult Care Facility

1. Assisted Living Program

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. In order to maintain the total number of approved ALP beds, an empty AH or EHP bed can be designated 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 or 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. The ALP may use the form "Notification of Transfer from ALP Services to a Non-ALP Bed"(Attachment A) for this notification.

Medicaid payment for the home care services component of 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.

2. Adult Care Facility

If and when a hospice patient exceeds ACF retention standards, the ACF must initiate transfer of the individual to an appropriate alternative placement or apply for a retention standards waiver request. Generally, ACF retention standards are exceeded if the patient is chronically bed or chairfast requiring lifting equipment or two persons to transfer for a prolonged period of time, or if the patient is cognitively, physically or medically impaired to a degree that his/her safety or the safety of others would be endangered.

The facility may submit a retention standards waiver request to the Department in accordance with 92 ADM-15, "Provision of Title XIX Home Care Services in Adult Care Facilities and Implementation of Retention Standards Waiver Program in Adult Homes and Enriched housing Programs" and the Adult Care Facility Directive No. 6-91, entitled "Implementation of the Retention Standards Waiver Program".

B. Actions Required by the Local Department of Social Services (LDSS)

When the ALP notifies the district of fiscal responsibility that a Medicaid recipient is terminating ALP participation and has elected to receive hospice services in the ACF, the district must use the transfer date to a non-ALP bed as the end date of the ALP prior authorization. The district must also enter the same end date on the Welfare Management System's (WMS) Principal Provider subsystem. Community budgeting rules continue to be used to determine the recipient's Medicaid eligibility.

Effective March 1, 2002, the residency rules for the district of fiscal responsibility are the same for persons entering adult care facilities certified by the Department of Health, as they are for the ALP. Therefore, the district of fiscal responsibility for the ALP remains the resident's district of fiscal responsibility for the hospice. Persons residing in adult care facilities on or after March 1, 2002, who were receiving Medicaid, continue to be the responsibility of the district providing such assistance or care, including Medicaid. For example, an Albany county Medicaid recipient who had been residing in an ALP in Schenectady County, elects to receive hospice services in the ACF after March 1, 2002, Albany County would still be responsible for providing Medicaid even though the person is now receiving hospice in an ACF in Schenectady.

The social services district can consult with the Department of Health's Regional Office regarding the retention standard waiver approved for an ACF hospice patient.

C. Actions Required by Hospice

A hospice may only admit residents of ACFs whose care needs can be met without impairing the ACF operator's ability to meet the needs of other ACF residents.

Once hospice admits a patient, they are responsible for ensuring all of the patient's safety and care needs are identified and met on a timely basis, regardless of the source of the service. Hospice is responsible for case management and care planning.

Hospices must provide directly or under contract the following services: nursing, physician, social work, nutrition, physical therapy, occupational therapy, speech and language pathology, audiology, respiratory therapy, psychological, pharmaceutical, laboratory, medical supplies, equipment and appliances, home health aide, personal care, housekeeper, homemaker, bereavement, pastoral care and inpatient services.

Hospice is required by federal regulation to provide home health aide and homemaker services related to the patient's terminal condition in an amount that is adequate to meet the needs of the patient. These needs are determined by the hospice interdisciplinary team and should be noted as part of the hospice plan of care. The hospice is required to provide these services under the Medicare/Medicaid hospice benefit when it is related to

the care of the patient's terminal illness. Medicaid services determined to be necessary and part of the plan of care that are not included in the Medicare benefit or which are unrelated to the terminal illness or which preceded the terminal illness may be paid for on a fee for service basis.

As Medicaid is always the payer of last resort, hospice must first bill Medicare for hospice services when a Medicaid recipient is dually eligible.

Residents cannot move at will back and forth between the ALP and the hospice. Once an ALP resident is discharged from the ALP and in a non-ALP bed and admitted to the hospice, the resident is discharged from the hospice and readmitted to the ALP only through the procedures established for patients to revoke the hospice benefit.

V. SYSTEMS IMPLICATIONS

At the time of ALP discharge, the local district social service staff must use the WMS Principal Provider Subsystem (PPS) to close the ALP component/authorization. When notified of an ALP discharge, the district staff accesses the PPS and inputs an "00" as a Provider Type and enters the date of actual discharge from the ALP. This establishes the resident's discharge from the ALP.

The district must also end date the ALP prior authorization as the date of discharge to prevent any billing of ALP services and to allow for Medicaid fee-for-services to be reimbursed if appropriate.

VI. EFFECTIVE DATE

This Administrative Directive is effective on December 1, 2002.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

ATTACHMENT A

ASSISTED LIVING PROGRAM (ALP) NOTIFICATION OF TRANSER FROM ALP SERVICES TO NON-ALP BED DUE TO ELECTION OF HOSPICE

LDSS RESPONSIBLE FOR RECIPIENT LISTED (County Name) _____
ASSISTED LIVING PROGRAM NAME_____
PROVIDER NUMBER_____
ADDRESS_____ZIP CODE_____
CONTACT PERSON_____PHONE NUMBER( )_____

ALP AGENCY DATA

RESIDENT NAME (Last, First)	CLIENT ID (CIN)	SSN (optional)	DOB	TRANSFER THRU DATE

SIGNATURE OF PERSON COMPLETING THIS FORM_____

DATE _____

INSTRUCTIONS FOR COMPLETING THE ASSISTED LIVING PROGRAM (ALP) NOTIFICATION OF TRANSFER FROM ALP SERVICES TO NON-ALP BED DUE TO ELECTION OF HOSPICE FORM

INSTRUCTIONS FOR THE ALP: Use the ALP "Notification of Transfer from ALP Services to Non-ALP Bed Due to Election of Hospice" form to transfer a resident from your ALP agency. **The ALP must complete this form**.

1. Fill in the required information for your Assisted Living Program and for each resident transferred. Include:

   - THRU DATE: This is the date that the resident transferred from ALP Services to NON-ALP bed.

   - SIGNATURE OF PERSON COMPLETING THIS FORM: The person completing this form must sign and date the form. By signing s/he certifies the accuracy of the information submitted.

2. Mail the completed form to the Local Department of Social Services (LDSS) fiscally responsible for the resident.