# HOME CARE PRIMER

CONTINUING LEGAL EDUCATION
March 22, 2007

## Agenda
## Home Care Primer

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| I. Overview of Home Care Services | 9:00 am – 9:15 am |
| II. Home Health Services | 9:15 am – 9:45 am |
| III. Catanzano Discussion | 9:45 am – 10:00 am |
| **Questions and Answers** | 10:00 am – 10:20 am |
| **10 Minute Break** | |
| IV. Personal Care Services Program | 10:30 am – 11:30 am |
| **Questions and Answers** | 11:30 am - noon |

# Biographies

Diane R. Jones

Has two years of experience in the State Department of Health in administering various aspects of New York State's Medicaid funded home and community-based services and programs, including but not limited to: Long Term Home Health Care Program (LTHHCP) and Hospice Program. Has over 25 years of nursing experience including supervision, education, inpatient and home care. She has a B.S. in Nursing

Doreen Sharp

Registered Nurse with many years of experience in acute care as well as outpatient primary care. Worked for the State Department of Health since 1998; has been involved in Medicaid policy/ program development including, but not limited to, Medicaid Disability Review and community based long term care related to home health care services, hospice, and the Long Term Home Health Care Program (LTHHCP).

Kathleen Sherry

Has over 28 years of experience in the State Department of Social Services and the State Department of Health in administering various aspects of New York State's Medicaid funded home and community-based services and programs, including but not limited to: Personal Care Services Program (PCSP), Consumer Directed Personal Assistance Program (CDPAP), Assisted Living Program (ALP), Limited Licensed Home Care Services Agencies (LLHCSA). Education: B.S. in Child-Family Services and M.P.A.

Margaret O. Willard

Has over 27 years of experience in the field of long term care. For 11 years was employed at the district level as both a caseworker and supervisor in the area of long term care. In that capacity directed local administration of the Personal Care Services Program, and implemented the Long Term Home Health Care Program, Private Duty Nursing Services and Care at Home in the district. At the State Department of Social Services/ Department of Health has been involved in the administration of various aspects of: Personal Care Services Program (PCSP), Consumer Directed Personal Assistance Program (CDPAP), Assisted Living Program (ALP), and Limited Licensed Home Care Services Agencies (LLHCSA). She has a B.A. in Communications and a M.A. in Interpersonal Communications

Jane McCloskey

Jane McCloskey is an Associate Attorney with the newly formed Bureau of Health Insurance Programs within the Department of Health's Division of Legal Affairs, which provides counsel and litigation support to the Department's also recently formed Office of Health Insurance Programs with respect to Medicaid, managed care, long term care, Child Health Plus, EPIC and reimbursement issues. From 1985 to 1996, she was a Senior

Attorney with the Bureau of Medicaid Law with the former NYS Department of Social Services, specializing in home care and other long term care and related litigation, and performed similar responsibilities when the Medicaid program was transferred to the Department of Health in 1996.

SELECTED
PCSP POLICY DIRECTIVES

| ADMINISTRATIVE DIRECTIVES | |
|---|---|
| 80 ADM-9 | Personal Care Services – Scope & Procedures |
| 92 ADM-4 | Personal Care Services: Development and Implementation of Shared Aide Programs |
| 92 ADM-15 | Provider of Title XIX Home Care Services in Adult Care Facilities and Implementation of Retention Standards Waiver Program in Adult Homes and Enriched Housing Programs |
| 94 ADM-9 | The Assisted Living Program (ALP) |
| 98 OCC/ADM-1 | Limited Licensed Home Care Services Agencies (LLHCSAs) |
| **LOCAL COMMISSIONERS MEMORANDUM** | |
| 95 LCM-102 | Consumer Directed Personal Assistance Program (CDPAP) |
| 95 LCM-135 | Personal Care Services Program: Nursing Assessment & Supervision |
| 01 OMM LCM-3 | Supplementation of Hospice Benefit |
| 04 OMM LCM-3 | Provision of Personal Care and Home Health Aide Services In Certain Residential and Day programs Certified a, Operated or Funded by the Office of Mental Retardation and Developmental Disabilities (OMRDD) |
| 06 OMM/LCM-1 | CDPAP Q&A |
| 06 OMM/LCM-2 | CDPAP Q&A |
| **General Information System Messages** | |
| GIS 01/07/94 | Burland v Dowling TRO |
| GIS 96 MA/013 | Dowd v Bane (S.Ct., New York Co.)Task Based Assessment |

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|---|---|
| GIS 96 MA/019 | Reductions or Discontinuances of personal Care Services: (Mayer et.al. v Wing) |
| GIS 96 MA/021 | Initial Authorizations for Personal Care Services (DeLuca et al. v Hammons and Wing) |
| GIS 96 MA/023 | New Notice Aid Continuing and Related Procedures Applicable to Hospitalized MA Recipients who Received PCS immediately Prior to Hospitalization (Granato v Bane; McCoy,v Schimke; Burland v Dowling) |
| GIS 97 MA/004 | Task Based Assessment |
| GIS 97 MA/016 | Task Based Assessment Plans (Rodriguezetal. V Debouno) |
| GIS 97 MA/033 | Clarifying Instructions regarding Mayer v Wing |
| GIS 99 MA/013 | Stay of Permanent Injunction Order in Rodriquez v DeBouno and Wing |
| GIS 99 MA/036 | Task-based Assessment Plans; Rodriguez v. DeBuono U.S. Second Circuit Decision |
| GIS 01 MA/044 | Personal Care Services Regulations and Mayer vs Wing |
| GIS 02 MA/001 | District of Fiscal Responsibility for Medical Assistance |
| GIS 02 MA/014 | Personal Care in Emergency Shelters for the Homeless |
| GIS 02 MA/024 | Consumer Directed Personal Assistance Program Scope of Service see revised GIS 04 MA 010 |
| GIS 03 MA/001 | Hospice |
| GIS 03 MA/003 | Rodriquez v Novello |
| GIS 04 MA/010 | Consumer Directed Personal Assistance Program Scope of Services (Revision of GIS 02 MA/024) |
| GIS 06 MA/027 | Personal Care Services Contracts |
| GIS 06 MA/030 | Respite/Personal Care Clarification |

# 18 NYCRR 505.14 PERSONAL CARE SERVICES

**Effective Date:** 12/06/2006
**Title:** Section 505.14 - Personal care services.

505.14 Personal care services.

(a) Definitions and scope of services.

(1) Personal care services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with the regulations of the Department of Health; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

(2) Some or total assistance shall be defined as follows:

(i) Some assistance shall mean that a specific function or task is performed and completed by the patient with help from another individual.

(ii) Total assistance shall mean that a specific function or task is performed and completed for the patient.

(3) Continuous 24-hour personal care services shall mean the provision of uninterrupted care, by more than one person, for a patient who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day and night.

(4) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

(i) The patient's medical condition shall be stable, which shall be defined as follows:

(a) the condition is not expected to exhibit sudden deterioration or improvement; and

(b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and

(c)(1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or

(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

(ii) The patient shall be self-directing, which shall mean that he/she is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. Patients who are nonself-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services, except under the following conditions:

(a) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or

(b) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

(c) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The local social services department may be the outside agency.

(5) Acting as an extension of a self-directing patient means that the individual providing personal care services carries out the functions and tasks identified in the patient's plan of care in accordance with specific instructions by the patient.

(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions shall include some or total assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The initial authorization for Level I services shall not exceed eight hours per week. An exception to this requirement may be made under the following conditions:

(1) The patient requires some or total assistance with meal preparation, including simple modified diets, as a result of the following conditions:

(i) informal caregivers such as family and friends are unavailable, unable or unwilling to provide such assistance or are unacceptable to the patient; and

(ii) community resources to provide meals are unavailable or inaccessible, or inappropriate because of the patient's dietary needs.

(2) In such a situation, the local social services department may authorize up to four additional hours of service per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions shall include some or total assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(8) feeding;

(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(10) providing routine skin care;

(11) using medical supplies and equipment such as walkers and wheelchairs; and

(12) changing of simple dressings.

(b) When continuous 24-hour care is indicated, additional requirements for the provision of services, as specified in clause (b)(4)(i)(c) of this section, must be met.

(7) Shared aide means a method of providing personal care services under which a social services district authorizes one or more nutritional and environmental support functions or personal care functions for each personal care services recipient who resides with other personal care services recipients in a designated geographic area, such as in the same apartment building, and a personal care services provider completes the authorized functions by making short visits to each such recipient.

(b) Criteria and authorization for provision of services. (1) When the local social services department

receives a request for services, that department shall determine the applicant's eligibility for medical assistance.

(2) The initial authorization for personal care services must be based on the following:

(i) a physician's order that meets the requirements of subparagraph (3)(i) of this subdivision;

(ii) a social assessment that meets the requirements of subparagraph (3)(ii) of this subdivision;

(iii) a nursing assessment that meets the requirements of subparagraph (3)(iii) of this subdivision;

(iv) an assessment of the patient's appropriateness for hospice services and assessments of the appropriateness and cost-effectiveness of the services specified in subparagraph (3)(iv) of this subdivision; and

(v) such other factors as may be required by paragraph (4) of this subdivision.

(3) The initial authorization process shall include the following procedures:

(i) A physician's order must be completed on the form required by the department.

(a) The physician's order form must be completed by a physician licensed in accordance with Article 131 of the Education Law, a physician's assistant or a specialist's assistant registered in accordance with Article 131-B of the Education Law, or a nurse practitioner certified in accordance with Article 139 of the Education Law.

(1) Such medical professional must complete the physician's order form within 30 calendar days after he or she conducts a medical examination of the patient, and the physician's order form must be forwarded to a social services district or another entity in accordance with clause (c) of this subparagraph.

(2) Such medical professional must complete the physician's order form by accurately describing the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks and by providing only such other information as the physician's order form requires.

(3) Such medical professional must not recommend the number of hours of personal care services that the patient should be authorized to receive.

(b) A physician must sign the physician's order form and certify that the patient can be cared for at home and that the information provided in the physician's order form accurately describes the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks, at the time of the medical examination.

(c) Within 30 calendar days after the medical examination of the patient, the physician, other medical professional, the patient or the patient's representative must forward a completed and signed copy of the physician's order form to the social services district for completion of the social assessment; however, when the social services district has delegated, pursuant to subdivision (g) of this section, the responsibility for completing the social assessment to another agency, the physician, other medical professional, the patient or the patient's representative must forward a completed and signed copy of the physician's order form to such other agency rather than to the social services district.

(d) When the social services district, or the district's designee pursuant to subdivision (g) of this section, is responsible for completing the social assessment but is not also responsible for completing the nursing assessment, the district or its designee must forward a completed and signed copy of the physician's order form to the person or agency responsible for completing the nursing assessment.

(e) The physician's order is subject to the provisions of Parts 515, 516, 517 and 518 of this Title. These Parts permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services, or supplies when medical care, services, or supplies that are unnecessary, improper or exceed patients' documented medical needs are provided or ordered.

(ii) The social assessment shall be completed by professional staff of the local social services department on forms approved by the State Department of Social Services.

(a) The social assessment shall include a discussion with the patient to determine perception of his/her circumstances and preferences.

(b) The social assessment shall include an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and shall consider all of the following:

(1) number and kind of informal caregivers available to the patient;

(2) ability and motivation of informal caregivers to assist in care;

(3) extent of informal caregivers' potential involvement;

(4) availability of informal caregivers for future assistance; and

(5) acceptability to the patient of the informal caregivers' involvement in his/her care.

(c) The social assessment shall be completed on a timely basis and shall be current.

(iii) The nursing assessment shall be completed by a nurse from the certified home health agency, or a nurse employed by the local social services department, or a nurse employed by a voluntary or proprietary agency under contract with the local social services department.

(a) A nurse employed by the local social services department or by a voluntary or proprietary agency under contract with the local social services department shall have the following minimum qualifications:

(1) a license and current registration to practice as a registered professional nurse in New York State; and

(2) at least two years of satisfactory recent experience in home health care.

(b) The nursing assessment shall be completed within five working days of the request and shall include the following:

(1) a review and interpretation of the physician's order;

(2) the primary diagnosis code from the ICD-9-CM;

(3) an evaluation of the functions and tasks required by the patient;

(4) the degree of assistance required for each function and task in accordance with the standards for levels of services outlined in subdivision (a) of this section;

(5) development of a plan of care in collaboration with the patient or his/her representative; and

(6) recommendations for authorization of services.

(iv) Assessment of other services.

(a) Before authorizing or reauthorizing personal care services, a social services district must assess each patient to determine the following:

(1) whether personal care services can be provided according to the patent's plan of care, whether such services are medically necessary and whether the social services district reasonably expects that such services can maintain the patient's health and safety in his or her home, as determined in accordance with the regulations of the Department of Health;

(2) whether the patient can be served appropriately and more cost-effectively by personal care services provided under a consumer directed personal assistance program authorized in accordance with Section 365-f of the Social Services Law;

(3) whether the functional needs, living arrangements and working arrangements of a patient who receives personal care services solely for monitoring the patient's medical condition and well-being can be monitored appropriately and more cost-effectively by personal emergency response services provided in accordance with section 505.33 of this Part;

(4) whether the functional needs, living arrangements and working arrangements of the patient can be maintained appropriately and more cost-effectively by personal care services provided by shared aides in accordance with subdivision (k) of this section;

(5) whether a patient who requires, as a part of a routine plan of care, part-time or intermittent nursing or other therapeutic services or nursing services provided to a medically stable patient, can be served appropriately and more cost-effectively through the provision of home health services in accordance with section 505.23 of this Part;

(6) whether the patient can be served appropriately and more cost-effectively by other long-term care services, including, but not limited to, services provided under the long-term home health care program (LTHHCP), the assisted living program or the enriched housing program;

(7) whether the patient can be served appropriately and more cost-effectively by using specialized medical equipment covered by the MA program including, but not limited to, insulin pens; and

(8) whether personal care services can be provided appropriately and more cost-effectively by the personal care services provider in cooperation with an adult day health program.

(b) If a social services district determines that a patient can be served appropriately and more cost-effectively through the provision of services described in subclauses (a)(2) through (8) of this subparagraph, and the social services district determines that such services are available in the district,

the social services district must first consider the use of such services in developing the patient's plan of care. The patient must use such services rather than personal care services to achieve the maximum reduction in his or her need for home health services or other long-term care services.

(c) A social services district may determine that the assessments required by subclauses (a)(1) through (8) of this subparagraph may be included in the social assessment or the nursing assessment.

(d) A social services district must have an agreement with each hospice that is available in the district. The agreement must specify the procedures for notifying patients who the social services district reasonably expects would be appropriate for hospice services of the availability of hospice services and for referring patients to hospice services. A social services district must not refer a patient to hospice services if the patient's physician has determined that hospice services are medically contraindicated for the patient or the patient does not choose to receive hospice services.

(v) An authorization for services shall be prepared by staff of the local social services department.

(4) The initial authorization process shall include additional requirements for authorization of services in certain case situations:

(i) An independent medical review of the case shall be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the local social services department to review personal care services cases when:

(a) there is disagreement between the physician's order and the social, nursing and other required assessments; or

(b) there is question about the level and amount of services to be provided; or

(c) the case involves the provision of continuous 24-hour personal care services as defined in paragraph (a)(3) of this section. Documentation for such cases shall be subject to the following requirements:

(1) The social assessment shall demonstrate that all alternative arrangements for meeting the patient's medical needs have been explored and/or are infeasible including, but not limited to, the provision of personal care services in combination with other formal services or in combination with contributions of informal caregivers.

(2) The nursing assessment shall document that the functions required by the patient, the degree of assistance required for each function and the time of this assistance require the provision of continuous 24-hour care.

(ii) The local professional director, or designee, must review the physician's order and the social, nursing and other required assessments in accordance with the standards for levels of services set forth in subdivision (a) of this section, and is responsible for the final determination of the level and amount of care to be provided. The final determination must be made within five working days of the request.

(5) The authorization for personal care services shall be completed prior to the initiation of services.

(i) The local social services department shall authorize only the hours of services actually required by the patient. When the individual providing personal care services is living in the home of the patient, the local social services department shall determine whether or not, based upon the social and nursing assessments, the patient can be safely left alone without care for a period of one or more hours per day.

(ii) The duration of the authorization period shall be based on the patient's needs as reflected in the required assessments. In determining the duration of the authorization period, the following shall be considered:

(a) the patient's prognosis and/or potential for recovery; and

(b) the expected length of any informal caregivers' participation in caregiving; and

(c) the projected length of time alternative services will be available to meet a part of the patient's needs.

(iii) No authorization for personal care services shall exceed six months. The local social services department may equest approval for an exception to allow for authorization periods up to 12 months. The request must be accompanied by the following:

(a) a description of the patients who will be considered for an expanded authorization period; and

(b) a description of the local social services department's process to assure that the delivery of services is responsive to changes in the patient's condition and allows immediate access to services by the patient, patient's physician, assessing nurse and provider agency if the need for services changes during the expanded authorization period.

(iv) When the patient needs Level I or Level II services immediately to protect his or her health or safety and the nursing assessment cannot be completed in five business days, the social services district may authorize the services based on the physician's order and the social assessment, provided that:

(a) the nursing assessment is obtained within 30 calendar days; and

(b) the recommendations of the nursing assessment are reviewed and changes are made in the authorization as required.

(v)(a) The social services district must deny or discontinue personal care services when such services are not medically necessary or are no longer medically necessary or when the social services district reasonably expects that such services cannot maintain or continue to maintain the client's health and safety in his or her home.

(b) The social services district must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services on forms required by the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements outlined in Part 358 of this Title.

(c) The social services district's determination to reduce, discontinue or deny a client's prior authorization must be stated in the client notice. Appropriate reasons and notice language to be used when reducing, discontinuing or denying personal care services include, but are not limited to:

(1) the client's medical, mental, economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

(2) a mistake occurred in the previous personal care services authorization;

(3) the client refused to cooperate with the required assessment of services;

(4) a technological development renders certain services unnecessary or less time consuming;

(5) the client can be more appropriately and cost-effectively served through other Medicaid programs and services;

(6) the client's health and safety cannot be assured with the provision of personal care services;

(7) the client's medical condition is not stable;

(8) the client is not self-directing and has no one to assume those responsibilities;

(9) the services the client needs exceed the personal care aide's scope of practice; and

(10) the client resides in a facility or participates in another program or receives other services which are responsible for the provision of needed personal care services.

(d) The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24 hour personal care, including continuous (split-shift or multi-shift) care, 24 hour sleep-in care or the equivalent provided by formal or informal caregivers. The determination of the need for such 24 hour personal care, including continuous (split-shift or multi-shift) care, shall be made without regard to the availability of formal or informal caregivers to assist in the provision of such care.

(vi) When services are authorized, the local social services department shall provide the agency or person providing services, the patient receiving the services, and the agency or individual supervising the services, with written information about the services authorized, including the functions and tasks required and the frequency and duration of the services.

(vii) All services provided shall be in accordance with the authorization. No change in functions or tasks, degree of assistance required for each function or tasks, or hours of services delivered shall be made without notification to, or approval of, the local social services department.

(viii) The local social services department shall notify the patient in writing when a change in the amount of services authorized is being considered. Notification shall be provided in accordance with the requirements specified in subparagraph (b)(5)(v) of this section.

(ix) Reauthorization for personal care services shall follow the procedures outlined in paragraphs (2) through (4) of this subdivision, with the following exceptions:

(a) Reauthorization of Level I services shall not require a nursing assessment if the physician's order indicates that the patient's medical condition is unchanged.

(b) Reauthorization of Level II services shall include an evaluation of the services provided during the previous authorization period. The evaluation shall include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

(x) When an unexpected change in the patient's social circumstances, mental status or medical condition occurs which would affect the type, amount or frequency of personal care services being provided during the authorization period, the social services district is responsible for making necessary changes in the authorization on a timely basis in accordance with the following procedures:

(a) When the change in the patient's services needs results solely from a change in his/her social circumstances including, but not limited to, loss or withdrawal of support provided by informal caregivers, the local social services department shall review the social assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new physician's order and nursing assessment shall not be required.

(b) When the change in the patient's services needs results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the local social services department shall review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated.

(c) When the change in the patient's services needs results from a change in his/her medical condition, the local social services department shall obtain a new physician's order and a new nursing assessment and shall complete a new social assessment. If the patient's medical condition continues to require the provision of personal care services, and the nursing assessment can not be obtained within five working days of the request from the local social services department, the local department may make changes in the authorization in accordance with the procedures specified in subparagraph (b)(5)(iv) of this section.

(6) Nothing in this subdivision shall preclude the provision of personal care services in combination with other services when a combination of services can appropriately and adequately meet the patient's needs.

(c) Contracting for the provision of personal care services.

(1) Each social services district must have contracts or other written agreements with all agencies or persons providing personal care services or any support functions for the delivery of personal care services. As used in this subdivision, support functions for the delivery of personal care services include, but are not necessarily limited to, nursing assessments, nursing supervision and case management, when provided according to subdivisions (b), (f) and (g) of this section, respectively.

(2) The social services district must use the model contract for personal care services that the department requires to be used, except as provided in paragraph (4) of this subdivision.

(3) (i) Under the following conditions, the social services district may attach local variations to the model contract:

(a) The local variations do not change the model contract's requirements; and

(b) The social services district submits its proposed local variations to the department on forms the department requires to be used.

(ii) The social services district must not implement any local variations to the model contract until the department approves the local variations. The department will notify the social services district in writing of its approval or disapproval of the local variations within 60 business days after it receives the local variations. If the department disapproves the local variations, the social services district may submit revisions to the local variations. The department will notify the social services district in writing

of its approval or disapproval of such revisions within 60 business days after it receives the revisions.

(4) (i) Under the following conditions, the social services district may use a local contract or other written agreement as an alternative to the model contract:

(a) The social services district cannot use the model contract due to local programmatic, legal, or fiscal concerns;

(b) The social services district can demonstrate that the local contract or agreement includes a provision comparable to each provision contained in the model contract and, if the local contract or agreement is with another public or governmental agency, it includes all requirements specified in this section; and

(c) The social services district submits a request for use of a local contract or agreement to the department on forms the department requires to be used.

(ii) The social services district must not implement a local contract or agreement until the department approves it. The department will notify the social services district in writing of its approval or disapproval of the local contract or agreement within 60 business days after it receives the district's request to use the local contract or agreement. The district's request must be accompanied by the proposed local contract or agreement and a comparison of the contents of the proposed local contract or agreement with the department's requirements. If the department disapproves the local contract or agreement, the social services district may submit revisions to the contract or agreement. The department will notify the social services district in writing of its approval or disapproval of such revisions within 60 business days after it receives the revisions.

(5) (i) The social services district must use a contract or other written agreement for support functions for the delivery of personal care services, including case management, nursing assessments and nursing supervision, that the department approves to be used.

(ii) The social services district must not implement any contract or agreement for case management, nursing assessments, nursing supervision, or any other support function until the department approves such contract or agreement.

(iii) The department will notify the social services district in writing of its approval or disapproval of the contract or agreement within 60 business days after it receives the contract or agreement. If the department disapproves the contract or agreement, the social services district may submit revisions to the contract or agreement. The department will notify the social services district in writing of its approval or disapproval of such revisions within 60 business days after it receives the revisions.

(6) The social services district must include in each contract or other written agreement with a provider of personal care services the rate at which the provider will be reimbursed for the provision of personal care services or for any support functions for the delivery of personal care services. The rate at which the provider will be reimbursed will be determined in accordance with subdivision (h) of this section.

(7) The social services district must base the duration of the contract or other written agreement on the district's fiscal year, or a portion thereof.

(8) Before entering into a contract or other written agreement with any provider agency, the social services district must determine that:

(i) the provider agency is certified in accordance with 10 NYCRR Parts 760 and 761, licensed in

accordance with 10 NYCRR Part 765 or exempt from licensure in accordance with 10 NYCRR Subpart 765-2 because it provides personal care services exclusively to persons who are eligible for medical assistance (MA);

(ii) the provider agency, without subcontracting with other provider agencies, is able to provide personnel who meet the minimum criteria for providers of personal care services, as described in subdivision (d) of this section, and who have successfully completed a training program approved by the department, as provided in subdivision (e) of this section;

(iii) the provider agency is fiscally sound;

(iv) the provider agency has obtained appropriate insurance coverage to protect the social services district from liability claims resulting from acts, omissions, or negligence of provider agency personnel that cause personal injuries to personal care services recipients or such personnel and that the provider agency has agreed to maintain such insurance coverage while its contract with the social services district is in effect; and

(v) the provider agency has agreed that it will not substitute another provider agency to provide personal care services to an MA recipient unless the provider agency has notified the district of the provider agency's need to substitute another provider agency and the district has approved such substitution.

(9) Each social services district must have a plan to monitor and audit the delivery of personal care services provided pursuant to its contracts or other written agreements with provider agencies. The social services district must submit this plan to the department for approval. At a minimum, the plan must include the following:

(i) an evaluation of the provider agency's ability to deliver personal care services, including the extent to which trained personnel are available to provide such services;

(ii) a comparison of the provider agency's performance with the requirements of this section and with the performance standards specified in the contract or agreement; and

(iii) a review of the provider agency's fiscal practices.

(10) When the provider agency is a home care services agency that provides personal care services exclusively to persons eligible for MA and is therefore exempt from licensure, the social services district must include the following items in the monitoring plan in addition to those required by paragraph (11) of this subdivision:

(i) a review of the provider agency's administrative and personnel policies;

(ii) a review of all provider agency recordkeeping relevant to the provision of personal care services; and

(iii) an evaluation of the quality of care the provider agency provides.

(11) Each social services district must also have a plan to monitor and audit any support functions for the delivery of personal care services, as defined in paragraph (1) of this subdivision. The social services district must submit this plan to the department for approval.

(12) The social services district must maintain a record of its monitoring activities. The district must

include a report of such monitoring activities in the annual plan the district submits to the department pursuant to subdivision (j) of this section.

(d) Providers of personal care services.

(1) Personal care services may be provided by persons with the title of homemaker, homemaker-home health aide, home health aide, or personal care aide. Such persons must meet all other requirements of this section. When Level I (environmental and nutritional) personal care functions only, as defined in subdivision (a) of this section, are required, persons with the title of housekeeper may be used.

(2) The local social services department shall use one or a combination of the following to provide personal care services:

(i) local social services department staff employed and trained to provide personal care services and other home care services;

(ii) a contractual agreement with a long-term home health care program for services of a person providing personal care services;

(iii) a contractual agreement approved by the Department and the State Director of the Budget with a certified home health agency for the services of a person providing personal care services;

(iv) a contractual agreement approved by the Department and the State Director of the Budget with a voluntary homemaker-home health aide agency for the service of persons providing personal care services;

(v) a contractual agreement approved by the Department and the State Director of the Budget with a proprietary agency for the service of persons providing personal care services;

(vi) a contractual agreement approved by the Department and the State Director of the Budget with an individual provider of service for the provision of Level I (environmental and nutritional) personal care functions only;

(vii) a contractual agreement approved by the Department and the State Director of the Budget with an individual provider of service when the service needs require more than Level I (environmental and nutritional) personal care functions only. Such providers of service may be used only under the following conditions:

(a) prior approval has been received by the local social services department from the Department to use individual providers in cases where the local social services department can justify that such providers of service are the only alternative available to the district. Such approval will be based upon the justification provided by the local department of social services and the agency's plan for the use of such individual providers of service;

(b) the local social services department shall review and evaluate the qualifications of each individual provider in accordance with procedures established by the local department of social services and approved by the Department;

(c) in each case where an individual provider of personal care services is used, the individual provider shall receive on-the-job instruction and on-going nursing supervision from a nurse on staff of the local department of social services or a nurse from a certified home health agency. When such supervision is

provided under contract with a certified home health agency, the local social services department shall monitor the case to assure that the service is delivered as authorized;

(d) the local social services department shall conform with all State and Federal requirements for employment benefits and taxes and shall follow appropriate procedures for payment for this service under this Title. Appropriate insurance coverage shall be provided to cover both personal injury and property damage liability; and

(e) State approval shall be limited to a period or periods not in excess of one year, but may be renewed.

(3) The provider agency or the local department of social services shall assign a person to provide the required services according to the authorization. In the event that this person is unable to meet the client's needs or is unacceptable to the client, the local department of social services shall request assignment of another person. Attention should be given in the selection of a person to provide services to assure that the person can communicate with a patient or on behalf of the patient.

(4) The minimum criteria for the selection of all persons providing personal care services shall include, but are not limited to, the following:

(i) maturity, emotional and mental stability, and experience in personal care or homemaking;

(ii) ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;

(iii) sympathetic attitude toward providing services for patients at home who have medical problems; and

(iv) good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of Health requires for employees of certified home health agencies pursuant to 10 NYCRR 763.4.

(v) a criminal history record check to the extent required by 10 NYCRR 400.23.

(e) Required training. (1) Each person performing personal care services other than household functions only shall be required as condition of initial or a continued participation in the provision of personal care services under this Part to participate successfully in a training program approved by the Department.

(2) An approved training program shall include basic training, periodic and continuing in-service training, and on-the-job instruction and supervision.

(i) Basic training shall meet the following minimum requirements:

(a) Include content related to:

(1) orientation to the agency, community and services;

(2) the family and family relationships;

(3) the child in the family;

(4) working with the elderly;

(5) mental illness and mental health;

(6) body mechanics;

(7) personal care skills;

(8) care of the home and personal belongings;

(9) safety and accident prevention;

(10) family spending and budgeting; and

(11) food, nutrition and meal preparation.

(b) Total 40 hours in length.

(c) Be directed by a registered professional nurse, or a social worker, or home economist who has, at a minimum, a bachelor's degree in an area related to the delivery of human services or education.

(d) Involve appropriate staff and community resources, such as public health nurses, home economics, physical therapists and social workers. Skills training in personal care techniques shall be taught by a registered nurse.

(e) Include, as an integral part, evaluation of each person's competency in the required content. Criteria and methods for determining each person's successful completion of basic training shall be established. Criteria shall include attendance at all classes or equivalent instruction. Additional criteria shall be established to determine whether each person can competently perform required tasks and establish good working relationships with others. Methods of evaluating competency may include written, performance and oral testing; instructor observations of overall performance, attitudes and work habits; preparation of assignments/home study materials or any combination of these and other methods. Attendance records, and evaluation materials for determining each person's successful completion of basic training shall be maintained.

(ii) In-service training shall be provided, at a minimum, for three hours semiannually for each person providing personal care services to develop specialized skills or knowledge not included in basic training or to review or expand skills or knowledge included in basic training.

(iii) On-the-job training shall be provided, as needed, to instruct the person providing personal care services in a specific skill or technique, or to assist the person in resolving problems in individual case situations. Criteria and methodology for evaluating the overall job performance of each person providing personal care services shall be established. The supervising professional registered nurse shall be responsible for evaluating each person's ability to function competently and safely and for providing or arranging for necessary on-the-job training.

(3) Prior to performing any service, each person providing personal care services, other than household functions only, shall successfully complete the prescribed part of the basic training program. The prescribed part of basic training shall include the following content areas:

(i) orientation to the agency, community and the service;

(ii) working with the elderly;

(iii) body mechanics;

(iv) personal care skills;

(v) safety and accident prevention; and

(vi) food, nutrition and meal preparation.

The entire basic training program shall be completed by each person providing personal care services within three months after the date he is so hired.

(4) The requirement for completion of a basic training program may be waived by the department if the person performing personal care services can demonstrate competency in the required areas of content included in the basic training as specified in clause (2)(i)(a) of this subdivision. Methods of evaluating competency shall be approved by the Department and shall meet the following minimum requirements:

(i) Be designed for persons having:

(a) documented training through related training programs such as nurse's aide and home health aide training programs; or

(b) documented related experience in an institutional or home setting which involves the performance of skills included in required basic training.

(ii) Include procedures and instruments for evaluating each person's competency. Content of evaluation instruments shall be compatible with required basic training program content, and shall assess appropriate skills and understandings of persons providing personal care services.

(iii) Identify the standard(s) of competency which shall be achieved through application of the procedures and instruments included.

(iv) Include a plan for remedial basic training of persons who fail to meet the standard(s) of competency established. Remedial basic training shall be provided which includes the prescribed part of basic training set forth in paragraph (3) of this subdivision.

(v) Include a mechanism for documenting successful demonstration of competency. Certificates awarded on the basis of successful demonstration of competency shall be designed to reflect issuance on this basis.

(5) Persons performing household tasks only shall be oriented to their responsibilities at the time of assignment by the supervising registered professional nurse.

(6) Each local social services department shall require that agencies with whom they contract for services submit to them a training program for providers of personal care services. This training program shall be submitted by the local social services department to the Department for approval. The Department shall notify the local social services department of its decision within 45 days of the plan's receipt by the department.

(7) The successful participation of each person providing personal care services in approved basic training, competency testing and continuing in-service training programs shall be documented in that person's personnel records. Documentation shall include the following items:

(i) a completed employment application or other satisfactory proof of the date on which the person was hired; and

(ii) a dated certificate, letter or other satisfactory proof of the person's successful completion of a basic training program approved by the department; or

(iii) dated certificates, written references, letters or other satisfactory proof that the person:

(a) meets the qualifications specified in clause (4)(i)(a) or (b) of this subdivision; and

(b) has successfully completed competency testing and any remedial basic training necessary as a result of such testing. The dated and scored competency testing instruments and record of any remedial training provided shall be maintained;

(iv) an in-service card, log or other satisfactory proof of the employee's participation in three hours of in-service training semiannually.

(8) The local social services district shall develop a plan for monitoring the assignments of individuals providing personal care services to assure that individuals are in compliance with the training requirements. This plan shall be submitted by the local social services district to the Department for approval and shall include, as a minimum, specific methods for monitoring each individual's compliance with the basic training, competency testing, and in-service requirements specified in this subdivision. Methods of monitoring may include: onsite reviews of employee personnel records; establishment of a formal reporting system on training activities; establishment of requirements for submittal of certificates or other documentation prior to each individual's assignment to a personal care service case; or any combination of these or other methods.

(9) When a provider agency is not in compliance with department requirements for training, or when the agency's training efforts do not comply with the approved plan for that agency, the Department shall withdraw the approval of that agency's training plan. No reimbursement shall be available to local social services districts, and no payments shall be made to provider agencies for services provided by individuals who are not trained in accordance with department requirements and the agency's approved training plan.

(f) Administrative and nursing supervision. (1) All persons providing personal care services are subject to administrative and nursing supervision.

(2) Administrative supervision must assure that personal care services are provided according to the authorization of the agency responsible for case management (the case management agency) for the level, amount, frequency and duration of personal care services to be provided and the social services district's contract or other written agreement with the agency providing such services.

(i) The agency providing personal care services is responsible for administrative supervision.

(ii) Administrative supervision includes the following activities:

(a) receiving initial referrals from the case management agency, including its authorization for the level,

amount, frequency and duration of personal care services to be provided;

(b) notifying the case management agency when the agency providing services accepts or rejects a patient; and

(1) when accepted, the arrangements made for providing personal care service; or

(2) when rejected, the reason for such rejection;

(c) initially assigning a person to provide personal care services to a patient according to the case management agency's authorization for the level, amount, frequency and duration of personal care services to be provided. In making assignments, the agency providing services must consider the following:

(1) the patient's cultural background, primary language, personal characteristics and geographic location;

(2) the experience and training required of the person providing personal care services; and

(3) the ability of the person providing personal care services to communicate with the patient or on the patient's behalf.

(d) assigning another person to provide personal care services to a patient when the person the agency providing services initially assigned is:

(1) unable to work effectively with the patient and any informal caregivers involved in the patient's care; or

(2) providing personal care services inappropriately or unsafely; or

(3) unavailable to provide personal care services due to unexpected illness or other reasons;

(e) promptly notifying the case management agency when the agency providing services cannot assign another person to provide personal care services to the patient;

(f) verifying that the patient is receiving personal care services according to the case management agency's authorization;

(g) notifying the case management agency, or cooperating with the nurse supervisor to notify such agency, when the agency providing services has questions regarding the adequacy of the case management agency's authorization for personal care services;

(h) promptly notifying the case management agency when the agency providing services is unable to maintain case coverage, including cases requiring services at night, on weekends or on holidays;

(i) participating in, or arranging for, the orientation of persons providing personal care services to the employment policies and procedures of the agency providing services;

(j) evaluating the overall job performances of persons providing personal care services, or assisting the nurse supervisor or other personnel of the agency providing nursing supervision, with such evalu ations;

(k) giving support to persons providing personal care services;

(l) checking time cards of persons providing personal care services for required documentation;

(m) maintaining scheduling records and any other records necessary to implement required administrative activities; and

(n) complying with the requirements for advance directives that are set forth in 10 NYCRR 700.5 or any successor regulation. The agency providing personal care services, as well as any individual provider of personal care services who provides services pursuant to his or her contract with the social services district, may contract with another entity, including but not limited to a case management agency, to perform such agency's or individual provider's advance directive responsibilities.

(3) Nursing supervision must assure that the patient's needs are appropriately met by the case management agency's authorization for the level, amount, frequency and duration of personal care services and that the person providing such services is competently and safely performing the functions and tasks specified in the patient's plan of care.

(i) Nursing supervision must be provided by a registered professional nurse employed by a voluntary, proprietary, or public agency with which the social services district has a contract or other written agreement or by the social services district. When an individual provider of personal care services is used, nursing supervision must be provided in accordance with the requirements specified in subdivision (d) of this section.

(ii) The agency providing nursing supervision must employ nurses meeting the qualifications in subparagraph (iii) of this paragraph in sufficient numbers to perform the activities in subparagraph (iv) of this paragraph.

(iii) Nursing supervision must be provided by a registered professional nurse who:

(a) is licensed and currently certified to practice as a registered professional nurse in New York State;

(b) meets the health requirements specified in subdivision (d)(4)(iv) of this section; and

(c) meets either of the following qualifications:

(1) has at least two years satisfactory recent home health care experience; or

(2) has a combination of education and experience equivalent to the requirement described in subclause (1) of this clause, with at least one year of home health care experience; or

(d) acts under the direction of a registered professional nurse who meets the qualifications listed in clauses (a) and (b) of this subparagraph and either of the qualifications listed in subclause (1) or (2) of clause (c) of this subparagraph.

(iv) Nursing supervision includes the following activities:

(a) orienting the person providing personal care services to his or her responsibilities.

(1) Except as otherwise provided in subclause (3) of this clause, the nurse supervisor must conduct an

orientation visit in the patient's home when the person providing personal care services is also present.

(i) For all initial authorizations of personal care services, the nurse supervisor must conduct an orientation visit within seven calendar days after the person providing personal care services is assigned to the patient.

(ii) Scheduling of orientation visits for all initial authorizations of personal care services, should be based on the following four criteria:

(A) the patient's ability to be self-directing, as defined in subdivision (a) (4) (ii) of this section;

(B) the availability of any informal caregivers who will be involved in the patient's plan of care;

(C) the scope and complexity of the functions and tasks identified in the patient's plan of care; and

(D) the training and experience the person providing personal care services has in performing the functions and tasks identified in the patient's plan of care.

(2) The nurse supervisor must perform the following functions during the orientation visit and document his or her performance of these functions in the report he or she prepares pursuant to subparagraph (vii) of this paragraph:

(i) review, with the person providing personal care services, the patient, and the patient's family, the plan of care received from the case management agency to assure that all parties understand the functions and tasks that the person providing services must perform and the frequency at which the person must perform these functions and tasks;

(ii) instruct the person providing personal care services in the observations the person must make and the oral and written reports and records the person must submit and maintain; and

(iii) demonstrate, when indicated, any procedures that the person providing personal care services is to perform with or for the patient.

(3) The nurse supervisor is not required to conduct an orientation visit when:

(i) personal care services are reauthorized, the patient requires a continuation or resumption of services initially authorized and the patient's mental status, social circumstances and medical condition have not changed; or

(ii) the person providing personal care services is temporarily substituting for or replacing the person assigned to provide services; the patient's plan of care is current and available to the person providing personal care services; the patient is self directing, as defined in subparagraph (a)(4)(ii) of this section or, if non-self directing, has a self-directing individual or other agency willing to assume responsibility for making choices about the patient's activities of daily living, as provided in such subdivision; and the person providing personal care services has the documented training or experience to appropriately and safely perform the functions and tasks identified in the patient's plan of care.

(4) The nurse supervisor must continue to perform the functions specified in items (iv) (a) (2) (i) and (ii) of this paragraph when an exception is made to the requirement for a home orientation visit.

(b) making nursing supervisory visits at the frequency established pursuant to subparagraph (vi) of this

paragraph.

(1) The supervisory visit must be made to the patient's home when the person providing personal care services is present, except when a supervisory visit is made solely to obtain the patient's evaluation of the person's job performance.

(2) The nurse supervisor must perform the following functions during the supervisory visit and document his or her performance of these functions in the report he or she prepares pursuant to subparagraph (vii) of this paragraph:

(i) evaluate the patient's needs to determine if the level, amount, frequency and duration of personal care services authorized continue to be appropriate;

(ii) evaluate the skills and performance of the person providing personal care services, including the person's ability to work effectively with the patient and the patient's family;

(iii) arrange for or provide on-the-job training according to subparagraph (e) (2) (iii) of this section;

(c) immediately notifying the case management agency when either of the following occurs:

(1) there is a change in the patient's social circumstances, mental status or medical condition that would affect the level, amount, frequency or duration of personal care services authorized or indicate the patient needs a different type of service; or

(2) the actions taken by persons involved in the patient's care are inappropriate or jeopardize the patient's health and safety;

(d) participating in case conferences to discuss individual patient cases;

(e) assisting in complaint investigations according to the policies and procedures of the agency that employs the nurse supervisor;

(f) participating, if requested, in basic, supplementary and in-service training, as defined in subdivisions (a) and (e) of this section, of persons providing personal care services;

(g) being available to the person providing personal care services for nursing consultation while such person is in the patient's home;

(h) evaluating the overall job performance of persons providing personal care services, or assist the administrative supervisor or other personnel with such evaluations;

(i) reviewing reports prepared by persons providing personal care services;

(j) preparing, maintaining or forwarding written reports of orientation visits and nursing supervisory visits, according to subparagraph (vii) of this paragraph; and

(k) reporting to the registered professional nurse responsible for directing a nurse supervisor lacking home health care experience, when applicable, and in accordance with policies and procedures of the agency that employs the nurse supervisor.

(v) The registered professional nurse who provides direction to nurse supervisors without the home

health care experience specified in clause (3) (iii) (c) of this subdivision is responsible for the following activities:

(a) training and orienting the nurse supervisor to his or her supervisory responsibilities;

(b) consulting with the nurse supervisor regarding patients or persons providing personal care services;

(c) monitoring orientation visits and nursing supervisory visits to assure that such visits are performed at the required frequencies;

(d) assuring availability of nursing consultation to the person providing personal care services when such person is in the patient's home;

(e) reviewing the orientation visit reports and nursing supervisory reports and assuring that copies are maintained or forwarded according to subparagraph (vii) of this paragraph; and

(f) evaluating each nurse supervisor's overall job performance or assisting with such evaluations.

(vi) The nurse who completes the nursing assessment, as specified in subparagraph (b)(3)(iii) of this section, must recommend the frequency of nursing supervisory visits for a personal care services patient and must specify the recommended frequency in the patient's plan of care.

(a) Frequency of nursing supervisory visits must be recommended on an individual patient basis. The following factors must be considered:

(1) the patient's ability to be self-directing, as defined in subparagraph (a) (4) (ii) of this section;

(2) the patient's need for assistance in carrying out specific functions and tasks in the plan of care; and

(3) the skills needed by the person who will be providing personal care services.

(b) The nursing supervisor must make nursing supervisory visits at least every 90 days for a personal care services patient except that:

(1) nursing supervisory visits must be made more frequently than every 90 days when:

(i) the patient's medical condition requires more frequent visits; or

(ii) the person providing personal care services needs additional or more frequent on-the-job training to perform assigned functions and tasks competently and safely; and

(2) supervisory and nursing assessment visits may be combined and conducted every six months when:

(i) the patient is self-directing, as defined in subparagraph (a)(4)(ii) of this section; and

(ii) the patient's medical condition is not expected to require any change in the level, amount or frequency of personal care services authorized during this time period.

(vii) The nurse supervisor must prepare a written report of each orientation visit and each nursing supervisory visit. These reports must be prepared on a form prescribed by the department.

(a) The nurse supervisor must maintain a copy of each report in the patient's record.

(b) The nurse supervisor must maintain a copy of each report in the personnel record of the person providing personal care services or forward a copy, within 14 calendar days of the orientation visit or nursing supervisory visit, to the provider agency for inclusion in such person's personnel record.

(c) The nurse supervisor must forward a copy of each report to the case management agency, if different from the agency providing nursing supervision, within 14 calendar days of each orientation visit or nursing supervisory visit.

(viii) Arrangements for nursing supervision must be reflected in the social services district's annual plan for the delivery of personal care services.

(ix) Arrangements for nursing supervision provided by a voluntary, proprietary or public agency must be specified in the contract or other written agreement between the social services district and the agency providing nursing supervision.

(g) Case management. (1) All patients receiving personal care services must be provided with case management services according to this subdivision.

(2) Case management may be provided either by social services district professional staff who meet the department's minimum qualifications for caseworker, professional staff of one or more agencies to which the district has delegated case management responsibility and that meet standards established by the department, or both.

(i) The social services district may delegate, pursuant to standards established by the department, responsibility for performance of either or both of the following:

(a) one or more of the case management activities listed in paragraph (3) of this subdivision;

(b) one or more such case management activities at specific times, such as during weekends or at night.

(ii) A social services district may delegate responsibility for case management activities only when:

(a) the department has approved the delegation of case management responsibilities;

(b) the social services district and each agency that is to perform case management activities have a contract or other written agreement pursuant to subdivision (c) of this section; and

(c) the social services district monitors the case management activities provided under the contract or other written agreement to ensure that such activities comply with the requirements of this subdivision.

(3) Case management includes the following activities:

(i) receiving referrals for personal care services, providing information about such services and determining, when appropriate, that the patient is financially eligible for Medical Assistance;

(ii) informing the patient or the patient's representative that a physician's order is needed, making copies of the physician's order form available to hospital discharge planners, physicians, and other appropriate persons or entities, and assisting the patient to obtain a physician's order when the patient or the patient's representative is unable to obtain the order.

(iii) completing the social assessment according to subdivision (b) of this section, including an evaluation of:

(a) the potential contribution of informal caregivers to the patient's plan of care, as specified in subparagraph (b) (3) (ii) of this section;

(b) the patient's physical environment, as determined by a visit to the patient's home; and

(c) the patient's mental status;

(iv) obtaining or completing the nursing assessment according to subparagraph (b)(3)(iii) of this section;

(v) assessing the patient's eligibility for hospice services and assessing the appropriateness and cost-effectiveness of the services specified in subparagraph (b)(3)(iv) of this section;

(vi) forwarding the physician's order; the social and nursing assessments; the assessments required by subparagraph (b)(3)(iv) of this section for an independent medical review according to subparagraph (b) (4)(i) of this section;

(vii) negotiating with informal caregivers to encourage or maintain their involvement in the patient's care;

(viii) determining the level, amount, frequency and duration of personal care services to be authorized or reauthorized according to subdivisions (a) and (b) of this section, or, if the case involves an independent medical review, obtaining the review determination;

(ix) obtaining or completing the authorization for personal care services, according to subdivision (b) of this section;

(x) assuring that the patient is provided written notification of personal care services initially authorized, reauthorized, denied, increased, reduced, discontinued, or suspended and his or her right to a fair hearing, as specified in Part 358 of this Title and subparagraph (b) (5) (v) of this section;

(xi) arranging for the delivery of personal care services according to subdivision (c) of this section;

(xii) forwarding, prior to the initiation of personal care services, a copy of the patient's plan of care developed by the nurse responsible for completion of the nursing assessment, as specified in subdivision (a) of this section, to the following persons or agencies:

(a) the patient or the patient's representative;

(b) the agency providing personal care services under a contract or other written agreement with the social services district; and

(c) the agency providing nursing supervision under a contract or other written agreement with the social services district;

(xiii) monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met;

(xiv) obtaining or completing a copy of the orientation visit report and the nursing supervisory visit report and forwarding a copy of these reports in accordance with subparagraphs (f)(3)(vi) of this section;

(xv) allowing access by the patient to his or her written records, including physicians' orders and nursing assessments and, pursuant to 10 NYCRR 766.2 (e), by the State Department of Health and licensed provider agencies;

(xvi) receiving and promptly reviewing recommendations from the agency providing nursing supervision for changes in the level, amount, frequency or duration of personal care services being provided;

(xvii) promptly initiating and complying with the procedures specified in subparagraph (b) (5) (x) of this section when the patient's social circumstances, mental status or medical condition unexpectedly change during the authorization period;

(xviii) assuring that capability exists 24 hours per day, seven days per week for the following activities:

(a) arranging for continued delivery of personal care services to the patient when the agency providing such services is unable to maintain case coverage; and

(b) making temporary changes in the level, amount or frequency of personal care services provided or arranging for another type of service when there is an unexpected change in the patient's social circumstances, mental status or medical condition;

(xix) informing the patient or the patient's representative of the procedure for addressing the situations specified in subparagraph (xv) of this paragraph;

(xx) establishing linkages to services provided by other community agencies including:

(a) providing information about these services to the patient and the patient's family; and

(b) identifying the criteria by which patients are referred to these services;

(xxi) establishing linkages to other services provided by the social services district including, but not limited to, adult protective services as specified in paragraph (5) of this subdivision;

(xxii) arranging for the termination of personal care services when indicated and, when necessary, making referrals to other types of services or levels of care that the patient may require; and

(xxiii) complying with the requirements for advance directives that are set forth in the regulations at 10 NYCRR 700.5 or any successor regulation when personal care services are provided by social services district employees. For purposes of this subparagraph, the term facility/agency as used in such regulations is deemed to mean the case management agency.

(4) The case management agency must maintain current case records on each patient receiving personal care services. Such records must include, at a minimum, a copy of the following documents:

(i) the physician's orders;

(ii) the nursing and social assessments;

(iii) the assessment of the patient's eligibility for hospice services and the assessments of the appropriateness and cost-effectiveness of the services specified in subparagraph (b)(3)(iv) of this section;

(iv) for a patient whose case must be referred to the local professional director or designee in accordance with subparagraph (b)(4)(i) of this section, a record that the physician's order, the social and nursing assessments and the assessments required by subparagraph (b)(3)(iv) of this section were forwarded to the local professional director or designee;

(v) for a patient whose case must be referred to the local professional director or designee in accordance with subparagraph (b)(4)(i) of this section, a copy of the local professional director's or designee's determination;

(vi) the patient's plan of care;

(vii) any consent form signed by the patient authorizing release of confidential information;

(viii) the authorization for personal care services;

(ix) the written notification of personal care services initially authorized, reauthorized, denied, increased, reduced, discontinued, or suspended and the patient's right to a fair hearing;

(x) notifications of acceptance, rejection or discontinuance of the case by the agency providing personal care services;

(xi) the orientation visit and nursing supervisory reports;

(xii) the case narrative notes; and

(xiii) any criminal investigation or incident reports involving the patient or any person providing personal care services to the patient.

(5) (i) Social services district professional staff responsible for personal care services and staff responsible for adult protective services, as specified in Part 457 of this Title, must coordinate their activities to assure that:

(a) they identify and understand the criteria for referring personal care services patients to adult protective services and for referring adult protective services clients to the personal care services program;

(b) mechanisms exist to discuss individual patients;

(c) personal care services as part of an adult protective services plan are provided according to existing requirements; and

(d) staff understand their respective responsibilities in cases involving the provision of personal care services as part of adult protective services plans.

(ii) Professional staff responsible for adult protective services have primary responsibility for case

management for a patient who:

(a) is eligible for protective services for adults, as defined in section 457.1(b) of this Title;

(b) receives or requires personal care services as part of an adult protective services plan; and

(1) is non self-directing and has no self-directing individual or agency to assume responsibility for his or her direction, as specified in subparagraph (a) (4) (ii) of this section; or

(2) is self-directing, as defined in subparagraph (a) (4) (ii) of this section, but refuses to accept personal care services in accordance with the plan of care developed by the nurse who completed the nursing assessment.

(iii) Professional staff responsible for personal care services must assist adult protective services staff with arrangements for provision of personal care services.

(6) Arrangements for case management, including arrangements for delegation of case management activities, must be reflected in the social services district's annual plan for the delivery of personal care services.

(h) Payment. (1) No payment to the provider shall be made for authorized service unless such claim is supported by the documentation of the time spent in provision of service for each individual patient. Such documentation must be maintained by the provider pursuant to section 540.7(a)(8) of this Title.

(2) Payment for personal care services shall not be made to a patient's spouse, parent, son, son-in-law, daughter or daughter-in-law, but may be made to another relative if that other relative:

(i) is not residing in the patient's home; or

(ii) is residing in the patient's home because the amount of care required by the patient makes his presence necessary.

(3) For personal care services, payment shall be made as follows:

(i) If services are provided directly by the staff of the local department of social services, payment shall be based upon the local department's salary schedule. The local department is responsible for withholding all applicable income taxes and payment of the employer's share of FICA, Workers' Compensation, Unemployment Insurance and all other benefits covered under labor management contracts.

(ii) (a) When personal care services are provided by a voluntary, proprietary or public personal care services provider, payment is based upon the following:

(1) For providers having contracts with social services districts for the provision of personal care services during a rate year or years beginning prior to January 1, 1994, payment is made at the lower of the local prevailing rate or a rate that is negotiated between the district and the provider, unless a different rate has been ordered by a court for any such rate year or years. The social services district must submit the rates to the department on forms the department requires to be used and must not implement the rates until the Department and the Director of the Budget approve them. Such rates are also subject to the provisions of paragraph (5) or (6), as applicable, of this subdivision.

(2) For providers having contracts with social services districts for the provision of personal care services during a rate year or years beginning on or after January 1, 1994, payment will be made in accordance with paragraph (7) of this subdivision.

(b) Providers must pay salaries to the personal care workers they employ; comply with all required State, federal or local income tax or other payroll withholding requirements; and pay FICA, Workers' Compensation, Unemployment Insurance, and other employee benefits as required by the providers' labor contracts.

(iii) If the services are provided by or under arrangements with an individual provider of personal care services, payment is made directly to the individual provider of service at a rate approved by the department and the Director of the Budget. The social services district is responsible for establishing policies for the withholding of all applicable income taxes and payment of the employer's share of FICA, Workers' Compensation, Unemployment Insurance and any other benefits included in the contract with the provider.

(4) Payment for assessment and supervisory services provided by a certified home health agency as part of a local social services department's plan for delivery of personal care services shall be at rates established by the State Commissioner of Health and approved by the State Director of the Budget.

(5)(i) This paragraph applies to Medical Assistance (MA) payments to personal care services providers that had personal care services payment rates in effect for the rate or contract year beginning prior to July 1, 1990, and seek approval of personal care services payment rates for the rate or contract year beginning on or after July 1, 1990.

(ii) For the rate or contract year beginning on or after July 1, 1990, MA payments to a provider of personal care services must be based on and, except as provided in subparagraph (iv) of this paragraph, be at or below the provider's personal care services payment rate in effect for the rate or contract year beginning prior to July 1, 1990, as adjusted by a personal care services trend factor that the department establishes with the approval of the Director of the Budget.

(iii) The department will establish the personal care services trend factor by designating an external price indicator for each of the three components that comprise the total costs of personal care services, determining the average percentage of total personal care services costs that each component represents, and weighing each component's average percentage of total personal care services costs by the external price indicator for that component. The three components of the costs of personal care services are listed below:

(a) an aide wage and benefit component;

(b) an administrative and operating component; and

(c) a clinical component.

(iv) At the written request of a social services district and with the approval of the Director of the Budget, the department may grant an exception to the requirement that a personal care services provider's payment rate must be based on, and be at or below, the provider's personal care services payment rate in effect for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor. The personal care services provider must cooperate with the social services district's exception request by providing such reports or other information that may be necessary to justify the exception request. The department will grant a social services district's exception

request only when the social services district demonstrates to the department's and the Director of the Budget's satisfaction that:

(a) the social services district will otherwise be unable to ensure that personal care services recipients will receive the personal care services for which they are authorized;

(b) additional payment for personal care services is necessary to maintain the quality of services provided; or

(c) additional payment for personal care services is necessary due to extraordinary or other circumstances, as specified in department guidelines.

(v) A social services district must submit each proposed personal care services payment rate to the department in a format that the department requires. The district must not implement any proposed personal care services payment rate until the department and the Director of the Budget approve the rate.

(vi) Within two months after the day on which the department and the Director of the Budget receive a proposed personal care services payment rate that is equal to or less than the provider's personal care services payment rate for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor, the department and the Director of the Budget will approve the rate. The department will send the social services district written notice of the approval of the rate.

(vii) Within four months after the day on which the department and the Director of the Budget receive a proposed personal care services payment rate that exceeds the provider's personal care services payment rate for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor, and for which the social services district has requested an exception to the trend factor requirement, the department and the Director of the Budget will approve, disapprove, or otherwise act upon the rate. The department will send the social services district written notice of the approval or disapproval of the proposed personal care services rate or the results of the department's and the Director of the Budget's other action regarding the proposed rate. If the department and the Director of the Budget disapprove a proposed personal care services payment rate, the social services district may submit a revised rate for the Department's and the Director of the Budget's approval, disapproval, or other action.

(viii) The department and the Director of the Budget, when determining whether to approve a proposed personal care services payment rate, may consider various factors including, but not limited to, the following:

(a) whether the proposed personal care services payment rate exceeds the provider's personal care services payment rate for the rate or contract year beginning prior to July 1, 1990, as adjusted by the personal care services trend factor; and

(b) if the proposed personal care services payment rate exceeds the provider's personal care services payment rate for such rate or contract year, as adjusted by the personal care services trend factor, whether the social services district has requested an exception to the trend factor requirement and demonstrated to the department's and the Director of the Budget's satisfaction that an exception should be granted.

(6)(i) This paragraph applies to MA payments to the following personal care services providers:

(a) a provider that did not have a personal care services payment rate in effect for a rate or contract year beginning prior to July 1, 1990; and

(b) a provider that had a personal care services payment rate in effect for a rate or contract year beginning prior to July 1, 1990, and seeks approval of a personal care services payment rate for a rate or contract year beginning prior to July 1, 1990.

(ii) The department and the Director of the Budget, when determining whether to approve a proposed personal care services payment rate under this paragraph, may consider various factors including, but not limited to, the following:

(a) the justification the social services district provides, in a format the department requires, for the proposed rate;

(b) any changes in the appropriate consumer price index for urban or rural consumers;

(c) any changes in federal or State mandated standard payroll deductions;

(d) the applicable minimum wage laws;

(e) a comparison of the proposed personal care services payment rate to other personal care services providers' payment rates in the social services district and to personal care services providers' payment rates in social services districts of similar size, geography and demographics; and

(f) a comparison of the proposed personal care services payment rate for the provider to the provider's personal care services payment rate, if any, for the previous rate or contract year.

(iii) A social services district must submit each proposed personal care services payment rate to the department in a format that the department requires. The district must not implement any proposed personal care services payment rate until the department and the Director of the Budget approve the rate. The department will send the social services district written notice of the approval or disapproval of the proposed rate.

(7) This paragraph sets forth the methodology by which the department will determine MA payment rates for personal care services providers that have contracts with social services districts for any rate year that begins on or after January 1, 1994.

(i) Providers' submission of required cost reports.

(a) Providers with cost experience.

(1) This clause applies to providers with cost experience. A provider with cost experience is defined as any provider of personal care services that can report its actual operating costs for the full rate year specified in the required cost report.

(2) Each provider must complete and submit to the department such cost report as the department may require. Each provider must complete the cost report by reporting such of the provider's actual operating costs of providing personal care services as the cost report may require for the full rate year specified in the cost report.

(3) The department will furnish each provider with the cost report form. The cost report form will

specify the date by which the provider must submit the completed report to the department; however, no provider will have fewer than 90 calendar days to submit the report after its receipt. The department may grant a provider an additional 30 calendar days to submit the cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date the report is due for reasons beyond the provider's control.

(4) (i) If the department determines that the cost report submitted by a provider is inaccurate or incomplete, the department will notify the provider in writing. The notice will advise the provider of the corrected or additional information that the provider must submit.

(ii) The provider must submit the corrected or additional information within 30 calendar days from the date the provider receives the department's notice. The department may grant the provider an additional 30 calendar days to submit the corrected or additional information when the provider, prior to the date that the corrected or additional information is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the corrected or additional information by the date the information is due for reasons beyond the provider's control.

(5) If the provider determines that the cost report that it has submitted to the department is inaccurate or incomplete, the provider must submit corrected or additional information. The provider must submit such corrected or additional information to the department within 45 calendar days from the date the provider submitted the original cost report to the department.

(6) (i) In the event a provider fails to file the required cost report on or before the due date, or as the same may be extended pursuant to subclause (3) of this clause, the State Commissioner of Health shall reduce the current rate paid by state governmental agencies by two percent for a period beginning on the first day of the calendar month following the original due date of the required report and continuing until the last day of the calendar month in which the required report is filed.

(ii) Failure to timely file the corrected or additional data as required pursuant to subclause (4) of this clause will result in application of item (i) of this subclause. Lack of certification by the operator or by the accountant, as required pursuant to subclauses (8) and (9) of this clause, shall render a cost report incomplete.

(7) The provider must complete the cost report in accordance with generally accepted accounting principles as applied to the provider, unless the department specifies otherwise on the cost report form.

(8) The cost report must be certified by the owner or administrator of a proprietary personal care services provider, the chief executive officer or administrator of a voluntary personal care services provider, or the public official responsible for the operation of a publicly operated personal care services provider. The cost report form will include a certification form, which will specify who must certify the report.

(9) The provider must submit an opinion of an independent certified public accountant that the provider's cost report, or such portions of the cost report as the department may specify, has been examined and determined to comply with generally accepted accounting principles and with the allowable costs and recoveries of expenses requirements specified in subclauses (ii) (a) (3) and (4), respectively, of this paragraph. The provider must submit such independent certified public accountant's opinion on a form as the department may require.

(b) New providers.

(1) This clause applies to new providers of personal care services. A new provider of personal care services is defined as any provider of personal care services that cannot report its actual operating costs for the full rate year specified in the required cost report.

(2) Each new provider must complete and submit to the department such cost report as the department may require. Each new provider must complete the cost report by reporting such of the provider's estimated operating costs of providing personal care services as the cost report may require for the full rate year specified in the cost report.

(3) The department will furnish each new provider with the cost report form. The cost report form will specify the date by which the provider must submit the completed report to the department; however, no provider will have fewer than 90 calendar days to submit the report after its receipt. The department may grant a provider an additional 30 calendar days to submit the cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date the report is due for reasons beyond the provider's control.

(4) (i) If the department determines that the cost report that a new provider has submitted is inaccurate or incomplete, the department will notify the provider in writing. The notice will advise the provider of the corrected or additional information that the provider must submit.

(ii) The new provider must submit the corrected or additional information within 30 calendar days from the date the provider receives the department's notice. The department may grant the provider an additional 30 calendar days to submit the corrected or additional information when the provider, prior to the date that the corrected or additional information is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the corrected or additional information by the date the information is due for reasons beyond the provider's control.

(5) If the new provider determines that the cost report that it has submitted to the department is inaccurate or incomplete, the provider must submit corrected or additional information. The provider must submit such corrected or additional information to the department within 45 calendar days from the date the provider submitted the original cost report to the department.

(6) If a new provider fails to submit the cost report or any corrected or additional information regarding the cost report by the original or extended date on which such report or such corrected or additional information is due, the provider's existing approved payment rate, if any, will remain in effect until such time as the provider submits such cost report or such corrected or additional information and otherwise complies with the requirements of this clause, and the department is able to determine a rate for the provider. The rate will be effective for the full rate year regardless of the date on which the provider submitted such cost report or such corrected or additional information and otherwise complied with the requirements of this clause.

(7) The new provider must complete the cost report in accordance with generally accepted accounting principles as applied to the provider, unless the department specifies otherwise on the cost report form.

(8) The cost report must be certified by the owner or administrator of a proprietary personal care services provider, the chief executive officer or administrator of a voluntary personal care services provider, or the public official responsible for the operation of a publicly operated personal care services provider. The cost report form will include a certification form, which will specify who must certify the

report.

(9) When a new provider has contracted with a social services district for the provision of personal care services for one year and can report its actual operating costs for such year, the provider must report its actual operating costs for such year to the department by completing a new cost report and submitting such report to the department in accordance with the requirements for providers with cost experience as set forth in clause (a) of this subparagraph.

(ii) Determination of payment rate.

(a) Providers with cost experience.

(1) Medical assistance payments to personal care services providers for any rate year beginning on or after January 1, 1994, are made at the lower of the following rates:

(i) the rate the provider charges the general public for personal care services; or

(ii) the rate determined by the department in accordance with subclauses (2) through (7) of this clause.

(2) The department will determine a provider's payment rate based on the cost report the provider submits. Each provider must report its personnel and non-personnel operating costs as specified in the cost report. The department will consider only the provider's operating costs that are allowable costs, as defined in subclause (3) of this clause and as adjusted by the provider in accordance with subclause (4) of this clause. The department will adjust the provider's allowable costs by trend factors, as determined in accordance with subclause (5) of this clause. The department will determine whether the provider's allowable costs exceed the ceilings that the department has established for such costs in accordance with subclause (6) of this clause and, if so, consider only such of the provider's allowable costs that do not exceed such ceilings. The department will calculate an amount for profit, for proprietary providers, or surplus, for voluntary providers, as determined in accordance with subclause (7) of this clause. The resulting rate will be payment-in-full for all personal care services provided to MA recipients during the applicable rate year, subject to any revisions the department may make in accordance with the rate revision or audit processes authorized by subparagraphs (iii) or (iv) of this paragraph.

(3) Allowable costs.

(i) Allowable costs are defined as a provider's documented costs that are necessary for the provider's operation, are directly or indirectly related to recipients' care, and are not expressly declared to be nonallowable by federal or State law or regulations.

(ii) Allowable costs will be determined in accordance with reimbursement principles developed for determining payments under title XVIII of the federal Social Security Act (Medicare). These reimbursement principles are set forth in the Medicare Provider Reimbursement Manual, Part 1, entitled "HCFA Pub. 15-1 Thru T. 365," which is published by the Health Care Financing Administration of the United States Department of
Health and Human Services. The department has incorporated by reference Chapters 1 - 14, 21 - 23 and 26 of such manual, as revised effective January 1, 1992. A copy of such manual is available for public use and inspection at the Department of Social Services, 40 North Pearl St., Albany, NY 12243.

(iii) Allowable costs include the following:

(A) a monetary value assigned to services provided by religious orders and for services rendered by an

owner or operator of a provider;

(B) only that portion of the dues the provider pays to any professional association that has been demonstrated, to the department's satisfaction, to be allocable to expenditures other than for public relations, advertising or political contributions;

(C) costs allocated to the provider from a related organization when the costs are reasonably related to the efficient provision of personal care services and the bases of allocation of such costs are consistent with regulations applicable to the cost reporting of the related organization. An organization is related to the provider when the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies. To a significant extent means that:

(i) the provider or an officer, director or partner of such provider has an ownership interest, as defined in section 505.2(i) of this Part, in such organization equal to five percent or more; has an indirect ownership interest, as defined in section 505.2(g) of this Part, in such organization equal to five percent or more; has a combination of an ownership interest and an indirect ownership interest in such organization equal to five percent or more; has an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by such organization if that interest equals at least five percent of the value of the organization's property or assets; or is an officer, director or partner of such organization or otherwise has the power, directly or indirectly, significantly to influence or direct the actions or policies of such organization; or

(ii) the organization furnishing the services, facilities or supplies to the provider, or an officer, director or partner of such organization has an ownership interest, as defined in section 505.2(i) of this Part, in the provider equal to five percent or more; has an indirect ownership interest, as defined in section 505.2 (g) of this Part, in the provider equal to five percent or more; has a combination of an ownership interest and an indirect ownership interest in the provider equal to five percent or more; has an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least five percent of the value of the provider's property or assets; or is an officer, director or partner of the provider or otherwise has the power, directly or indirectly, significantly to influence or direct the actions or policies of the provider;

(D) reasonable compensation for owners or operators, their employees and their relatives for services actually performed and required to be performed. A relative is defined in accordance with Section 902.5 of the Medicare Provider Reimbursement Manual as follows: the spouse; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-inlaw, son-in-law, daughter-in-law, brother-in-law and sister-in-law; and grandparent and grandchild of an owner or operator. The amount of allowable costs for reasonable compensation is equal to the amount of compensation normally required to be paid for the same services provided by a nonrelated employee, as determined by the department. Allowable costs do not include compensation for any services which owners or operators and their employees and relatives are not authorized to perform under State law or regulation;

(E) costs of advertising, public relations or promotion when such costs are specifically related to the provision of personal care services and are not for the purpose of attracting patients; and

(F) such other costs as are determined to be allowable in accordance with reimbursement principles specified in the Medicare Provider Reimbursement Manual.

(iv) Allowable costs do not include the following:

(A) amounts in excess of reasonable or maximum costs authorized under title XVIII of the federal Social Security Act or in excess of customary charges to the general public. This provision does not apply to services furnished by public providers free of charge or at a nominal fee;

(B) expenses or portions of expenses reported by providers that the department determines are not reasonably related to the efficient provision of personal care services because of either the nature or the amount of the particular item;

(C) costs that are not properly related to patient care and that principally afford diversion, entertainment or amusement to owners, operators, their employees or relatives;

(D) any interest paid by the provider that is related to rate determinations or penalties imposed by governmental agencies or courts except tax penalties that are imposed through no fault of the provider and the costs of insurance policies that the provider obtains solely to insure against the imposition of such penalties;

(E) costs of contributions or other payments to political parties, political candidates or political organizations;

(F) any element of cost as determined by the department to have been created by the sale of a provider;

(G) the amount of the personal care services provider assessment required by section 367-i of the Social Services Law or section 3614-b of the Public Health Law; or

(H) such other costs as are determined to be unallowable in accordance with reimbursement principles specified in the Medicare Provider Reimbursement Manual.

(4) Recoveries of expenses. The provider must reduce its reported operating costs by the costs of services or activities that are not properly chargeable to patient care. When the department determines that it is not practical to establish the costs of such services or activities, the provider will reduce its reported operating costs by the income that the provider receives from such services or activities. Examples of such income include, but are not limited to, the following:

(i) any amount the provider receives as a discount on purchases;

(ii) any amount the provider receives from tuition payments or from other payments made to the provider for educational services or other services not directly related to personal care services;

(iii) any amount the provider receives from a lease of office or other space to concessionaires that provide services not related to personal care services; and

(iv) any amount the provider charges for the use of telephone, telefax or telegraph services.

(5) Trend factors.

(i) The department will establish annual trend factors to be applied to providers' reported allowable costs for the provision of personal care services other than nursing supervision or nursing assessment. The department will also establish annual trend factors to be applied to providers' reported allowable costs for the provision of nursing supervision and nursing assessment when providers have contracts with social services districts for the provision of nursing supervision and nursing assessment.

(ii) The department has designated an external price indicator for the aide/nurse direct care component, the administrative component and the training component of the costs of personal care services and the costs of nursing supervision and nursing assessment.

(A) The external price indicators that the department has designated for the costs of personal care services are as follows: for the aide direct care component, the external price indicator is the Employment Cost Index for Compensation for December of each year, as published by the United States Department of Labor, Bureau of Labor Statistics; for the administrative component, the external price indicator is the Consumer Price Index for All Urban Consumers, as published for December of each year by the United States Department of Labor, Bureau of Labor Statistics; and for the training component, the external price indicator is the trend factor established by the Department of Health for certified home health agencies in upstate urban areas.

(B) The external price indicators that the department has designated for the costs of nursing supervision and nursing assessment are as follows: for the nurse direct care and the training components, the external price indicator is the trend factor established by the Department of Health for certified home health agencies in upstate urban areas; and for the administrative component, the trend factor is the Consumer Price Index for All Urban Consumers, as published for December of each year by the United States Department of Labor, Bureau of Labor Statistics.

(iii) The department will determine the average percentage of all providers' total reported costs for personal care services and for nursing supervision and nursing assessment that each component represents as of June 30th of the year prior to the year for which the department is establishing a rate; and the department will weigh each component's average percentage of total personal care services costs and nursing supervision and nursing assessment costs by the external price indicator for that component.

(iv) The department will multiply each provider's reported allowable costs for personal care services and, if applicable, for nursing supervision and nursing assessment, for the year specified in the required cost report by two annual projected trend factors: a projected trend factor that the department has estimated for the year that immediately follows the year for which the provider has reported its costs and a projected trend factor that the department has estimated for the year for which the department is determining a rate.

(v) The department will revise trend factors as specified in this item. Such revisions, if they occur, will occur after the department has determined providers' rates for a particular rate year and is determining providers' rates for the subsequent rate year. When the department determines, based upon the external price indicators, that the actual trend factor for the previous rate year deviated by one-half of one percent or more from the department's projected trend factor for such rate year, the department will revise the projected trend factor for the year immediately following such rate year by the amount of the deviation.

(6) Ceilings on payment for allowable costs.

(i) The department will establish ceilings on payment for providers' allowable costs. The department will determine the ceilings as set forth in this item:

(A) The department will assign providers to one of the following five regional groups:

(i) the Metropolitan Downstate Group, which includes providers located in Nassau, Rockland, Suffolk or Westchester County;

(ii) the Metropolitan Upstate Group, which includes providers located in Albany, Broome, Dutchess, Erie, Monroe, Niagara, Oneida, Onondaga or Orange County;

(iii) the Suburban Group, which includes providers located in Cayuga, Fulton, Genesee, Madison, Montgomery, Ontario, Oswego, Rensselaer, Saratoga, Schenectady or Wayne County;

(iv) the New York City Group, which includes providers located in the five boroughs of New York City; and

(v) the Rural County Group, which includes providers located in any of the remaining 33 social services districts not included in the Metropolitan Downstate, Metropolitan Upstate, Suburban or New York City group.

(B) The department will use providers' reported allowable costs for the 1990 calendar year as the base from which it will determine the ceilings for the rate year that begins on or after January 1, 1994. The department will use providers' reported allowable costs for the 1992 calendar year as the base from which it will determine the ceilings for each rate year that begins on or after January 1, 1995.

(C) For each regional group of providers, the department will calculate the centered means of the appropriate base year costs, other than costs attributable to the administrative component, that the providers in the regional group have reported on the cost reports required by the department.

(D) The department will apply an annual trend factor, as determined in accordance with subclause (5) of this clause, to the centered means of the appropriate base year costs. The department will apply such an annual trend factor for each of the following years: the year that immediately follows the appropriate base year and each subsequent year up to and including but not exceeding the year for which the department will be determining providers' rates.

(E) The department will determine regional ceilings for allowable costs within the combined aide/nurse direct care and the training components of the costs of personal care services and nursing supervision and nursing assessment. The ceiling will be expressed as a percentage of the applicable centered mean, as adjusted by annual trend factors, for each such allowable cost.

(F) The department will establish the following ceilings:

(i) Within the combined aide/nurse direct care and the training components, the ceiling for allowable costs will be 115 percent of the applicable trended regional centered mean; however, any costs providers may incur under their contracts with social services districts to determine whether prospective personal care aides or nurses have federal or state criminal records or to fingerprint personal care aides will not be subject to such ceiling;

(ii) (Effective January 1, 1994, to December 31, 1994) Payment for a provider's administrative and general expenses, excluding capital costs, will not exceed 28 percent of the provider's total allowable costs, as reported by the provider in its cost report. The department will reduce payment for a provider's administrative and general expenses in accordance with the following schedule: when a provider's reported administrative and general expenses, expressed as a percentage of the provider's total allowable costs, are greater than 26 percent, but do not exceed 31 percent, of the provider's total allowable costs, the department will reduce payment for the provider's administrative and general expenses by four percent; when a provider's reported administrative and general expenses, expressed as a percentage of the provider's total allowable costs, are greater than 22 percent, but do not exceed 26 percent, of the

provider's total allowable costs, the department will reduce payment for the provider's administrative and general expenses by three percentage points; and when a provider's reported administrative and general expenses, expressed as a percentage of the provider's total allowable costs, are greater than 20 percent, but do not exceed 22 percent, of the provider's total allowable costs, the department will reduce payment for the provider's administrative and general expenses by two percentage points; however, no provider's administrative and general expenses will be reduced to less than 20 percent of the provider's total allowable costs.

(iii) (Effective January 1, 1995) Payment for a provider's administrative and general expenses, excluding capital costs, will not exceed 28 percent of the provider's total allowable costs, as reported by the provider in its cost report.

(ii) The department will apply the ceilings as follows: when a provider's reported allowable costs are equal to or less than the ceiling that the department has established, the provider will receive full payment for its reported allowable costs. When a provider's reported allowable costs exceed the ceiling that the department has established, the provider will receive payment for such reported allowable costs in an amount not to exceed the ceiling.

(7) Adjustments for profit or surplus.

(i) The department will include an adjustment for profit, for proprietary providers, or surplus, for voluntary providers. The department will determine the amount of the adjustment by calculating the ratio of the provider's allowable costs for aide wages and benefits to the provider's total allowable personal care services costs; multiplying such ratio by the 26 week United States Treasury Bill rate ("treasury bill rate"), as published by the United States Department of the Treasury in the last week of September of the year preceding the year for which the department is determining the rate; and multiplying the provider's rate, as determined in accordance with subclauses (2) - (6) of this clause, by the product of such multiplication. The result is an amount which the department will add to the provider's rate, subject to items (ii) and (iii) of this subclause.

(ii) When the treasury bill rate used for purposes of this subclause has increased or decreased from the previous applicable treasury bill rate by more than two percent, the department will consider only a two percent increase or decrease in the treasury bill rate when determining providers' adjustments for profit or surplus for a particular year.

(iii) The amount that the department will add to the provider's rate as an adjustment for profit or surplus will in no event exceed an amount equal to five percent of the provider's rate absent such adjustment for profit or surplus.

(b) New providers.

(1) Medical assistance payments to new personal care services providers for any rate year beginning on or after January 1, 1994, will be made at the lower of the following rates:

(i) the rate the provider charges the general public for personal care services; or

(ii) the rate determined by the department in accordance with subclause (2) of this clause.

(2) (i) The department will determine a new provider's payment rate based on the cost report the provider submits. Each provider must report its estimated personnel and non-personnel operating costs as specified in the cost report.

(ii) The department will consider only the provider's estimated operating costs that are allowable costs, as determined in accordance with subclause (a)(3) of this subparagraph and as adjusted by the provider in accordance with subclause (4) of such clause.

(iii) The department will determine whether the provider's estimated allowable costs exceed the ceilings that the department will establish for such costs in accordance with subclause (a)(6) of this subparagraph, except that the limitation on providers' administrative and general expenses that is set forth in subitems (a)(6)(i)(F)(II) and (III) of this subparagraph will not apply to new providers in the first year of operation, and if the provider's estimated allowable costs otherwise exceed such ceilings, the department will consider only such of the provider's estimated allowable costs that do not exceed such ceilings.

(iv) The department will calculate an amount for profit, for proprietary providers, or surplus, for voluntary providers, as determined in accordance with subclause (a)(7) of this subparagraph.

(v) The resulting rate will be payment-in-full for all personal care services provided to MA recipients during the applicable rate year, subject to any revisions the department may make in accordance with the rate revision or audit processes authorized by subparagraphs (iii) or (iv) of this paragraph.

(iii) Revisions to rates.

(a) The department will notify each provider of its approved rates of payment at least thirty days prior to the beginning of an established rate period for which the rate is to become effective. In the case of payments to be made by state governmental agencies notification shall be made only after approval of rate schedules by the state director of the budget. The advance notification of rates shall not apply to prospective or retroactive adjustments to rates that are based on rate appeals filed by the provider, audits, corrections of errors or omission of data or errors in the computation of such rates or the submission of cost report data from providers without an estimated cost basis.

(b) (1) Within 90 calendar days after the provider receives the written notification of its rate, the provider must notify the department of any errors in the rate resulting either from the provider's submission of erroneous information in its cost report or the department's erroneous computation of the rate and of the provider' s request for a revised rate.

(2) The provider must submit its notice and request for a revised rate on forms as may be required by the department. The request for a revised rate must specify the basis for the revision, as specified in clause (c) of this subparagraph, and contain documentation supporting the request. The department may request such additional documentation as determined necessary.

(c) The department will consider only those requests for rate revisions that are based on one or more of the following:

(1) the provider's claim that the rate contains mathematical, statistical, fiscal or clerical errors;

(2) the provider's claim that it has incurred new or unanticipated costs for programs or services mandated or approved by the department and that the cost report that the provider submitted to the department does not reflect the provider's actual costs for reasons beyond the provider's control; or

(3) the provider's desire to obtain a rate that is lower than the rate promulgated by the department.

(d) When the department determines that a provider's request for a revised rate does not meet one or more requirements of clause (c) of this subparagraph, the department will notify the provider in writing within 30 calendar days of such determination.

(e) When the department determines that a provider's request for a revised rate meets one or more requirements of clause (c) of this subparagraph, the department will determine whether the provider's rate should be revised. The department will notify the provider in writing of the results of its determination and, if the department determines that the provider's rate should be revised, of the revised rate. Within six months after the date the department receives the provider's request for a revised rate, the department will submit its determination regarding the revised rate to the Division of the Budget for its review and approval.

(f) Within 30 calendar days after the provider receives the written notification of its revised rate, the provider must notify the department in writing of any errors in the revised rate.

(iv) Audits, hearings and recoveries of overpayments. Parts 517, 518, and 519 of this Title, which concern provider audits, recoveries of overpayments and provider hearings respectively, apply to audits of, recoveries of overpayments from, and hearings granted to providers subject to the requirements of this paragraph.

(v) Exemptions.

(a) A social services district may request an exemption from the application of the methodology, as set forth in subparagraphs (i) through (iii) of this paragraph, to providers with which the district has contracts for the provision of personal care services. A social services district that seeks an exemption must submit a written exemption request to the department. The exemption request must describe the alternative rate methodology that the district has developed and will use to determine payments to personal care services providers and such other information as the department may require.

(b) The department may grant a social services district's exemption request when it determines that the alternative rate methodology that the district will use is based on providers' costs of providing personal care services; includes an adjustment for inflationary increases in the providers' costs of doing business; and contains provisions comparable, as determined by the department, to the rate methodology and other provisions set forth in this paragraph.

(i) Reimbursement. State reimbursement shall be available pursuant to section 368-a of the Social Services Law for expenditures for services provided in accordance with the provisions of this section.

(j) Annual plan. The local social services department shall submit annually to the New York State Department of Social Services a plan for provision of personal care services on forms required by the department.

(k) Shared aide plans. (l) Except as provided in paragraph (2) of this subdivision, each social services district must implement a shared aide plan approved by the department.

(i) Prior to implementing a shared aide plan, a social services district must develop a proposed shared aide plan and submit the proposed plan to the department for its review and approval or disapproval. The social services district must submit its proposed shared aide plan to the department on forms the department requires and within 60 business days after the department issues an administrative directive to all social services districts regarding the districts' development
and implementation of shared aide plans.

(ii) In its proposed shared aide plan, the social services district must document the following information to the department's satisfaction:

(a) the number of shared aide sites the social services district plans to establish and the projected implementation date at each site;

(b) the number of nurse supervisors, case managers, provider agency coordinators, and other personnel who will serve personal care services recipients under the district's shared aide plan;

(c) the methods the social services district will use to inform personal care services recipients and providers regarding the district's shared aide plan;

(d) the methods the social services district will use to select the personal care services providers that will participate in the district's shared aide plan;

(e) the differences, if any, between the provision of nursing assessments, nursing supervision, and case management to personal care services recipients under the district's shared aide plan and the district's existing method of delivering personal care services; and

(f) the methods the social services district will use to monitor and evaluate the district's shared aide plan, including how the district will evaluate personal care services recipients' satisfaction with the district's shared aide plan.

(iii) The department will approve proposed shared aide plans that comply with the requirements set forth in this paragraph. The department will notify the social services district in writing of its approval or disapproval of the district's proposed plan within 45 business days after receipt of the plan. If the department disapproves the social services district's proposed plan, the district must submit a revised plan within 30 business days after receipt of the department's disapproval notice. The department will notify the social services district in writing of its approval or disapproval of the district's revised plan within 45 business days after receipt of the revised plan.

(iv) Each social services district with an approved shared aide plan must submit to the department such reports or information relating to the plan's implementation as the department may require. Personal care services providers must furnish such reports or information relating to the social services district's implementation of its shared aide plan as the district or the department may require.

(v) Except as otherwise provided in this subdivision, personal care services provided under a shared aide plan must conform to the standards specified in this section.

(vi) A social services district may delegate to another agency or entity the responsibility for developing and implementing a shared aide plan provided that the department has approved the delegation, and the social services district and such other agency or entity have a written agreement or contract specifying each entity's responsibilities.

(2) A social services district is not required to develop and implement a shared aide plan if the district has requested an exemption from the shared aide plan requirement and the department has approved the district's exemption request.

(i) A social services district that seeks an exemption from the shared aide plan requirement must submit an exemption request to the department for its review and approval or disapproval. The social services

district must submit its exemption request to the department on forms the department requires and within 60 business days after the department issues an administrative directive to all social services districts regarding the districts' development and implementation of shared aide plans.

(ii) In its exemption request, the social services district must satisfactorily document that the district's existing method of delivering personal care services adequately meets, and can continue to meet, recipients' personal care services needs and that a sufficient supply of personal care services providers is available, and is reasonably expected to continue to be available, to provide personal care services to recipients in the district. A social services district's exemption request must also satisfactorily document that at least one of the following exemption criteria exists in the district:

(a) the number of personal care services recipients is either too few to support a shared aide plan or so geographically dispersed that the district cannot identify a group of recipients for which a shared aide plan would be appropriate;

(b) the annual costs of delivering personal care services under a shared aide plan would be equal to, or greater than, the annual costs of delivering personal care services under the district's existing method; or

(c) the district has another cost-effective method to improve the efficiency of the delivery of personal care services.

(iii) The department will approve exemption requests that comply with the requirements set forth in this paragraph. The department will notify the social services district in writing of its approval or disapproval of the district's exemption request within 45 business days after receipt of the exemption request.

(a) If the department disapproves the district's exemption request, the district must submit either a revised exemption request or a proposed shared aide plan within 30 business days after receipt of the disapproval notice. The department will notify the social services district in writing of its approval or disapproval of the district's revised exemption request or proposed shared aide plan within 45 business days after receipt of the revised exemption request or proposed shared aide plan.

(1) If the social services district submits a revised exemption request and the department disapproves the revised exemption request, the district must submit a proposed shared aide plan within 30 business days after receipt of the disapproval notice. The social services district's proposed shared aide plan, and the department's review and approval or disapproval of the proposed shared aide plan, must otherwise meet the requirements of paragraph (1) of this subdivision.

(2) If the social services district submits a proposed shared aide plan and the department disapproves the proposed shared aide plan, the district must submit a revised shared aide plan within 30 business days after receipt of the disapproval notice. The social services district's revised shared aide plan, and the department's review and approval or disapproval of the revised shared aide plan must otherwise meet the requirements of paragraph (1) of this subdivision.

(iv) An approved exemption request is effective only for the year covered by the social services district's current approved annual plan for the provision of personal care services, as required by subdivision (j) of this section. A social services district that has been exempted from the shared aide plan requirement must submit a new exemption request or a proposed shared aide plan when the district submits a new annual plan for the provision of personal care services or before the day that the district's approved exemption request expires.

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# 18 NYCRR 505.23 APPENDIX 1 CATANZANO IMPLEMENTATION PLAN

(f) APPENDIX 1--Catanzano Implementation Plan.

CATANZANO IMPLEMENTATION PLAN

Revised effective March 20, 1996

by order of the United States District Court

Western District of New York

This is to advise you that the Department has been ordered to issue the following directive by Order of the United States District Court, Western District of New York, in an action entitled "Catanzano et al. v. Dowling et al." 89 CV 1127L.

The Order is limited to adverse actions taken contrary to a treating physician's orders with respect to home health services.

I. HOME HEALTH SERVICES APPLICANTS: Section1.0. A home health services applicant means:

(a) each MA recipient who is not currently receiving home health services and who resides in his or her own home or in any other community setting in which home health services may be provided; and

(b) each hospitalized MA recipient who did not receive home health services immediately prior to hospitalization.

A. APPLICANT DENIALS BASED ON HEALTH AND SAFETY: Section100. Instructions to CHHAs:

(a) The following instructions apply when a certified home health agency (CHHA) determines that it will not admit a Medical Assistance

(MA) recipient because the CHHA believes that the home health services ordered by the recipient's physician cannot maintain the recipient's health and safety in the home for one or more of the reasons specified in the New York State Department of Health (DOH) regulations at Title 10 NYCRR Section763.5(b) (1) (i) through (iv), Section763.5(b) (2) (i) or Section763.5(b) (2)

(iv). These instructions do not apply when a CHHA determines not to admit an MA recipient for one or more of the reasons specified in DOH regulations at 10 NYCRR Section763.5(b) (2) (ii) (a) through (c) or õ763.5(b)

(2) (iii).

(b) When a CHHA determines that the home health services that an MA recipient's physician has ordered would not maintain the recipient's health and safety, the CHHA must consult with the physician. The purpose of this consultation is for the physician and the CHHA to develop, if possible, a plan of care that would maintain the recipient's health and safety.

õ101. If, after consulting with the MA recipient's physician, the CHHA determines not to admit the recipient because the CHHA and the physician are unable to develop a plan of care that the CHHA believes would maintain the recipient's health and safety, the CHHA must follow the procedures set forth below:

(a) Hospitalized MA recipients: The CHHA must refer a hospitalized MA recipient's case to the hospital

discharge planner who, in accordance with existing procedures, will attempt to locate another CHHA that will agree to admit the recipient and provide home health services in accordance with the physician's order. If the discharge planner is unable to locate another CHHA, the discharge planner or the original CHHA must refer the recipient's case to the social services district. The referral must include a copy of the CHHA's assessment of the recipient, all other documentation that the CHHA has either prepared regarding the recipient or has received from the recipient's physician, and the name and telephone number or fax number of the recipient's physician. The CHHA or the discharge planner must inform the recipient and the recipient's physician that the recipient's case has been referred to the social services district.

(b) Non-hospitalized MA recipients: The CHHA must refer a non-hospitalized MA recipient's case to the social services district. The CHHA's referral must include a copy of the documentation set forth in (a), above. The CHHA must inform the recipient and the recipient's physician that it has referred the recipient's case to the social services district.

§102. Instructions to social services districts:

(a) When a CHHA or a hospital discharge planner refers an MA recipient to the social services district in accordance with the procedures outlined in õ101(a) or (b) above, the social services district must forward the recipient's case and all relevant documentation to the local professional director or designee.

(b) The local professional director or designee will review the documentation and determine, on behalf of the social services district, whether home health services should be denied contrary to the physician's order or should be provided according to the physician' s order.

(c) The local professional director or designee will notify the social services district and the CHHA of his or her final determination within 10 business days after receiving the MA recipient's case and all supporting documentation from the social services district.

§103. Depending on the local professional director's or designee's determination, the social services district must take the following action:

(a) Determinations denying home health services contrary to physician' s order:

When the local professional director or designee determines that home health services should be denied contrary to the physician's order, the social services district must send the MA recipient an adequate notice, as defined in Department regulation 18 NYCRR õ 358-2.2. The social services district must use the new notice attached to this directive as Appendix A and entitled "NOTICE OF INTENT TO DENY HOME HEALTH SERVICES

(HEALTH AND SAFETY)." Until further notice, the social services district must photocopy this notice and issue it on legal-size rather than letter-size paper. The social services district must also issue the notice as a two-sided rather than a two-paged notice.

(b) Decisions that home health services should be provided according to physician's order:

When the local professional director or designee determines that home health services should be provided according to the physician's order, the social services district must attempt to refer the MA recipient's case to a CHHA that will agree to admit the recipient and provide home health services according to the physician's order. If the social services district is unable to find a CHHA that will do so,

the social services district must direct a CHHA to admit the recipient and to provide the recipient with home health services according to the physician's order.

7 B. APPLICANT DENIALS BASED ON FISCAL ASSESSMENTS: ō104. By letter dated February 18, 1994, the Department advised CHHAs and social services districts that, until further notice, CHHAs must not conduct, and social services districts must not review, fiscal assessments of home health services applicants. The Department is now changing those instructions, as set forth below.

ō105. Instructions to CHHAs: Beginning immediately, each CHHA must resume the conduct of fiscal assessments of each MA recipient who is applying for home health services and whom the CHHA reasonably expects will require home health services for more than 60 continuous days.

Section106. Instructions to social services districts: Beginning immediately, each social services district must resume the review of fiscal assessments that CHHAs conduct of MA recipients who are applying to the CHHAs for home health services.

Section107. Agreement with CHHA's determination that home health services should be denied based on the fiscal assessment:

(a) The social services district must send the recipient an adequate notice when the district agrees with the CHHA's determination that the home health services ordered by the recipient's physician should be denied based on the fiscal assessment or should be denied because the recipient is appropriate for an "efficiency." (A list of the "efficiencies" is set forth at page 8 of 92 ADM-50.)

(b) The social services district must use the new notice attached to this directive as Appendix B and entitled "NOTICE OF INTENT TO DENY HOME HEALTH SERVICES (FISCAL ASSESSMENT AND EFFICIENCIES)." Until further notice, the social services district must photocopy this notice and issue it on legal-size paper rather than on letter-size paper. The social services district must also issue the notice as a two-sided notice, rather than a two-paged notice, and attach the one-page list of exception criteria to the notice.

Section108. Disagreement with CHHA's determination that home health services should be denied or provided based on the fiscal assessment or based on the use of an "efficiency":

(a)The social services district must refer the recipient's case to the local professional director or designee when the district disagrees with the CHHA's determination that the home health services ordered by the recipient's physician should be denied or provided based on the fiscal assessment or based on the use of one or more "efficiencies."

(b) The local professional director or designee must review the documentation submitted by the social services district and determine whether the recipient should be denied or provided home health services.

(c) The local professional director or designee must notify the social services district and the CHHA of his or her determination within 10 business days after receiving the recipient's case and all supporting documentation from the social services district.

(d) When the local professional director or designee determines that the MA recipient should be denied home health services, the social services district must send the recipient an adequate notice. The social services district must use the new notice attached to this directive as Appendix B and entitled "NOTICE OF INTENT TO DENY HOME HEALTH SERVICES

(FISCAL ASSESSMENT AND EFFICIENCIES)." This is the same notice described in Section 107 (b) above. Until further notice, the social services district must photocopy this notice and issue it on legal-size paper rather than on letter-size paper. The social services district must also issue the notice as a two-sided notice, rather than a two-paged notice, and attach the one-page list of exception criteria to the notice.

(e) When the local professional director or designee determines that the MA recipient should be provided home health services, the social services district must attempt to refer the MA recipient's case to a CHHA that will agree to admit the recipient and provide home health services according to the physician's order. If the social services district is unable to find a CHHA that will do so, the social services district must direct a CHHA to admit the recipient and to provide the recipient with home health services according to the physician's order.

II. HOME HEALTH SERVICES RECIPIENTS: Section2.0 A home health services recipient means:

(a) each MA recipient who is currently receiving home health services in his or her own home or in any other community setting in which home health services may be provided; and

(b) each hospitalized MA recipient who received home health services immediately prior to hospitalization.

A. CHHA DETERMINATIONS, CONTRARY TO PHYSICIAN'S ORDERS, TO DISCHARGE MA RECIPIENTS BECAUSE HOME HEALTH SERVICES CANNOT MAINTAIN RECIPIENTS' HEALTH AND SAFETY:

Section 200. Instructions to CHHAs: (a) The following instructions apply when a CHHA determines that it should discharge an MA recipient, although the physician disagrees, because the home health services ordered by the recipient's physician can no longer maintain the recipient's health and safety for one or more of the reasons specified in DOH regulations at 10 NYCRR õ763.5(h) (1), õ763.5(h) (4) or õ763.5(h) (5).

(b) These instructions do not apply when a CHHA determines that it should discharge an MA recipient for one or more of the reasons specified in DOH regulations at 10 NYCRR õ763.5(h) (2).

(c) Determinations to discharge based on a recipient's request [10 NYCRR 763.5(h) (3)] are covered in õ215 and õ216 below.

õ201. When a CHHA determines that the home health services ordered by the recipient's physician can no longer maintain an MA recipient's health and safety, the CHHA must consult with the physician. The CHHA may discharge the recipient if the recipient's physician provides the CHHA with a written statement that the recipient may be discharged or if the recipient's physician directs the CHHA to immediately comply with his oral statement that the recipient may be discharged, in which event a written statement from the physician authorizing discharge shall be provided within seven (7) days.

õ202. When the recipient's physician does not provide the CHHA with such a written or oral statement agreeing to the discharge, the CHHA must:

(a) refer the recipient's case to a CHHA that, after assessing the recipient, agrees to admit the recipient and provide home health services according to the physician's order and continue to provide home health services according to the physician's order until the new CHHA has assessed and admitted the recipient;

OR

(b) refer the recipient's case to the social services district and continue to provide home health services according to the physician's order until notified otherwise by the social services district. The CHHA's referral must include a copy of the CHHA's assessment of the recipient, all other documentation that the CHHA has either prepared regarding the recipient or has received from the recipient's physician, and the name and telephone number or fax number of the recipient's physician. The CHHA must inform the recipient and the recipient's physician that it has referred the recipient's case to the social services district.

§203. Instructions to social services districts:

(a) When a CHHA refers an MA recipient to the social services district in accordance with the procedures outlined in õ 202(b) above, the social services district must forward the recipient's case and all relevant documentation to the local professional director or designee.

(b) The local professional director or designee must review the documentation and determine, on behalf of the social services district, whether home health services should be discontinued contrary to the physician's order or should be provided according to the physician's order.

(c) The local professional director or designee will notify the social services district and the CHHA of his or her determination within 10 business days after receiving the MA recipient's case and all supporting documentation from the social services district.

§204. Depending on the local professional director's or designee's determination, the social services district must take the following action:

(a) Determinations that home health services should be discontinued contrary to physicians' orders:

When the local professional director or designee determines that home health services should be discontinued contrary to the physician's order, the social services district must send the MA recipient a timely and adequate notice. The social services district must use the new notice attached to this directive as Appendix C and entitled "NOTICE OF INTENT TO REDUCE OR DISCONTINUE HOME HEALTH SERVICES (HEALTH AND SAFETY)." Until further notice, the social services district must photocopy this notice and issue it on legal-size paper rather than letter-size paper. The social services district must also issue this notice as a two-sided notice rather than a two-paged notice.

(b) Determinations that home health services should be provided according to physicians' orders:

When the local professional director or designee determines that home health services should be provided according to the physician's order, the social services district must inform the CHHA of the determination and that the CHHA must provide the services according to the physician's order.

Section205. Aid-continuing instructions to CHHAs and social services districts:

(a) When the social services district determines that home health services should be discontinued contrary to the physician's order, the CHHA must not discharge the recipient until the effective date of the fair hearing notice. The CHHA must also continue to provide the recipient with aid-continuing, for which the CHHA will continue to be reimbursed by the Medical Assistance Program, when the recipient requests a fair hearing prior to the effective date of the notice.

(b) The Department's Office of Administrative Hearings will notify the social services district of each recipient who has timely requested a fair hearing with aid-continuing. The social services district must then notify the CHHA of each such recipient who is entitled to receive aidcontinuing.

B. CHHA DETERMINATIONS, CONTRARY TO PHYSICIANS' ORDERS, TO REDUCE MA RECIPIENTS' HOME HEALTH SERVICES BECAUSE THE RECIPIENTS' MEDICAL CONDITIONS HAVE IMPROVED:

Section206. Instructions to CHHAs: These instructions apply when a CHHA determines that a recipient's home health services should be reduced because the recipient's medical condition has improved, or for other reasons related to the recipient's medical condition or health and safety, but the recipient's physician disagrees with the CHHA's determination.

Section207. When a CHHA determines that a recipient's home health services should be reduced for such reasons, the CHHA must consult with the recipient's physician. The CHHA may reduce the recipient's home health services if the recipient's physician provides the CHHA with a written statement that the recipient's services may be reduced or if the recipient's physician directs the CHHA to immediately comply with his oral statement to reduce services, in which event a written statement from the physician authorizing a reduction in services shall be provided within seven (7) days.

Section208. If the recipient's physician does not provide the CHHA with such a written or oral statement agreeing to the reduction, the CHHA must:

(a) refer the recipient's case to a CHHA that, after assessing the recipient, agrees to admit the recipient and provide home health services according to the physician's order and continue to provide home health services according to the physician's order until the new CHHA has assessed and admitted the recipient; OR

(b) refer the recipient's case to the social services district and continue to provide home health services according to the physician's order until notified otherwise by the social services district. The CHHA's referral must include a copy of the CHHA's assessment of the recipient, all other documentation that the CHHA has either prepared regarding the recipient or has received from the recipient's physician, and the name and telephone number or fax number of the recipient's physician. The CHHA must inform the recipient and the recipient's physician that it has referred the recipient's case to the social services district.

Section209. Instructions to social services districts:

(a) When a CHHA refers an MA recipient to the social services district in accordance with the procedures outlined in Section 208(b) above, the social services district must forward the recipient's case and all relevant documentation to the local professional director or designee.

(b) The local professional director or designee must review the documentation and determine, on behalf of the social services district, whether home health services should be reduced contrary to the physician's order or should be provided according to the physician' s order.

(c) The local professional director or designee will notify the social services district and the CHHA of his or her determination within 10 business days after receiving the MA recipient's case and all supporting documentation from the social services district.

δ210. Depending on the local professional director's or designee's determination, the social services district must take the following action:

(a) Determinations that home health services should be reduced contrary to physicians' orders:

When the local professional director or designee determines that home health services should be reduced contrary to the physician's order, the social services district must send the MA recipient a timely and adequate notice. The social services district must use the new notice attached to this directive as Appendix C and entitled: "NOTICE OF INTENT TO REDUCE OR DISCONTINUE HOME HEALTH SERVICES (HEALTH AND SAFETY)." Until further notice, the social services district must photocopy this notice and issue it on legal-size paper rather than letter-size paper. The social services district must also issue the notice as a two-sided notice rather than a two-paged notice.

(b) Determinations that home health services should be provided according to physicians' orders:

When the local professional director or designee determines that home health services should be provided according to the physician's order, the social services district must inform the CHHA of the determination and that the CHHA must provide the services according to the physician's order.

§211. Aid-continuing instructions to CHHAs and social services districts:

(a) When the social services district determines that home health services should be reduced contrary to the physician's order, the CHHA must not reduce the recipient's home health services until the effective date of the notice. The CHHA must also continue to provide the recipient with aid-continuing, for which the CHHA will continue to be reimbursed by the Medical Assistance Program, when the recipient requests a fair hearing prior to the effective date of the notice.

(b) The Department's Office of Administrative Hearings will notify the social services district of each recipient who has timely requested a fair hearing with aid-continuing. The social services district must then notify the CHHA of each such recipient who is entitled to receive aidcontinuing.

C. DISCONTINUANCES BASED ON FISCAL ASSESSMENTS AND REDUCTIONS BASED ON THE USE OF EFFICIENCIES:

§212. Agreement cases: When a social services district agrees with a CHHA's determination, which was made contrary to the physician's order, that the recipient's home health services should be reduced based on the use of one or more efficiencies or discontinued based on the fiscal assessment, the district must follow the procedures set forth below: (a) Agreement on reductions:

When the social services district agrees with the CHHA that the recipient's home health services should be reduced based on the use of one or more efficiencies, the district must send the recipient a timely and adequate "NOTICE OF INTENT TO REDUCE HOME HEALTH SERVICES (FISCAL ASSESSMENT/EFFICIENCIES)" This is a new notice that is attached to this directive as Appendix D and that replaces Attachment 4 of 92 ADM-50. Until further notice, the social services district must photocopy this new notice and issue it as a two-sided notice rather than a two-paged notice on legal-size paper.

(b) Agreement on discontinuances: When the social services district agrees with the CHHA that the recipient's home health services should be discontinued based on the fiscal assessment, the social services district must send the recipient a timely and adequate "NOTICE OF INTENT TO DISCONTINUE HOME HEALTH SERVICES

(FISCAL ASSESSMENT)." This is a new notice that is attached to this directive as Appendix E and that replaces Attachment 5 of 92 ADM-50. Until further notice, the social services district must photocopy this new notice and issue it as a two-sided notice rather than a two-paged notice on legal-size paper. The social services district must also attach the one-page list of exception criteria as page 3 of this discontinuance notice.

Section213. Disagreement cases:

(a) When a social services district disagrees with a CHHA's determination that a recipient's home health services should be reduced based on the use of one or more efficiencies, or discontinued based on the fiscal assessment, the district must refer the recipient's case to the local professional director or designee.

(b) The local professional director or designee will review the documentation submitted by the social services district and determine whether the recipient's home health services should be reduced or discontinued.

(c) The local professional director or designee will notify the social services district and the CHHA of his or her final determination within 10 business days after receiving the recipient's case and all supporting documentation from the social services district.

(d) When the local professional director or designee determines that the recipient's home health services should be reduced or discontinued, the social services district must provide the recipient with timely and adequate notice. For reductions, the district must use the notice attached to this directive as Appendix D and entitled "NOTICE OF INTENT TO REDUCE HOME HEALTH SERVICES (FISCAL ASSESSMENT/EFFICIENCIES)." For discontinuances, the district must use the notice attached to this directive as Appendix E and entitled "NOTICE OF INTENT TO DISCONTINUE HOME HEALTH SERVICES (FISCAL ASSESSMENT)."

Section214. Aid-continuing instructions to CHHAs and social services districts:

(a) The CHHA must not reduce or discontinue the recipient's home health services until the effective date of the fair hearing notice. In addition, the CHHA must continue to provide the recipient with aid-continuing, for which the CHHA will continue to be reimbursed by the Medical Assistance Program, when the recipient requests a fair hearing prior to the effective date of the notice. The Department's Office of Administrative Hearings will notify the social services district of each recipient who has timely requested a fair hearing with aid-continuing.

(b) The social services district must then notify the CHHA of each such recipient who is entitled to receive aid-continuing.

E. RECIPIENTS' REQUESTS TO BE DISCHARGED: Section215. Written requests for discharge:

(a) Instructions to CHHAs: When a CHHA receives a clear, written statement that has been signed by a recipient and states that the recipient no longer wishes home health services, the CHHA must consult with the recipient's physician. When the recipient's physician believes that the recipient should continue to receive home health services according to the physician's recommendations, the CHHA must inform the social services district that the recipient wishes to be discharged contrary to the physician's recommendations. The CHHA must continue to provide home health services to the recipient in accordance with the physician's recommendations.

(b) Instructions to social services districts:

(i) When a social services district is informed by a CHHA, in accordance with Section 215(a), that the recipient has submitted a clear, written statement that he or she no longer wishes to receive home health services, the district must send the recipient an adequate notice, as defined in Department regulation 18 NYCRR Section 358-2.2. The social services district must use the new notice attached to this directive as Appendix F and entitled "ADEQUATE NOTICE OF INTENT TO DISCONTINUE HOME HEALTH CARE SERVICES (AT RECIPIENT'S REQUEST)." Until further notice, the social services district must photocopy this notice and issue it on legal-size paper rather than letter-size paper. The social services district must also issue the notice as a two-sided notice rather than a two-paged notice.

(ii) When the recipient requests a fair hearing within 10 days after the date that the fair hearing notice is postmarked, the social services district must notify the CHHA that it must provide aid-continuing, for which the CHHA will be reimbursed by the Medical Assistance Program.

(iii) The Department's Office of Administrative Hearings will notify the social services district of each recipient who has timely requested that his or her benefits be reinstated. The social services district must then notify the CHHA that it must provide aid-continuing to the recipient pending issuance of a fair hearing decision.

Section216. Oral requests for discharge:

(a) Instructions to CHHAs: When a recipient orally states to CHHA personnel that he or she no longer wishes to receive home health services, the CHHA must consult with the recipient's physician. When the recipient's physician believes that the recipient should continue to receive home health services according to the physician's recommendation, the CHHA must inform the social services district that the recipient wishes to be discharged contrary to the physician's recommendation and continue to provide home health services according to the physician' s recommendations.

(b) Instructions to social services districts:

(i) When a social services district is informed by a CHHA, in accordance with õ 216 (a), that the recipient has orally stated that he or she no longer wishes to receive home health services, the district must send the recipient a timely and adequate notice. The social services district must use the new notice attached to this directive as Appendix G and entitled "TIMELY AND ADEQUATE NOTICE OF INTENT TO DISCONTINUE HOME HEALTH SERVICES (AT RECIPIENT'S REQUEST)" Until further notice, the social services district must photocopy this notice and issue it on legal-size paper rather than letter-size paper. The social services district must also issue this notice as a two-sided notice rather than a two-paged notice.

(ii) When the recipient requests a fair hearing prior to the effective date of the notice, the social services district must notify the CHHA that it must provide aid-continuing, for which the CHHA will be reimbursed by the Medical Assistance Program.

(iii) The Department's Office of Administrative Hearings will notify the social services district of each recipient who has timely requested a fair hearing with aid-continuing. The social services district must then notify the CHHA that it must provide aid-continuing to the recipient pending issuance of a fair hearing decision.

III. RETROACTIVE RELIEF: A. CHHA DETERMINATIONS MADE ON OR AFTER NOVEMBER

15, 1993, TO DENY ADMISSION TO OR DISCHARGE MA RECIPIENTS FOR REASONS RELATED TO RECIPIENTS' HEALTH AND SAFETY OR TO REDUCE MA RECIPIENTS' HOME HEALTH SERVICES FOR REASONS RELATED TO RECIPIENTS' HEALTH AND SAFETY:

õ301. Except as provided below, the following instructions apply to the following CHHA determinations made on or after November 15, 1993:

(a) CHHA determinations not to admit MA recipients because home health services cannot maintain the recipients' health and safety;

(b) CHHA determinations to discharge MA recipients because home health services can no longer maintain the recipients' health and safety for one or more of the reasons specified in DOH regulations at 10 NYCRR õ763.5(h) (1), õ763.5(h) (4) or õ763.5(h) (5); and

(c) CHHA determinations to reduce MA recipients' home health services because the recipients' medical conditions have improved or for other reasons related to the recipients' medical conditions or health and safety.

õ302. These instructions DO NOT apply to the following CHHA determinations made on or after November 15, 1993:

(a) Any CHHA determination made on or after November 15, 1993, to deny admission to an MA recipient when the recipient's physician agreed with the CHHA's determination not to admit the recipient;

(b) Any CHHA determination made on or after November 15, 1993, to reduce an MA recipient's home health services when the recipient's physician had ordered that the recipient's services be reduced and the CHHA reduced the services consistent with the physician's order;

(c) Any CHHA determination made on or after November 15, 1993, to discharge an MA recipient for reasons related to the recipient's medical
condition when the recipient's physician had ordered that the recipient be discharged and the CHHA discharged the recipient consistent with the physician's order;

(d) Any CHHA determination made on or after November 15, 1993, to discharge an MA recipient for one or more of the reasons specified in DOH regulations at 10 NYCRR Section763.5(h) (2) or Section763.5(h) (3); and

(e) Any CHHA determination made with respect to an MA recipient who is now deceased.

Section303. Instructions to CHHAs:

(a) Each CHHA must review its case records on all MA recipients whom the CHHA either denied admission to or discharged on or after November 15, 1993, or whose home health services were reduced on or after such date.

(b) The CHHA is not required to take any further action with respect to any MA recipient who was denied admission or discharged or whose services were reduced in accordance with Section302(a), (b), (c), (d), or (e) above. The CHHA is required, however, to take certain action with respect to all other MA recipients whom the CHHA denied admission to or discharged on or after November 15, 1993, or whose services were reduced on or after such date and who did not receive an adequate fair hearing

notice and an opportunity to request a fair hearing with aid-continuing, when aid-continuing was appropriate.

Specifically, the CHHA must obtain a new physician's order and conduct a new assessment of the MA recipient in accordance with DOH regulations.

Section304. When the CHHA agrees with the new physician's order, the CHHA must admit or discharge the recipient or provide the recipient services in accordance with the order.

Section305. When the CHHA disagrees with the new physician's order, the CHHA must follow the appropriate instructions to CHHAs previously set forth in this directive. Specifically, the CHHA must follow the instructions to CHHAs in õ100 et seq. when the CHHA determines not to admit the recipient contrary to the physician's order; the CHHA must follow the instructions to CHHAs in õ200 et seq. and the aid-continuing instructions in õ205, when the CHHA determines that the recipient should be discharged contrary to the physician's order; and the CHHA must follow the instructions to CHHAs in õ206 et seq. and the aid-continuing instructions in õ211 when the CHHA determines that the recipient's services should be reduced contrary to the physician's order. Aid-continuing must be provided at the level of services required by the physician's new order.

õ306. Instructions to social services districts: The social services district must follow the appropriate instructions to social services districts set forth in this directive. Specifically, the social services district must follow the instructions to social services districts in õ102 et seq. when acting upon a CHHA's determination, contrary to the physician's order, not to admit an MA recipient for health and safety reasons; the district must follow the instructions to social services districts in õ203 et seq. and the aid-continuing instructions in õ205 when acting upon a CHHA's determination, contrary to the physician's order, to discharge an MA recipient for health and safety reasons; and the district must follow the instructions to social services districts in õ209 et seq. and the aid-continuing instructions in õ211 herein when acting upon a CHHA's determination, contrary to the physician's order, to reduce a recipient's home health services. Aidcontinuing must be provided at the level of services required by the physician's new order.

B. SOCIAL SERVICES DISTRICT DETERMINATIONS MADE ON OR AFTER NOVEMBER 15, 1993, TO DENY, REDUCE OR DISCONTINUE MA RECIPIENTS' HOME HEALTH SERVICES BASED UPON FISCAL ASSESSMENTS:

§307. Reductions or discontinuances: Social services districts and CHHAs are reminded that the instructions set forth in the Department's February 25, 1994, memorandum entitled "Further Catanzano instructions: retroactive relief" remain in effect. These instructions apply to MA recipients whose home health services were reduced or discontinued on or after November 15, 1993, for reasons related to fiscal assessments. A copy of these instructions is attached to this directive as Appendix H.

§308. Denials contrary to physicians' orders: Social services districts must identify each case that meets the following requirements:

(a) The CHHA conducted an initial fiscal assessment on or after November 15, 1993, on any MA recipient, regardless of whether the recipient was hospitalized or residing at home, who was not receiving home health services from the CHHA when it conducted the fiscal assessment;

(b) The social services district agreed or disagreed with the CHHA's determination not to admit the MA recipient because the recipient's home care costs exceeded 90 percent of RHCF costs and the recipient did not meet any exception criteria;

(c) The recipient was denied home health services as a result of the fiscal assessment and contrary to the physician's order; and

(d) The social services district did not send the MA recipient an adequate fair hearing notice advising the recipient of his or her right to request a fair hearing to appeal the denial of home health services.

ō309. Social services districts have the following responsibilities for each MA recipient whom the districts identify as meeting the requirements set forth in (a) through (d) of ō308 above:

(a) The social services district must notify the CHHA of each recipient whom the district identifies as meeting these requirements;

(b) The CHHA must complete a new assessment of the recipient including a new fiscal assessment and forward the fiscal assessment to the district; and

(c) The social services district must follow the notice and fair hearing instructions previously set forth at ō107 herein when the social services district agrèes with the CHHA's determination that home health services should be denied based on the fiscal assessment. When the social services district disagrees with the CHHA's determination that home health services should be denied or provided based on the fiscal assessment, the district must follow the notice and fair hearing instructions previously set forth at ō108 herein.

ō310. Should you have questions regarding your responsibilities, please telephone Mary Jane Conroy, Medical Assistance Specialist II, at

(518) 473-5565 or by fax at (518) 486-4112.

NOTICE OF INTENT TO DENY HOME HEALTH SERVICES

(HEALTH AND SAFETY)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | |
| | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ______ |
| | | OR Agency conference ______ |
| | | Fair hearing information and assistance ______ |
| | | Record access ______ |
| | | Legal assistance information ______ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

This is to inform you that we intend to take the following action on your home health services effective on

______________________________.

☐ DENY YOUR REQUEST FOR ALL HOME HEALTH SERVICES ORDERED BY YOUR PHYSICIAN

Your physician wants you to receive the following home health services (list service and frequency):

______________________________

______________________________

______________________________.

Even though your physician wants you to receive these services, we do not think that these services can maintain your health and safety in your home because:

______________________________

______________________________

______________________________.

☐ DENY YOUR REQUEST FOR SOME HOME HEALTH SERVICES ORDERED BY YOUR PHYSICIAN

Your physician wants you to receive the home health services that we have listed above. We do not think that all of these services are necessary to maintain your health and safety at home. This means that we are denying your request for the following services that your physician thinks you need:

______________________________

______________________________

______________________________.

We intend to take this action because:

______________________________

______________________________

______________________________.

THE REGULATION WHICH ALLOWS US TO DO THIS IS 505.23

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Notice of Intent to Deny Home Health Services (Health and Safety)

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens or Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

OR

(2) Writing: By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The agency's action is wrong because:

________________________________________

________________________________________

________________________________________

Signature of Client ____________________ Date __________

Printed name of client ____________________

Address ____________________

________________________________________

Phone Number ____________________ Case Number __________

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you , your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS/INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record. Call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

(APPENDIX B)

NOTICE OF INTENT TO DENY HOME HEALTH SERVICES

(FISCAL ASSESSMENT AND EFFICIENCIES)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | |
| | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ____ |
| | | OR Agency conference ____ |
| | | Fair hearing information and assistance ____ |
| | | Record access ____ |
| | | Legal assistance information ____ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

This is to inform you that we intend to deny your request for home health services effective

______________________________.

We are taking this action because:

________ A. The average monthly cost of your home health services exceeds 90% (ninety percent) of the average monthly cost of residential health care facility (RHCF) services in the social services district that is financially responsible for your Medical Assistance.

Based on your fiscal assessment, the average monthly cost of your home health services is:

$______________ and 90% of the average cost of RHCF services in your district is:

$______________. The cost of your services is $______________ OVER the 90% of RHCF cost; AND

Your case does not meet any of the EXCEPTION CRITERIA listed in the enclosed attachment.

OR

________ B. We think that you should get the following service or services, which we call "efficiencies"

and have included this service or services in your plan of care even though your physician does not

agree with us: ______________________________________________

______________________________________________

______________________________________________.

THE REGULATION WHICH ALLOWS US TO DO THIS IS 18 NYCRR 505.23.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Notice of Intent to Deny Home Health Services (Fiscal Assessment and Efficiencies)

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

OR

(2) Writing: By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The agency's action is wrong because:

________________________________________

________________________________________

________________________________________

Signature of client ____________________ Date ____________

Printed name of client ____________________________

Address __________________________________

________________________________________

Phone Number ____________________ Case Number ____________

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you , your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS/INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record. Call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

Notice of Intent to Deny Home Health Services (Fiscal Assessment and Efficiencies)

DENIAL OF HOME HEALTH SERVICES: FISCAL ASSESSMENT AND EFFICIENCIES

LIST OF EXCEPTION CRITERIA

We have determined that you do not meet any of the following exception criteria. If you disagree with this determination and you think that you meet at least one of the following exception criteria, you may ask for a State fair hearing. Please refer to the attached denial notice to learn how you may ask for a State fair hearing.

The exception criteria are as follows:

1. You are not medically eligible for residential health care facility services (nursing home care) or other long-term care services, including other residential long-term care services, or other non-residential long-term care services.

2. Home health services are cost-effective when compared to the costs of other long-term care services appropriate for your needs. We determine whether home health services are cost-effective by following these rules:

   (a) If you would be placed in a general hospital, we compare the average monthly costs of the home health services you are reasonably expected to need for 12 months to the average monthly costs of care in a general hospital. The Department of Health determines the average monthly costs of care in a general hospital by adding the payments made to all general hospitals in the region for the diagnostic-related group (DRG) in which you would be classified, dividing the result by the sum of the group mean lengths of stay for persons classified in such DRG, multiplying the result by 365 and further dividing by 12.

   (b) If you would be placed in an intermediate care facility for the developmentally disabled, we compare the average monthly costs of the home health services you are reasonably expected to need for 12 months to the regional rate of payment for care in an intermediate care facility for the developmentally disabled, as determined by the Department in consultation with the Office of Mental Retardation and Developmental Disabilities.

   (c) If you would be placed in a residential health care facility (nursing home), we compare the average monthly costs of the home health services you are reasonably expected to need for 12 months to the average monthly costs of residential health care facility services in the social services district for recipients who are classified in the same resource utilization group (RUG) category as the RUGs category in which you would be classified.

   (d) If you would be placed in other residential long-term care services or other non-residential long-term care services, we compare the average monthly costs of the home health services that you are reasonably expected to need for 12 months to the average monthly costs, as determined by the Department, of such other residential long-term care services or non-residential long-term care services.

3. (a) You are employed. You are employed if you work and your work involves significant physical or mental activities for which you are paid or from which you receive or could receive a profit. We determine whether you are employed by using the federal regulations that are used to determine whether someone who seeks disability benefits under Title II of the federal Social Security Act can engage in "substantial gainful activity." These regulations are located at 20 C.F.R. 404.1571 through 404.1576.

   (b) You are in school. The educational program in which you are enrolled must have been approved by a committee on preschool special education established in accordance with Section 4410 of the Education Law, a committee on special education established in accordance with Section 4402 of the Education Law, or the State Board of Regents.

   (c) You are the parent or legal guardian of a child who lives with you and:

      (i) the child is younger than 18; or

      (ii) the child is younger than 21 and is enrolled in an educational program approved by the State Board of Regents; or

      (iii) the child is 18 years old or older and is blind or disabled, as determined in accordance with the Department's regulations (18 NYCRR Part 360, Subpart 360-5).

   (d) You are blind or disabled, and you would have to remain in a hospital or be admitted to a hospital for long-term hospitalization if home health services are not provided to you. Whether you are blind or disabled is determined in accordance with the Department's regulations at 18 NYCRR Part 360, Subpart 360-5.

4. A review of your medical history, certified by your physician and reviewed by a residential hea[illegible] care facility (nursing home) indicates that placement in such a facility would diminish your ability [illegible] perform the activities of daily living (e.g. eating and drinking, toileting, turning and posit[illegible] mobility, transferring, bathing, grooming and dressing).

5. You live with another person who would need services if you were to be placed in a residential [illegible] care facility (nursing home) or another type of residential care. The costs of continuing to prov[illegible] with home health services are reasonably expected to be less than the costs of placing you in a re[illegible] health care facility or another type of residential care combined with the costs of providing [illegible] to the person with whom you live.

(APPENDIX C)

NOTICE OF INTENT TO REDUCE
OR DISCONTINUE HOME HEALTH SERVICES
(HEALTH AND SAFETY)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ______ |
| | | OR Agency conference ______ |
| | | Fair hearing information and assistance ______ |
| | | Record access ______ |
| | | Legal assistance information ______ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

This is to inform you that we intend to take the following action on your home health services effective on

______________________________.

☐ REDUCE YOUR HOME HEALTH SERVICES

Although your physician disagrees with us, we think that your home health services should be reduced

FROM: ______________________________

______________________________

______________________________

TO: ______________________________

______________________________

______________________________.

We intend to take this action because of the following changes in your medical condition or for other reasons related to your health and safety:

______________________________

______________________________

______________________________

______________________________.

☐ DISCONTINUE YOUR HOME HEALTH SERVICES

Although your physician thinks that you should continue to receive home health services, we do not think that home health services can continue to maintain your health and safety because: ______________

______________________________

______________________________

______________________________

______________________________.

THE REGULATION WHICH ALLOWS US TO DO THIS IS 505.23

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Notice of Intent to Reduce or Discontinue Home Health Services (Health and Safety)

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island) (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

**OR**

(2) Writing: By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The agency's action is wrong because:

________________________________________

________________________________________

________________________________________

Signature of client ________________________ Date ____________

Printed name of client ________________________

Address ________________________

________________________________________

Phone Number ________________________ Case Number ____________

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR HOME HEALTH SERVICES:** If your home health services are being discontinued and you request a fair hearing before the effective date stated in this notice, you will continue to receive your home health services unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any home health services that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my home health services, as described in this notice, prior to issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

**ACCESS TO RECORDS/INFORMATION:** You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record. Call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

(APPENDIX D)

NOTICE OF INTENT TO REDUCE
HOME HEALTH SERVICES
(FISCAL ASSESSMENT/EFFICIENCIES)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | |
| | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ______ |
| | | OR Agency conference ______ |
| | | Fair hearing information and assistance ______ |
| | | Record access ______ |
| | | Legal assistance information ______ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

We are reducing your Home Health Services effective ______________________.

You will receive services FROM ______________ TO ______________

as long as you remain financially eligible for Medical Assistance and your service needs do not change.

Your services are being reduced:

FROM: (LIST SERVICES HERE: NURSING, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AUDIOLOGY SERVICES AND HOME HEALTH AIDE SERVICES, etc. AND DETAIL FREQUENCY OF EACH SERVICE.)

______________________________

______________________________

______________________________

TO: (LIST SERVICES HERE: NURSING, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AUDIOLOGY SERVICES AND HOME HEALTH AIDE SERVICES, etc. AND DETAIL FREQUENCY OF EACH SERVICE.)

______________________________

______________________________

______________________________

AND: (LIST ONE OR MORE "EFFICIENCIES" HERE: PERS, SHARED AIDE, PERSONAL CARE SERVICES, ADULT DAY HEALTH, LONG TERM HOME HEALTH CARE PROGRAM, ASSISTED LIVING PROGRAM, ENRICHED HOUSING PROGRAM, OTHER

______________________________

______________________________

______________________________

BECAUSE: We think that you are now appropriate for the "efficiency" or "efficiencies" listed above, even though your physician does not agree with us. We have added this "efficiency(ies)" to your plan of care. We have also reduced, but not stopped, the home health services you now receive. This means that you will receive the reduced home health services listed above AND the "efficiency(ies)" listed above.

You will also receive a plan of care which explains the tasks you will receive and how often you will receive help with these tasks.

If your medical condition or social situation changes, your needs will be reevaluated.

THE REGULATION WHICH ALLOWS US TO DO THIS IS 18 NYCRR 505.23.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Notice of Intent to Reduce Home Health Services (Fiscal Assessment and Efficiencies)

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in Nassau or Suffolk County: (516) 739-4868

OR

(2) Writing: By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The agency's action is wrong because:

_______________________________________________

_______________________________________________

_______________________________________________

Signature of client ______________________ Date ______________

Printed name of client ______________________

Address ______________________

_______________________________________________

Phone Number ______________________ Case Number ______________

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR HOME HEALTH SERVICES: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your home health services unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any home health services that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my home health services, as described in this notice, prior to issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS/INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record. Call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

(APPENDIX K)

NOTICE OF INTENT TO DISCONTINUE
HOME HEALTH SERVICES
(FISCAL ASSESSMENT)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | |
| | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ________<br>OR Agency conference ________<br>Fair hearing information and assistance ________<br>Record access ________<br>Legal assistance information ________ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

This is to inform you that we intend to discontinue Medical Assistance payments for home health services; however, payment for the home health services that you are currently receiving will continue until the appropriate long-term services listed below become available. This discontinuance will not happen before the effective date of this notice which is ____________________________________.

We are taking this action because we have decided that:

1. The average monthly cost of your home health services exceeds 90% (ninety percent) of the average monthly cost of residential health care facility (RHCF) services in the social services district that is financially responsible for your Medical Assistance.

   Based on your fiscal assessment, the average monthly cost of your home health services is $________________, and 90% of the average monthly cost of RHCF services in your district is $______________. The cost of your services is $________________ OVER the 90% of RHCF cost; AND

2. You do not meet any of the EXCEPTION CRITERIA listed in the enclosed attachment.

Based on your current medical condition, you must be referred to the following appropriate long-term care services:

________________________________________

________________________________________

________________________________________

If you refuse to participate in admission requirements for the RHCFs or refuse to accept the services listed above when they become available, Medical Assistance payments for your home health services will STOP.

THE REGULATION WHICH ALLOWS US TO DO THIS IS 18 NYCRR 505.23.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Notice of Intent to Discontinue Home Health Services (Fiscal Assessment)

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. *It is not the way you request a fair hearing.* If you ask for a conference you are still entitled to a fair hearing. *If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below.* A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens or Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

OR

(2) Writing: By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The agency's action is wrong because:

____________________________________________________

____________________________________________________

____________________________________________________

Signature of client ____________________________ Date ________________

Printed name of client ________________________________________

Address ________________________________________________

____________________________________________________

Phone Number __________________________ Case Number __________________

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR HOME HEALTH SERVICES: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your home health services unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any home health services that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my home health services, as described in this notice, prior to issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS/INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record. Call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

Notice of Intent to Discontinue Home Health Services (Fiscal Assessment)

## DISCONTINUANCE OF HOME HEALTH SERVICES: FISCAL ASSESSMENT

### LIST OF EXCEPTION CRITERIA

We have determined that you do not meet any of the following exception criteria. This means that you must be referred to long-term care services that are appropriate for your needs. However, the Medical Assistance (MA) program will continue to pay for your home health services until the other appropriate long-term care services become available to you. The certified home health agency that is providing you with home health services will notify you when other appropriate long-term care services become available to you.

If you disagree with our determination and you think that you meet at least one of the following exception criteria, you may ask for a State fair hearing and for your home health services to continue unchanged until the fair hearing decision is issued (aid-continuing). Please refer to the attached discontinuance notice to learn how you may ask for a State fair hearing and aid-continuing.

The exception criteria are as follows:

1. You are not medically eligible for residential health care facility (nursing home) services or other long-term care services, including other residential long-term care services, or other non-residential long-term care services.

2. Home health services are cost-effective when compared to the costs of other long-term care services appropriate for your needs. We determine whether home health services are cost-effective by following these rules:

   (a) If you would be placed in a general hospital, we compare the average monthly costs of the home health services you are reasonably expected to need for 12 months to the average monthly costs of care in a general hospital. The Department of Health determines the average monthly costs of care in a general hospital by adding the payments made to all general hospitals in the region for the diagnostic-related group (DRG) in which you would be classified, dividing the result by the sum of the group mean lengths of stay for persons classified in such DRG, multiplying the result by 365 and further dividing by 12.

   (b) If you would be placed in an intermediate care facility for the developmentally disabled, we compare the average monthly costs of the home health services you are reasonably expected to need for 12 months to the regional rate of payment for care in an intermediate care facility for the developmentally disabled, as determined by the Department in consultation with the Office of Mental Retardation and Developmental Disabilities.

   (c) If you would be placed in a residential health care facility (nursing home), we compare the average monthly costs of the home health services you are reasonably expected to need for 12 months to the average monthly costs of residential health care facility services in the social services district for recipients who are classified in the same resource utilization group (RUG) category as the RUGs category in which you would be classified.

   (d) If you would be placed in other residential long-term care services or other non-residential long-term care services, we compare the average monthly costs of the home health services that you are reasonably expected to need for 12 months to the average monthly costs, as determined by the Department, of such other residential long-term care services or non-residential long-term care services.

3. (a) You are employed. You are employed if you work and your work involves significant physical or mental activities for which you are paid or from which you receive or could receive a profit. We determine whether you are employed by using the federal regulations that are used to determine whether someone who seeks disability benefits under Title II of the federal Social Security Act can engage in "substantial gainful activity." These regulations are located at 20 C.F.R. 404.1571 through 404.1576.

   (b) You are in school. The educational program in which you are enrolled must have been approved by a committee on preschool special education established in accordance with Section 4410 of the Education Law, a committee on special education established in accordance with Section 4402 of the Education Law, or the State Board of Regents.

   (c) You are the parent or legal guardian of a child who lives with you and:

      (i) the child is younger than 18; or

      (ii) the child is younger than 21 and is enrolled in an educational program approved by the State Board of Regents; or

      (iii) the child is 18 years old or older and is blind or disabled, as determined in accordance with the Department's regulations (18 NYCRR Part 360, Subpart 360-5).

   (d) You are blind or disabled, and you would have to remain in a hospital or be admitted to a hospital for long-term hospitalization if home health services do not continue to be provided to you. Whether you are blind or disabled is determined in accordance with the Department's regulations at 18 NYCRR Part 360, Subpart 360-5.

4. A review of your medical history, certified by your physician and reviewed by a residential health care facility (nursing home), indicates that placement in such a facility would diminish your ability to perform the activities of daily living (e.g. eating and drinking, toileting, turning and positioning, mobility, transferring, bathing, grooming and dressing).

5. You live with another person who would need services if you were to be placed in a residential health care facility (nursing home) or another type of residential care. The costs of continuing to provide you with home health services are reasonably expected to be less than the costs of placing you in a residential health care facility or another type of residential care combined with the costs of providing services to the person with whom you live.

ADEQUATE
NOTICE OF INTENT TO DISCONTINUE
HOME HEALTH SERVICES
(BY RECIPIENT'S REQUEST)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | |
| | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ______ |
| | | OR Agency conference ______ |
| | | Fair hearing information and assistance ______ |
| | | Record access ______ |
| | | Legal assistance information ______ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

This is to inform you that we intend to discontinue your home health services effective on

______________________________________.

We are taking this action because we have received a clear written statement that you have signed and that tells us that you no longer want to receive any home health services from the certified home health agency (CHHA) that is providing you with services now.

If you know the name of the CHHA that is providing you with home health services now, please write the CHHA's name here: ______________________________________

______________________________________.

If you know the address of this CHHA, please write the address here: ______________________________________

______________________________________

______________________________________.

THE REGULATIONS WHICH ALLOW US TO DO THIS ARE 18 NYCRR 505.23 and 42 CFR 431.213(b).

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

(APPENDIX F)

Adequate notice of intent to discontinue home health services at recipient's request

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

(1) **Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens or Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

OR

(2) **Writing:** By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

________________________________________

________________________________________

________________________________________

Signature of client ____________________ Date ____________

Printed name of client ______________________________

Address ______________________________________

________________________________________

Phone Number ____________________ Case Number ____________

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you , your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR HOME HEALTH SERVICES:** If you request a fair hearing within 10 days of the date of the postmark of the mailing of this notice, your home health services will be reinstated (aid continuing) and will remain unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any home health services that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

[ ] I agree to have the action taken on my home health services, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

**ACCESS TO RECORDS/INFORMATION:** You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

TIMELY AND ADEQUATE
NOTICE OF INTENT TO DISCONTINUE
HOME HEALTH SERVICES
(BY RECIPIENT'S REQUEST)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME AND ADDRESS | | |
| | | GENERAL TELEPHONE No FOR QUESTIONS OR HELP ______<br>OR Agency conference ______<br>Fair hearing information and assistance ______<br>Record access ______<br>Legal assistance information ______ |

| Office No. | Unit No. | Worker No. | Unit or Worker Name | Telephone No. |
|---|---|---|---|---|
| | | | | |

This is to inform you that we intend to discontinue your home health services effective on

______________________________________________.

We are taking this action because we believe that you have told the certified home health agency (CHHA) that is providing you with home health services that you no longer want to receive home health services.

If you know the name of the CHHA that is providing you with home health services now, please write the CHHA's name here: ______________________________________________

______________________________________________.

If you know the address of this CHHA, please write the address here: ______________________

______________________________________________

______________________________________________.

THE REGULATION WHICH ALLOWS US TO DO THIS IS 18 NYCRR 505.23.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Timely and adequate notice of intent to discontinue home health services at recipient's request.

<u>RIGHT TO A CONFERENCE:</u> You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

<u>RIGHT TO A FAIR HEARING:</u> If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens or Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

<u>OR</u>

(2) Writing: By sending a completed copy of both pages of this notice to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The agency's action is wrong because:

____________________________________________

____________________________________________

____________________________________________

Signature of client ________________________ Date ____________

Printed name of client ________________________________

Address ______________________________________

____________________________________________

Phone Number ________________________ Case Number ____________

<u>YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING</u>

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, medical bills, medical verification, letters, etc. that may be helpful in presenting your case.

<u>CONTINUING YOUR HOME HEATH SERVICES:</u> If you request a fair hearing before the effective date stated in this notice, you will continue to receive your home health services unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any home health services that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my home health services, as described in this notice, prior to issuance of the fair hearing decision.

<u>LEGAL ASSISTANCE:</u> If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

<u>ACCESS TO RECORDS/INFORMATION:</u> You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record. Call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

## APPENDIX H

### MEMORANDUM
DSS-524EL

| | | | |
|---|---|---|---|
| TO: | All Social Services District Commissioners | DATE: | February 25, 1994 |
| FROM: | Barry T. Berberich Assistant Commissioner | SUBJECT: | Further Catanzano instructions: retroactive relief |

This memorandum contains further instructions regarding the preliminary injunction issued on February 16, 1994, in *Catanzano et al.* v. *Dowling et al.* (USDC, WDNY). In Section IV of the Department's February 18th letter to social services districts and CHHAs regarding the *Catanzano* preliminary injunction, the Department informed them that it would be providing such instructions regarding retroactive relief as soon as possible.

The specific section of the court's order directing retroactive relief requires the State and County defendants to:

"take immediate steps to provide notice and hearing rights to members of plaintiffs' class who have had their home health care services suspended, terminated or reduced without the benefit of notice, the right to a hearing or aid-continuing since November 15, 1993."

To comply with this order, each social services district must review its case records on each home health services recipient for whom a CHHA conducted a fiscal assessment and, as a result of the fiscal assessment, reduced or discontinued (*i.e.* suspended or terminated) the recipient's home health services on or after November 15, 1993.

Please note that the order does not apply to Medical Assistance recipients who were hospitalized when the CHHA conducted the fiscal assessment. In addition, the order does not apply to CHHA determinations to reduce or discontinue a recipient's home health services for reasons that are unrelated to the costs of the recipient's care when compared to 90 percent of residential health care facility costs and the recipient's failure to meet any exception criteria.

Specifically, each district must identify each case that meets the following requirements:

a. The CHHA conducted a fiscal assessment on a Medical Assistance recipient who, at the time of the fiscal assessment, was receiving home health services from the CHHA and was not hospitalized, and the CHHA reduced or discontinued the recipient's home health services on or after November 15, 1993, as a result of the fiscal assessment;

b. The social services district agreed with the CHHA's determination that the recipient's home health services should be reduced or discontinued on or after November 15, 1993; and

c. The social services district did not provide the recipient with a timely notice and an opportunity for a fair hearing to review the determination that the recipient's home health services should be reduced or discontinued.

Social services districts and CHHAs have the following responsibilities for each home health services recipient who meets the requirements set forth in a - c, above:

1. The social services district must notify the CHHA of each recipient whom the district has identified as meeting these requirements.

2. For each recipient who the district has determined meet these requirements, the CHHA must reinstate the home health services that the recipient received immediately prior to the CHHA's reduction or discontinuance made as a result of the fiscal assessment. The CHHA must notify the social services district when it has reinstated the recipient's home health services.

3. For each such recipient, the CHHA must then complete a new fiscal assessment in accordance with the provisions of 92 ADM-50 and notify the social services district of the results of the new fiscal assessment in accordance with 18 NYCRR 505.23(c) and 92 ADM-50.

4. The social services district must send the recipient a timely notice and an opportunity to request a fair hearing to review any proposed reduction or discontinuance that the CHHA proposes to take as a result of the new fiscal assessment that the CHHA has completed in accordance with Step 3, above. The district must use the appropriate fair hearing notice attached to 92 ADM-50, but must modify the notice as follows:

Agreement on Reductions:

When the social services district agrees with the CHHA that the recipient's home health services must be reduced, the social services district must send the recipient a timely "Notice of Decision to Reduce (Fiscal Assessment) Home Health Services" (Attachment 4 to 92 ADM-50). Please note that the social services district does not refer these cases to the local professional director or designee. In the "BECAUSE" section of the notice, the district must thus cross out the words, "Local Professional Director or designee," and insert the words, "social services official," so that the sentence reads as follows: "Your case has been reviewed by the social services official and it is his/her determination, based on your current medical condition, that your home health care services must be reduced."

Agreement on Discontinuances:

When the social services district agrees with the CHHA that the recipient's home health services must be discontinued, the social services district must send the recipient a timely "Notice of Decision to Discontinue (Fiscal Assessment) Home Health Services" (Attachment 5 to 92 ADM-50). Again, please note that the social services district does not refer these cases to the local professional director or designee. Consequently, in the first sentence of the second paragraph of the notice, the district must cross out the words, "the Local Professional Director or designee has," and insert the words, "the social services official," so that the sentence reads as follows: "We are taking this action because the social services official has decided that:"

5. The social services district must notify the CHHA of each recipient who timely requests a fair hearing with aid-continuing. The Department's Office of Administrative Hearings will notify the social services district of all such recipients.

6. The CHHA must not reduce or discontinue the recipient's home health services until the effective date of the notice and must continue to provide the recipient with aid-continuing upon being notified by the district that the recipient has timely requested a hearing with aid-continuing. Aid-continuing is defined as the same type of home health services, at the same scope and frequency, as the recipient received immediately prior to the reduction or discontinuance made as a result of the fiscal assessment.

The Department will issue instructions as soon as possible regarding notice and fair hearing rights for home health services applicants. Pending such further instructions, no fiscal assessments are to be performed on any MA recipient who first applies for home health services on or after February 16, 1994.

Please contact Mary Jane Conroy of my staff, at (518) 473-5565, should you have any questions regarding your responsibilities under this preliminary injunction.

**Historical Note**

Sec. filed Oct. 31, 1978; amd. filed June 28, 1988; repealed, new filed: Sept. 26, 1991 as emergency measure; Dec. 13, 1991 as emergency measure; Dec. 13, 1991; amds. filed: June 22, 1992 as emergency measure; July 1, 1992 as emergency measure; Sept. 29, 1992 as emergency measure; Nov. 27, 1992 as emergency measure; Nov. 27, 1992; April 11, 1996 as emergency measure; July 8, 1996 as emergency measure; Sept. 4, 1996 as emergency measure;. Oct. 31, 1996 as emergency measure eff. Oct. 31, 1996. Added Appendix 1.

# 10 NYCRR 763.5 PATIENT REFERRAL, ADMISSION AND DISCHARGE

**Effective Date:** 03/23/94
**Title:** Section 763.5 - Patient referral, admission and discharge

763.5 Patient referral, admission and discharge. The governing authority shall ensure that decisions regarding patient referral, admission and discharge are made based on the patient's assessed needs and the agency's ability to meet those needs in a manner that protects and promotes the patient's health and safety and does not jeopardize the safety of personnel. Such decisions shall reflect a commitment to providing authorized practitioner ordered care and services while honoring the patient's expressed needs and choices to the extent practicable and shall be made in accordance with the provisions of this section. For the purposes of this Part, authorized practitioner shall refer to a doctor of medicine, a doctor of osteopathy, a doctor of podiatry or any other practitioner authorized under Federal and State law and applicable rules and regulations to provide medical care and services to the patient.

(a) The initial patient visit shall be made within 24 hours of receipt and acceptance of a community referral or return home from institutional placement unless:

(1) the patient's authorized practitioner orders otherwise; or

(2) there is written documentation that the patient or family refuses such a visit.

→ (b) A patient shall be admitted to the agency after an assessment, using a form prescribed or approved by the department, is performed during the initial patient visit, which indicates that the patient's health and supportive needs can be met safely and adequately at home and that the patient's condition requires the services of the agency.

(1) In determining whether a prospective patient's health and supportive needs can be met safely at home, the agency shall consider for admission a prospective patient who meets at least one of the following criteria: is self-directing; is able to call for help; can be left alone; or has informal supports or other community supports who are willing, able and available to provide care and support for the patient in addition to the services being provided by the agency. For purposes of this section:

(i) A self-directing patient means an individual who is capable of making choices about his/her clinical care and activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice, or has informal supports willing and able to provide advise and/or direction on behalf of the patient, if needed, in accordance with State law;

(ii) A patient who is able to call for help means an individual who is physically, mentally and cognitively capable of initiating effective communication to individuals outside the immediate presence of the patient who can provide timely assistance to the patient;

(iii) A patient who can be left alone means an individual who, based on his/her physical, mental and cognitive capability, does not require the continuous presence of another individual to meet his/her minimal ongoing health and safety requirements; and

(iv) Informal supports or other community supports means friends, relatives or associates of the patient, whether compensated or not, unaffiliated with the agency, who are able, available and willing to provide needed care, support and other services to the patient during the periods agency personnel are not present. Such supports may include personnel of an adult care facility in which the patient resides.

(2) The agency shall not be required to admit a patient:

(i) who does not meet any of the criteria of paragraph (1) of this subdivision;

(ii) when conditions are known to exist in or around the home that would imminently threaten the safety of personnel, including but not limited to:

(a) actual or likely physical assault which the individual threatening such assault has the ability to carry out;

(b) presence of weapons, criminal activity or contraband material which creates in personnel a reasonable concern for personal safety; or

(c) continuing severe verbal threats which the individual making the threats has the ability to carry out and which create in personnel a reasonable concern for personal safety;

(iii) when the agency has valid reason to believe that agency personnel will be subjected to continuing and severe verbal abuse which will jeopardize the agency's ability to secure sufficient personnel resources or to provide care that meets the needs of the patient; or

(iv) who, based on previous experience with the delivery of care from the agency, is known to repeatedly refuse to comply with a plan of care or others interfere with the patient's ability to comply with a plan of care agreed upon, as appropriate, by: the patient; the patient's family; any legally designated patient representative; the patient's physician; agency personnel and/or any case management entity, and such non-compliance will: (a) lead to an immediate deterioration in the patient's condition serious enough so that home care will no longer be safe and appropriate; or

(b) make the attainment of reasonable therapeutic goals impossible.

(3) The assessment shall be conducted by a registered professional nurse, except in those instances where physical therapy or speech/language pathology is the sole service prescribed by the patient's physician and the agency elects to have the therapist conduct the assessment.

(c) At the time a determination is made to deny a patient admission based on the criteria listed in paragraph (2) of subdivision (b) of this section, the agency shall determine whether the patient appears to be eligible for services from the local Protective Services for Adults program in accordance with the criteria set forth in subdivision (b) of section 457.1 of 18 NYCRR.

(1) If the patient appears to be eligible for such services, the agency shall make a referral to the appropriate local Protective Services for Adults program. Such referral shall indicate the patient's ongoing care needs and the reason for the decision not to admit.

(2) If the local Protective Services for Adults program accepts the referral, takes action to address the problems preventing admission and notifies the agency that such problems have been resolved, the agency shall reassess the patient to determine whether admission has become appropriate or remains inappropriate.

(d) Any patient who is assessed or reassessed as inappropriate for agency services shall be assisted by the agency, in collaboration with the discharge planner, the local Social Service Department and other case management entity, as appropriate, with obtaining the services of an alternate provider, if needed, and the patient's authorized practitioner shall be so notified. If alternate services are not immediately available, and the local Protective Services for Adults program, the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health or other official agency requests that home care

services be provided on an interim basis, the agency may provide home care services which address minimally essential patient health and safety needs for a period of time agreed upon by the agency and the requesting entity, provided that the patient and family or informal supports, as appropriate, have been fully informed of the agency's intent to transfer the patient to an alternate service, when available, and have been consulted in the development of an interim plan of care.

(e) Services which the agency provides shall be available to all persons without regard to age, race, color, creed, sex, national origin, disability, service need intensity, location of patient's residence in the service area, or source of payment.

(f) Services shall not be diminished or discontinued solely because of the change in the patient's source of payment or the patient's inability to pay for care.

(g) A discharge plan shall be initiated prior to agency discharge to assure a timely, safe and appropriate transition for the patient.

→ (h) A patient may be discharged by the agency only after consultation, as appropriate, with the patient's authorized practitioner, the patient, the patient's family or informal supports, any legally designated patient representative and any other professional personnel including any other case management entity involved in the plan of care. If the agency determines that the patient's health care needs can no longer be met safely at home due to the circumstances specified in paragraphs (4) and (5) of this subdivision, the agency must continue to provide home health services only to the extent necessary to address minimally essential patient health and safety needs until such time as an alternative placement becomes available and such placement is made or the patient or the patient's legal representative, who has the authority to make health care decisions on behalf of the patient, makes an informed choice to refuse such placement. As appropriate, the patient and family or informal supports, any legally designated patient representative and any other professional personnel including any case management entity involved, shall be fully informed of the agency's intent to discharge the patient to an alternate service, when available, and shall be consulted in the development of an interim plan of care. Discharge shall be appropriate when:

(1) therapeutic goals have been attained and the patient can function independently or with other types of community support services;

(2) conditions in the home imminently threaten the safety of the personnel providing services or jeopardize the agency's ability to provide care as described in subparagraphs (ii) and (iii) of paragraph (2) of subdivision (b) of this section;

(3) all agency services are terminated by the patient;

(4) the patient, the patient's family, informal supports or any legally designated patient representative is non-compliant or interferes with the implementation of the patient's plan of care and the scope and effect of such non-compliance or interference:

(i) has led to or will lead to an immediate deterioration in the patient's condition serious enough that home care will no longer be safe and appropriate; or

(ii) has made attainment of reasonable therapeutic goals at home impossible; and

(iii) the likely outcome of such non-compliance or interference has been explained to the patient, or the patient's legally designated patient representative, family or informal supports, and any case

management entity, as appropriate, and the patient continues to refuse to comply with, or others continue to interfere with the implementation of, the plan of care; or

(5) the availability of home health services or community support services is no longer sufficient to meet the patient's changing care needs and to assure the patient's health and safety at home and the patient requires the services of a health care institution or an alternate health care provider. An agency may determine that the patient's health care needs can no longer be met safely at home by the agency if none of the criteria or circumstances of paragraph (1) of subdivision (b) of this section apply any longer to the patient.

(i) If a patient is to be discharged in accordance with subdivision (h) of this section, and the agency believes there will continue to be a substantial risk to the patient's health and safety subsequent to discharge, a referral shall be made to the appropriate local Protective Services for Adults program or other official agency, as appropriate, at the time the discharge determination is made.

(1) If the local Protective Services for Adults program or other official agency to which the patient has been referred accepts the referral, takes action to address adequately the problems leading to the discharge determination and notifies the home care agency that such problems have been resolved, the agency shall reassess the patient.

(2) After reassessment, the home care agency shall determine whether action to discharge the patient should be discontinued or the discharged patient should be readmitted.

**Volume:** D