DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

In reply, please refer to file:

STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE
601 KAMOKILA BOULEVARD, ROOM 337
KAPOLEI, HAWAII 96707

SUBMITTING REQUESTS FOR TWO (2) PRIVATE PAY INDIVIDUALS TO OCCUPY MEDICAID AND PRIVATE PAY BEDS AT THE SAME COMMUNITY CARE FOSTER FAMILY HOME (CCFFH)

INSTRUCTIONS FOR REQUESTING PERSONS AND CASE MANAGEMENT AGENCIES

Important Note: The aim of the Certified Foster Family Home (CCFFH) program is to provide persons on Medicaid equal access to nursing level of care services in CCFFHs as is available to non-Medicaid or private pay persons at other residential care facilities. Non-Medicaid or private pay persons have opportunities to access nursing level of care in residential care homes that are not readily available to persons on Medicaid.

It is the Department of Health's (Department) intent to maintain the CCFFH program primarily for Medicaid persons as was its original and historic purpose.

Only under truly unique, unforeseen, and unintended circumstances will the Department consider exercising its authorized discretion to allow two (2) non-Medicaid or private pay persons to occupy the same CCFFH, and only after satisfying the Department that all other options have been thoroughly explored and exhausted.

Instructions to Persons Requesting Occupancy

Persons requesting to occupy the same CCFFH must submit their request through a case manager from a licensed Case Management Agency (CMA). A current list of the licensed CMA may be found on the Department of Health's website at

http://health.hawaii.gov/ohca/state-licensing-section/

The attached “Request from the Resident” form must be completed in full, signed, and submitted through a case manager from a licensed CMA.

Instructions to Case Manager and Case Management Agency

Case managers must thoroughly document the truly unique circumstances leading to the request and certify by affixing their signature that those unique circumstances are true and accurate.

Instructions to Case Manager and Case Management Agency - *continued*

Case managers must submit documentation including but not limited to the following in order to verify:

1. The desired CCFFH has been certified and in operation for at least one (1) year;

2. The desired CCFFH primary caregiver is a Certified Nurse Aide, and the substitute caregiver is a nurse aide, with credentials in accordance with Act 30, SLH 2017;

3. The desired CCFFH is certified for three (3) beds;

4. The operator of the three-bed CCFFH had a vacant Medicaid bed for at least six (6) months;

5. The operator has not unreasonably denied admission of a Medicaid person for at least six (6) months;

6. The operator has not transferred out a Medicaid or private-pay client from the CCFFH in order to accept a private-pay individual;

7. The ability of the operator to provide current and anticipated care to the persons without jeopardizing care to any other person receiving care in the CCFFH;

8. There are no Medicaid recipients seeking placement in the CCFFH that the married or civil union private-pay individuals are seeking to occupy;

9. The two (2) private-pay individuals are in a relationship with each other as a married couple or in a civil union and one (1) of the private-pay individuals is currently residing in the CCFFH for at least six (6) months;

10. Prior to or soon after the admission of the first private-pay individual to the CCFFH, there was no reasonable knowledge or anticipation of the need to admit the second private-pay individual such that there should have been a thorough search for alternate accommodations at another licensed residential care home prior to admission of the first individual;

11. The second private-pay individual medically qualifies to occupy a CCFFH;

12. The CMA shall provide documentation on its search for alternative residential care and shall verify with any preceding CMA which provided case management services to the persons requesting occupancy at any time during the prior six-months, the extent of the search for alternative residential care;

13. The CMA shall attest that the operator is competent and has the capability to care for three (3) clients;

Instructions to Case Manager and Case Management Agency - *continued*

14. The CMA shall provide documentation to demonstrate the limited capability of other adult residential care homes, expanded adult residential care homes, or other qualified licensed health care facilities to provide the required care to the two (2) persons; and

15. There is no appearance or knowledge of exchange of incentives, gifts or enticements between or among any party associated with this request, other than reasonable payment for case management services between the two (2) private-pay individuals and their CMA, for an outcome considered by the state to be unfavorable to the state.

To request the Department to consider exercising its authorized discretion to allow two (2) non-Medicaid or private pay persons to occupy the same CCFFH under truly unique, unforeseen, and unintended circumstances, Case managers must submit:

1. A formal signed letter of request from the CMA on behalf of the requesting resident;

2. The completed “Request from the Resident” form, below;

3. The above documentation; and

4. Attach the “Case Manager Checklist” verifying the submission of all required information, below.

CASE MANAGER CHECKLIST

FOR TWO (2) PRIVATE PAY INDIVIDUALS TO OCCUPY MEDICAID AND PRIVATE PAY BEDS
AT THE SAME COMMUNITY CARE FOSTER FAMILY HOME (CCFFH)

Items and Documentation Submitted as Part of the Request

- ☐ Formal signed letter of request from the Case Management Agency on behalf of the requesting resident.
- ☐ Completed and signed “Request from the Resident” form.
- ☐ The desired CCFFH is certified and in operation for at least one (1) year.
- ☐ The primary caregiver is a Certified Nurse Aide, and the substitute caregiver is a nurse aide with credentials in accordance with Act 30, SLH 2017.
- ☐ The Case Management Agency shall attest that the operator is competent and has the capability to care for three (3) clients.
- ☐ The desired CCFFH s certified for three (3) beds.
- ☐ The operator of the three-bed CCFFH has had a vacant Medicaid bed for at least six (6) months.
- ☐ The operator has not unreasonably denied admission of a Medicaid person for at least six (6) months.
- ☐ The operator has not transferred out a Medicaid or private-pay client from the CCFFH in order to accept a private-pay individual.
- ☐ The ability of the operator to provide current and anticipated care to the persons without jeopardizing care to any other person receiving care in the CCFFH.
- ☐ The two (2) private-pay individuals are in a relationship with each other as a married couple or in a civil union and one (1) of the private-pay individuals is currently residing in the CCFFH for at least six (6) months.
- ☐ Prior to or soon after the admission of the first private-pay individual to the CCFFH, there was no reasonable knowledge or anticipation of the need to admit the second private-pay individual such that there should have been a thorough search for alternate accommodations at another licensed residential care home prior to admission of the firs individual.
- ☐ The second private-pay individual medically qualifies to occupy a CCFFH.
- ☐ The Case Management Agency shall provide documentation on its search for alternative residential care and shall verify with any preceding Case Management Agency which provided case management services to the persons requesting occupancy at any time during the prior six (6) months, the extent of the search for alternative residential care.
- ☐ The Case Management Agency shall provide documentation demonstrating the limited capability of other adult residential care homes, expanded adult residential care homes, or other qualified licensed health care facilities to provide the required care to the two (2) persons.
- ☐ There is no appearance or knowledge of exchange of incentives, gifts or enticements between or among any party associated with this request, other than reasonable payment for case management services between the two (2) private-pay individuals and their case management agency, for an outcome considered by the state to be unfavorable to the state.

REQUEST FROM THE RESIDENT

TO THE DEPARTMENT OF HEALTH FOR TWO (2) PRIVATE PAY INDIVIDUALS TO OCCUPY
THE SAME COMMUNITY CARE FOSTER FAMILY HOME (CCFFH)

Act 30, SLH 2017, authorizes the Department of Health (Department), in consultation with the Department of Human Services, and in the Department's discretion, and considering the past admission history and current client mix of the Community Care Foster Family Home (CCFFH), to allow two (2) private-pay individuals to be cared for in the same CCFFH after considering the following relevant factors:

1. The CCFFH has been certified and in operation for at least one (1) year;

2. The primary caregiver is a Certified Nurse Aide, and the substitute caregiver is a nurse aide, with credentials in accordance with Act 30, SLH 2017;

3. The CCFFH is certified for three (3) beds;

4. The operator of the three-bed CCFFH has had a vacant Medicaid bed for at least six (6) months; provided that the operator shall not transfer out a Medicaid or private-pay client from the CCFFH in order to accept a private-pay individual;

5. The two (2) private-pay individuals are in a relationship with each other as a married couple or in a civil union and one (1) of the private-pay individuals is currently residing in the CCFFH for at least six (6) months;

6. The Department, in its discretion, determines that no other adult residential care home, expanded adult residential care home, or healthcare facility within the area has an available opening and is capable of providing care to both private-pay individuals; and

7. There are no Medicaid recipients seeking placement in the CCFFH that the married or civil union private-pay individuals are seeking to occupy.

DATE OF REQUEST

CCFFH CURRENT PRIVATE PAY RESIDENT	**REQUESTING SECOND PRIVATE PAY RESIDENT**
Full Name of Current Resident (please type or print)	Full Name of Requesting Resident (please type or print)
Current Home Address	Current Home Address
Complete Name and Address of CCFFH where currently residing	Name and Address of health/home care facility where currently residing, or home address if not residing in a health/home care facility

CCFFH CURRENT PRIVATE PAY RESIDENT

Case Management Agency (CMA)
Name, Address and Contact Information

If applicable, Name, Address and Contact Information of Authorized Representative

REQUESTING SECOND PRIVATE PAY RESIDENT

Case Management Agency (CMA)
Name, Address and Contact Information.
If none, Name and Contact Information of Primary Care Physician or Advanced Practice Registered Nurse

If applicable, Name, Address and Contact Information of Authorized Representative

_____ (PRINT NAME) and _____ (PRINT NAME),

the above identified current private pay resident and the requesting second private pay resident, separately and individually, or the residents' authorized representative(s), by signing below, acknowledge our desire to reside in the same CCFFH identified above, and do authorize the CCFFH, CMA, health/home care facility and primary care physician or advanced practice registered nurse identified above to release to the Hawaii Department of Health (Department) copies of medical records or other records in their possession necessary for the Department to consider this request to allow a second private pay resident to reside at the above named CCFFH. Medical records include but are not limited to information on the past and current health status, health assessments and care plans for the provision of care, medication administration records, physical, speech or other therapeutic or rehabilitative care records, and any other information requested by the Department for the Department to use to consider this request. Further, _____ (PRINT NAME) and _____ (PRINT NAME) authorize the Department to review and use any and all relevant information necessary to reach a decision on this request and WE acknowledge that the decision is discretionary and that nothing in Act 30, SLH 2017 obligates the Department to approve this request.

(SIGNATURE) (DATE)

(SIGNATURE) (DATE)

Print Name of Resident
(or Authorized Representative)

Print Name of Requesting Resident
(or Authorized Representative)

Name and Contact Information of Person Submitting this Request If Other than Person Identified Above

Date of Request

FOR OFFICIAL USE ONLY:

Date Request Received at DOH: _____
Date Forwarded to DHS Med-QUEST: _____
Date Received from DHS Med-QUEST: _____
Date Request Decided by DOH: _____
Date Written Decision Provided by DOH: _____

APPROVED: ☐ **Yes** ☐ **No**
Name of DOH Representative: _____
Signature: _____
Signature Date: _____

DHS Med-QUEST Recommendation:
☐ Approve ☐ Deny
Name of DHS Representative: _____
Signature: _____
Date of Recommendation: _____