ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 92 ADM-25

DIVISION: Medical Assistance

TO: Commissioners of Social Services

DATE: June 15, 1992

SUBJECT: AIDS Home Care Program (Chapter 622 of the Laws of 1988)

SUGGESTED DISTRIBUTION:	Directors of Social Services Medical Assistance Staff Adult Services Staff Staff Development Coordinators
CONTACT PERSON:	Any questions concerning this release should be directed to Walt Gartner, Bureau of Long Term Care, Division of Medical Assistance, by telephoning 1-800-342-3715, extension 3-5497, user id 73U026.
ATTACHMENTS:	See Attachment A - List of Attachments [online]

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
83 ADM-74 85 ADM-27 88 INF-20 90 ADM-25		360-6.6 485.17 505.21	See Attachment-B		

DSS-296EL (REV. 9/89)

I. PURPOSE

This Directive describes the actions necessary to implement Social Services Law (SSL) Section 367-e as added by Chapter 622 of the Laws of 1988, which authorizes the Medical Assistance (MA) Program to include payment for AIDS Home Care Programs (AHCPs).

II. BACKGROUND

The AIDS epidemic is the most serious public health challenge New York State has faced in recent times. New York State leads the nation in AIDS cases and projected prevalence of Human Immuno-Deficiency Virus (HIV) infection among men, women, children and minorities. More than 42,000 New Yorkers have developed AIDS during the past decade and more than 25,000 have died prematurely as a result of the disease. The AIDS Institute of the Department of Health (DOH) has estimated that by 1994 68,800 New Yorkers will have been diagnosed with AIDS and 42,000 of these patients will have died. Estimates of New Yorkers already infected with the HIV virus but not yet symptomatic range from 150,000-250,000 individuals.

The cost of paying for the AIDS epidemic in New York State is staggering. During the 1989-90 State fiscal year, AIDS spending in New York from all sources totaled $1.08 billion, up 37 percent from 1988-89. A large portion of that amount can be attributed to the approximately 2,400 AIDS patients who occupy in-patient hospital beds each day. That number is expected to exceed 2,600 by 1994.

DOH estimates that as much as 35 percent of the in-patient AIDS cases could be discharged if there were alternative placements willing to accept them; and of those, 10 percent could be cared for in their homes. In fact, it is estimated that 35 percent of all AIDS patients could be served by home care programs. The cost of some in-patient beds for AIDS patients exceeds $800.00 per day, whereas home care programs can serve some of these clients for as little as $90.00 per day.

The natural progression of the disease is episodic in nature, with periods of limited service need when home care could be the most appropriate service model. Individuals may experience bouts of severe illness interspersed with periods of varying degrees of wellness during which the acute care provided by hospitals is inappropriate. Others may experience chronic illness and deterioration that may require acute care only in the final stages of the disease. The provision of home care in such instances promotes independence, improves the quality of life and enables people with AIDS to remain within familiar surroundings. In addition, home care maintains the integrity of an individual's physical and emotional support system and allows for maximum involvement of loved ones.

Recognizing the potential of home care to effectively treat a portion of AIDS patients outside of the in-patient setting, the State Legislature enacted Chapter 622 of the Laws of 1988. This Chapter Law provides for the development of AHCPs, which are designated to serve only those patients who have been diagnosed by a physician as having AIDS, or who are infected with the AIDS etiologic agent and have an illness, infirmity or disability which can be reasonably ascertained to be associated with that infection.

III. PROGRAM IMPLICATIONS

A. What Is An AHCP?

An AHCP (AIDS home care program) is a coordinated plan of care and services provided in a person's home or in the home of a responsible relative, other responsible adult, adult care facilities specifically approved to admit or retain residents for such program, or in other residential settings as approved by the Commissioner of Health in conjunction with the Commissioner of Social Services. Such program shall be provided only by a provider of a LTHHCP specifically authorized by the Commissioner of Health to provide an AHCP. Such program shall provide services including, but not limited to, the full complement of health, social and environmental services provided by LTHHCPs in accordance with regulations promulgated by the Commissioner of Health.

B. Who Can Be Served?

An AHCP can serve persons who are medically eligible for placement in a hospital or residential health care facility (RHCF), and who are diagnosed by a physician as having AIDS, or are deemed by a physician, within his or her judgement, to be infected with the etiologic agent of AIDS, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection.

The determination of whether or not a patient is medically eligible for the AHCP is made using the assessment form and process approved by the Commissioner of Health.

C. Which Provider Types Can Become AHCPs?

1. An AHCP can be provided only by a LTHHCP provider specifically authorized under Article 36 of the Public Health Law (PHL) to provide an AHCP as a discrete part of the LTHHCP. If an AIDS Center, as defined in 10 NYCRR 405.22(g), wants to provide an AHCP, it must also become a LTHHCP specifically authorized under PHL Article 36 to provide an AHCP.

2. Approved AHCPs are required to meet the federal conditions of participation for certified home health agencies (CHHAs) as specified in Part 484 of Title 42 of the Code of Federal Regulations and DOH requirements specified in Parts 700, 765, 766, 770 and 771 of 10 NYCRR. An AHCP provided by an AIDS center must also meet the DOH requirements specified in Part 722 of 10 NYCRR.

D. Differences Between AHCPs and LTHHCPs

While both AHCPs and LTHHCPs are required to provide a case managed, comprehensive package of services to individuals deemed eligible for those services, the following differences exist between them:

1. AHCP recipients will not be included in the approved patient capacity of a sponsoring LTHHCP.

2. Persons receiving services from an AHCP are not subject to a patient expenditure ceiling, regardless of the setting in which they are being served.

3. Patient roster and statistical data requirements as specified in Sections 771.3 (a)(9) and (10) of 10 NYCRR must be maintained separately for AHCP recipients.

LTHHCPs which have not become AHCPs may serve AIDS patients; however, they must do so within the normal regulatory requirements of the LTHHCP (see previous Administrative Directives and Informational Letters cited on the first page of this directive).

E. How Can a LTHHCP or AIDS Center Become an AHCP?

LTHHCPs or AIDS Centers seeking approval to become AHCPs must file an AHCP application with DOH.

Specific AHCP inquiries should be directed to Nancy R. Barhydt, D.P.H., Director, Bureau of Home Health Care Services, New York State Department of Health, Corning Tower Building, Room 1970, Empire State Plaza, Albany, New York 12237-0733. The Bureau of Home Health Care Services, in consultation with the AIDS Institute, will also respond to any inquiries regarding clinical and service delivery practices to patients with AIDS or HIV related illnesses.

F. Where Can Services Be Provided?

AHCP services can be provided in a person's home or in the home of a responsible relative, other responsible adult, adult care facilities, or in other residential settings approved by the Commissioner of Health in conjunction with the Commissioner of Social Services.

AHCP services may not be provided in shelters for adults.

G. How are Recipients Assessed for AHCP Services?

The following is a list of the activities relating to the provision of AHCP services in the order they should normally occur for MA recipients. This list is similar to the list for the LTHHCP, as set forth in 83 ADM-74, because the authorization procedures for the AHCP and LTHHCP are similar.

1. The recipient, or someone on his/her behalf, believes that the recipient is eligible for the AHCP and that the recipient is medically eligible for RHCF level of care.

2. A health and functional status assessment (Office of Health Systems Management Form DMS-1 or its successor) is completed and scored.

3. If a recipient is assessed as eligible for both AHCP care and admission to a RHCF, and an AHCP exists in the district, the client must be made aware in writing that the services provided by AHCPs are available as an option to the client.

4. The recipient or the recipient's family, or representative, must indicate whether or not he/she is interested in receiving AHCP services. If not interested, all activities related to this program cease. If he/she is interested, preparation is made for the AHCP home assessment.

5. For all recipients indicating they desire AHCP services, and for whom the responsible physician has indicated that home care can appropriately meet their needs, the responsible social services district must assure that physician's orders are obtained and require that a home assessment be done.

There are two different approaches to completing the home assessment. In the first approach (regular entry), the joint AHCP/social services district assessment and the district's authorization occur prior to the delivery of services. This approach must be used for persons requesting AHCP services in adult care facilities and may also be used for other persons. In the second approach (alternate entry), the AHCP can begin delivering services prior to the joint assessment and social services authorization. Paragraphs 6-10 outline the regular entry process, and paragraphs 11-18 outline the alternate entry process.

Joint Social Services/AHCP Assessment Prior to Delivery of Service:

6. The home assessment is completed on a Home Assessment Abstract form (or its successor) by representatives of both the AHCP and social services district. If the person is in an adult care facility, the home assessment must also be performed in consultation with the operator of the adult care facility.

7. A summary of services requirements, based on the joint assessment and the physician's orders, is developed jointly by the social services district case worker, the AHCP nurse, and when the recipient is currently in a hospital or other facility, by the discharge coordinator.

8. Should the responsible physician determine that the recipient's health and safety needs cannot be met in a home care setting, the recipient is deemed inappropriate for care by an AHCP.

9. Upon completion of the summary of service requirements, the social services district authorizes services and notifies the AHCP to begin providing care.

   NOTE: Upon approval or denial of AHCP services authorization, the recipient must be notified of his/her fair hearing rights in accordance with existing regulations and procedures, and by using the notice form attached to this directive as Attachment C.

10. The AHCP nurse representative is responsible for establishing health goals for the recipient as well as the plan of care. This includes specifying how service will be delivered within the home as well as assuring that staff delivering such services are doing so in a capable, effective and consistent goal-directed manner.

    Service Delivery Prior to a Joint Assessment and Social Service District Authorization

11. The AHCP representative performs a preliminary assessment based upon a physician's order and develops a proposed summary of service requirements.

12. If after reviewing the proposed summary of service requirements, the AHCP representative has determined that the recipient is a suitable candidate for the AHCP, then the AHCP may decide to provide AHCP services prior to the social services district's authorization.

13. Since the joint social services/AHCP assessment must be completed prior to or within thirty days after the social services district receives the written notification, the AHCP should notify the social services district as soon as possible. This notification, if made by telephone, should immediately be followed by the written notification which includes at a minimum:

    a. Recipient identification data (address, social security number, MA number, and Medicare eligibility information).

    b. Referral source.

    c. DMS-1 (or its successor), completed and scored.

    d. Physician orders.

    e. Proposed summary of service requirements.

14. Within 30 calendar days from the receipt of a referral, the social services district must complete the AHCP eligibility determination and notify the AHCP concerning this decision.

    This eligibility determination must be done in the same manner described above in the first assessment approach (paragraphs 6-10). In other words, there will be a joint social services/AHCP assessment, formulation of a summary of service requirements, social services district authorization and implementation of a plan of care.

15. Social services authorizations shall be retroactive to the start of the service.

16. The social services district and the AHCP are responsible for finding alternative care options for patients determined ineligible for the program.

17. The provider will be financially responsible for non-authorized AHCP services and all services provided to patients whom the social services district deems ineligible for the program.

18. If the social services district is late in completing assessments, the AHCP provider will only be financially responsible for non-authorized AHCP services provided within the thirty day period.

IV. Required Action

Social services districts' responsibilities with respect to AHCPs are almost identical to those associated with the provision of LTHHCP services. For example:

A. The Offer of AHCP Services

The responsibility for offering AHCP services to appropriate individuals is identical to that same responsibility found in the LTHHCP.

B. Joint Assessment

Social services district staff are expected to participate in the joint assessment exactly as district participation is required for the LTHHCP. Section III of this release describes that process in detail.

C. Care Plan Costs

Despite the absence of an expenditure cap on AHCP services, social services district staff should obtain the estimated plan of care costs from the AHCP. Social services district staff, in negotiating the service mix included in the plan of care, are expected to function as a "prudent buyer".

D. Periodic Reassessments

After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there must be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for AHCP services may exceed four months. This is identical to the LTHHCP requirement.

E. Solving Differences of Opinion

As is the case with any LTHHCP, if there is a difference of opinion among the persons performing the assessment concerning the appropriateness of the individual for the AHCP, the kind or amount of care to be provided, the summary of services required or the delivery of services, the issue must be referred by either party for review and resolution by the local professional director as designated within the area office of the Office of Health Systems Management of the DOH. When this individual is not a physician or where there is no local professional director, the State Commissioner of Health shall designate a physician to act in this capacity.

F. Services Included in the Summary of Service Computation

The services available through AHCPs will be identical (though additional waiver services may subsequently be added) to those available through any LTHHCP. They include:

1. Medical Assistance State Plan services:

    a. physician services
    b. skilled nursing
    c. skilled therapies
    d. drugs
    e. home health aides
    f. personal care services
    g. medical transportation
    h. durable medical equipment

2. Home and community based care waiver services:

    a. nutrition counseling and education
    b. respiratory therapy
    c. medical social services
    d. home maintenance tasks
    e. respite care
    f. social day care
    g. social transportation
    h. congregate meal services
    i. moving assistance
    j. housing improvement
    k. personal emergency response systems

Of the waived services, AHCPs are required to provide nutrition counseling and education, respiratory therapy and medical social services. The remaining waivered services are optional.

G. Other Services

Consistent with the requirements for LTHHCPs, each AHCP is responsible for providing case management and coordination of patient care services. Because of the special needs of persons with AIDS or HIV-related illnesses, DOH expects that AHCPs will establish and implement procedures for coordinating care with other facilities @ agencies conducting clinical trials of HIV therapies; for arranging substance abuse treatment services; and for assuring patient access to such services as pastoral care and mental health, dental and enhanced physician services. AIDS Home Care Programs are also responsible for providing or arranging for training, counseling and support to staff caring for persons with AIDS or HIV -related illnesses and for the security of staff in order to fully service patients in potentially unsafe geographic areas or living arrangements.

H. Payment for Assessments and Reassessments

Payments for initial assessments and reassessments shall be as follows:

1. Payment for staff participation in discharge planning is included in the current hospital facility MA rate and shall not be paid as a separate service.

2. If the patient is in a hospital or a RHCF and the physician is not on the staff, reimbursement for the initial assessment is included in the physician's visit fee.

3. If a patient is in the community and (a) the assessment takes place in a clinic, reimbursement for the initial assessment is included in the clinic rate for the care provided; or, (b) the assessment takes place in the home, reimbursement for a physician performed assessment is included in the physician's home visit fee; or, (c) the assessment takes place in the home, reimbursement for a CHHA nurse performed assessment is included in the CHHA home visit fee; or, (d) the assessment takes place in the physician's office, reimbursement for the initial assessment is included in the physician's office visit fee.

4. Payment for all initial assessments and reassessments by AHCP providers is included in their administrative costs.

5. No payment may be made for a person receiving AHCP services while payments are being made for that person for in-patient care in a RHCF or a hospital.

I. AIDS Nursing Rates

AHCPs are entitled to receive enhanced payment for regular nursing services. Those nursing rates are determined on a regional basis and are published by the DOH.

J. Discontinuance of AHCP Services

If the social services district determines that the AHCP is no longer appropriate for a recipient, a written notice of the district's intent to discontinue the AHCP must be sent to the recipient (see Attachment C). An AHCP recipient has the right to request a fair hearing to contest the district's proposed discontinuance of AHCP services. The recipient may also have a right to aid continuing. Consequently, the district's proposed discontinuance of the recipient's AHCP must comply with the notice, aid continuing and fair hearing requirements set forth in

Part 358 of the Department's regulations. When a recipient's AHCP authorization is terminated, the social services district must ensure, where applicable, that the appropriate level of care is provided to the recipient.

K. Maximization of Medicare Benefits

Chapter 895 of the Laws of 1977 states that no Medicaid payment shall be made for benefits available under Medicare without documentation that Medicare claims have been filed and denied. Since the AHCP, functioning as a LTHHCP, or any approved Medicaid provider subcontracting for certain services for the AHCP will be the only Medicaid billing source, each will be expected to assume responsibility for the Medicare maximization effort.

All AHCPs should have established Medicare home health provider status. Those who are not yet Medicare home health care providers will receive this status once the DOH has performed satisfactory on-site surveys and received approval from the federal Department of Health and Human Services. New Medicare providers will be expected to assume the responsibility for the major Medicare maximization effort starting on the date of their certification as a Medicare provider.

L. Reporting Requirements

Since the Department will be required to evaluate and report on the effectiveness of this legislation, social services districts will be required to submit an annual listing of those individuals who were admitted or discharged from an AHCP. The listing must contain the following: name of the recipient, Medicaid ID number, date of birth, date of admission, date of discharge and reason for discharge. Attachment D contains the reporting format which social services districts should use when submitting the listing. This listing is due to this Department no later than September 30 of each year. Please send the listing to:

Mr. Walt Gartner
New York State Department of Social Services
Division of Medical Assistance
(Twin Towers, Room 800A)
40 North Pearl Street
Albany, New York 12243

M. Claiming

Expenditures for AHCP Services are funded the same as for any other LTHHCP, and consequently eligible for 80 percent State funding after first deducting any available Federal financial participation.

N. Related Program Directives

Since the AHCPs incorporate many of the routine LTHHCP activities, staff should regularly refer to the following Administrative Directives:

1. 83 ADM-74, Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program;

2. 85 ADM-27, Long Term Home Health Care Program: Federal Waivers Permitting Expanded Medicaid Home and Community-Based Services for LTHHCPs; and,

3. 90 ADM-25, Chapter 854 of the Laws of 1987: Long Term Home Health Care Program Services Provided in Adult Care Facilities.

V. Effective Date

This Administrative Directive is effective June 1, 1992, retroactive to January 1, 1989.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

ATTACHMENT A

List of Attachments

Attachment A - List of Attachments [online]

Attachment B - Filing References for Social Services Law and Other Legal References [online]

Attachment C - Fair Hearing Notice to Authorize, Reauthorize, Deny or Discontinue the AIDS Home Care Program [not online]

Attachment D - Listing for AIDS Home Care Program [not online]

ATTACHMENT B

List of References

SSL 367-c

SSL 367-e

Public Health Law Article 36

10 NYCRR parts 700, 765, 766, 770-772