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 | ADMINISTRATIVE DIRECTIVE |
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TRANSMITTAL: 92 ADM-49

TO: Commissioners of
 Social Services

DIVISION: Health & Long
 Term Care

DATE: December 1, 1992

SUBJECT: Fiscal Assessment and Management of Personal Care Services

SUGGESTED
 DISTRIBUTION:

Medical Assistance Staff
 Home Care Staff
 Certified Home Health Agencies
 Staff Development Personnel
 Services Staff

CONTACT
 PERSON:

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ATTACHMENTS:

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 [All attachments are available on-line.]

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
	None	505.14	365-a(2)(e) 367-k; Sect. 23, Ch. 165, Laws of 1991; Sect. 71-73, Ch. 41 Laws of 1992	None	None

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I. PURPOSE

The purpose of this administrative directive is to inform social services districts of new policies and procedures to be followed when authorizing or reauthorizing personal care services. These policy and procedural changes reflect amendments to subdivisions (a), (b) and (g) of the Department's Personal Care Services regulations (505.14), as required by Section 367-k of the Social Services Law (SSL), as added by Section 23 of Chapter 165 of the Laws of 1991 and amended by Sections 71-73 of Chapter 41 of the Laws of 1992.

II. BACKGROUND

In recent years, the demand for home care services has dramatically increased due in part to an escalating growth of the aged population and the preference of persons to receive care in their homes. State policies, which broaden the use of home care as an alternative to institutionalization, have also contributed to the increased demand for home care services. With the increase in demand, home care services expenditures have risen to \$2.4 billion dollars in State fiscal year 1991-92. Expenditures for the personal care services program, the largest of all home care programs, account for 86% of all Medical Assistance (MA) home care costs.

The present system, which has allowed a high level of flexibility by social services districts, contains insufficient structure for evaluating alternative options for the provision of home care services to recipients and for assessing recipients for the cost effectiveness of home care as opposed to institutionalization.

While it is recognized that home care is usually a less costly alternative to institutional care, many districts identified that certain recipients' home care costs were exorbitant. The amount of financial and human resources being expended on many of these cases, as well as concern regarding some recipients' appropriateness for home care services, became an issue of concern to social services districts, provider agencies, and local and State governments.

Consequently, in 1988 the Department conducted a study of those home care cases with costs exceeding the cost of residential health care facility placement (RHCF). This study identified that while in many instances the recipient's home care services plan appeared appropriate and cost-effective, there were also indications that other high cost cases were inappropriate and could be more cost-effectively met by alternative long term care services. This information and projections

of cost growth of home care services, demographic increases in the number of persons seeking home care, as well as future work force limitations brought a new urgency to the search for more cost effective ways to provide needed services.

After much debate and compromise, home care cost containment legislation contained in Sections 20-26 of Chapter 165 of the Laws of 1991, was signed on June 12, 1991, and was effective July 1, 1991. Provisions governing personal care services are located at Section 21 of Chapter 165, which amended the definition of personal care services contained in Section 365-a(2)(e) of the Social Services Law (SSL) and Section 23 of Chapter 165, which added SSL Section 367-k.

On April 2, 1992, Chapter 41 of the Laws of 1992 was enacted. Sections 71 through 73 of Chapter 41 amend the fiscal assessment and other requirements for personal care services, as required by SSL Section 367-k.

The Chapter 165 and Chapter 41 legislation represents an initial effort to redefine home care and the home care entitlement by requiring social services districts to incorporate a new fiscal assessment and management process into the current assessment process used for determining a recipient's appropriateness for MA funded home care services.

III. PROGRAM IMPLICATIONS

The amendments to Department Personal Care Services regulation 505.14 will allow social services districts to provide the most appropriate and cost-effective means of delivering home care services to MA recipients.

For the first time, districts will be required to consider certain cost efficiencies in the development of every personal care recipient's care plan. Additionally, districts will be required to conduct a fiscal assessment for every recipient who receives, or is expected to receive, over 60 days of personal care services.

It is expected that by following the new management and fiscal assessment process, social services districts will, in some instances, be able to reduce or eliminate the number of personal care services hours authorized. Home care expenditures should eventually be reduced at both the local and State level. In other instances, services may be temporarily provided until a more appropriate and cost-effective placement for the recipient can be made. In some districts experiencing worker shortages, the implementation of the new legislation may alleviate or diminish the severity of the worker shortage.

It is also anticipated that the fiscal assessment process will provide critical information on high cost case characteristics and the rationale for their placement in home care services programs as opposed to a less costly institutionally-based alternative. This information

will serve as the foundation for future policy development in the long term care system of New York State.

IV. REQUIRED ACTION

In order to comply with the provisions of SSL Section 367-k and Department regulation 505.14, the following actions are required:

A. Medical Necessity

The district may only consider authorizing personal care services when such services are medically necessary. Determination of medical necessity is the responsibility of the assessing nurse and is based upon his/her professional judgment in consultation with the physician and/or physician's order, the social assessment, and any other information deemed relevant in making that determination.

Recipients whose needs require supervision only cannot receive personal care services. Such recipients should be referred to alternative services including, where indicated, protective services for adults, other Title XX funded adult services or supportive living arrangements within the community such as Office of Mental Retardation and Developmental Disabilities (OMRDD) and Office of Mental Health (OMH) family care homes or Department of Social Services (DSS) family-type homes. Services which may be available from informal support groups or other formal agencies in the community, such as companion and respite services, should also be considered.

B. Health and Safety of Recipient

Personal care services may only be authorized when the district reasonably expects that the recipient's health and safety can be maintained in the home. This determination must consider the following:

1. Stability of the Recipient's Medical Condition

The assessing nurse has primary responsibility for determining stability of the recipient's medical condition. The recipient and/or any informal caregiver should be given the opportunity to be involved in this determination. The determination should be based on information included in the nursing assessment and a review of the physician's order. In situations where there is a question about this determination, the assessing nurse may wish to involve the case manager or obtain consultation from the local professional director or his/her designee.

A stable medical condition is 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 recipient's plan of care; and
- c. the condition is such that a physically disabled individual is in need of routine supportive assistance to maintain his or her level of functioning and does not need skilled professional care in the home; or
- d. 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.

If the recipient's medical condition is not stable, the provision of personal care services is inappropriate unless a determination is made that the provision of personal care services in combination with the intervention of appropriate skilled nursing services, home health aide and/or therapy can adequately meet the recipient's needs.

2. Ability of the Recipient to be Self-Directing

The case manager has primary responsibility for determining the recipient's self-directing capability. The determination should be based on a review of available information in the physician's order and the social and nursing assessments. The case manager must be sensitive to the recipient's habits, factors in the recipient's physical environment and relationships with informal caregivers that might impede the recipient's ability to consistently be self-directing. In situations where there is a question about the final determination, the case manager should consult with the assessing nurse, the local professional director or his/her designee or protective services for adults case managers. The case manager may also wish to obtain a psychiatric evaluation.

Self-directing means that the recipient has the capability to make choices about activities of daily living, understand the impact of these choices and assume responsibility for the results of these choices. Characteristics of a self-directing recipient include:

- a. the recipient is alert, demonstrates unimpaired judgment, makes decisions which do not place himself/herself or others at risk, and is directly able to manage his/her own affairs; and
- b. the recipient understands what to do in emergency situations threatening his/her safety or health and can summon assistance from the appropriate source verbally or with the aid of a device; and

- c. the recipient knows how to obtain assistance during times when personal care services are not being provided, and when the individual providing services is out of the home to perform activities in the recipient's plan of care, i.e. shopping, or laundry, and when there is an unexpected interruption in the provision of services.

A non-self-directing recipient lacks the capability to make choices about the activities of daily living, understand the implications of these choices, and assume responsibility for the results of these choices. Characteristics of a non-self-directing recipient include:

- a. the recipient may be delusional, disoriented at times, have periods of agitation, or demonstrate other behavior which is inconsistent and unpredictable; or
- b. the recipient may have a tendency to wander during the day or night and to endanger his or her physical safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home; or
- c. the recipient may exhibit other behaviors which are harmful to himself or herself or to others such as hiding medications, taking medications without his or her physician's knowledge, refusing to seek assistance in a medical emergency, or leaving lit cigarettes unattended. The recipient may not understand what to do in an emergency situation or know how to summon emergency assistance.

Personal care services may only be provided to non-self-directing recipients if the responsibility for direction is assumed by another individual or an outside agency and any needed supervision or direction is provided on a part-time or interim basis by that individual or agency. Part-time or interim means the recipient has periods of time during the day or night when it is necessary for his/her actions to be supervised or directed by someone else. Supervision or direction as used in this context means someone assumes decision-making for the recipient and exercises independent judgments about the recipient's functioning. Supervision and direction may include, but are not limited, to the following functions:

- o managing the recipient's financial affairs.
- o deciding the order of, or manner in which, specific functions or tasks identified in the recipient's plan of care are to be performed, if such decisions are ordinarily left to the recipient's discretion.

- o establishing preferences for the recipient in terms of what he/she eats for a particular meal or where his/her medications are to be purchased.

Responsibility for part-time or interim supervision may be assumed by:

- o a self-directing individual who resides in the recipient's household; or
- o a legally or non-legally responsible relative, friend, neighbor, or other informal caregiver who is self-directing; or
- o a formal agency such as an area office for the aging; or
- o a self-directing individual who lives in another household.

If the individual assuming part-time or interim supervision resides outside of the recipient's home, consideration should be made as to whether that individual has substantial daily contact with the recipient in the recipient's home.

Factors used to determine whether substantial daily contact in the recipient's home is being made include:

- o the individual is physically present in the home at times throughout the day or night as necessary to assure the safety of the recipient; and
- o any discretionary decisions or choices involved in carrying out the functions and tasks identified in the recipient's plan of care are conveyed to the person providing personal care services.

Substantial daily contact does not mean the individual must be physically present in the home for a specified amount of time. The frequency of contact needed to assure a safe situation and provide discretionary direction should be based on each recipient's case situation as reflected in the social and nursing assessments and in the recipient's plan of care.

Supervision and direction of non-self-directing recipients is not an appropriate role for individuals providing personal care services. Such individuals can perform the functions or tasks specified in the recipient's plan of care as instructed by another person. They can also observe and monitor the recipient for possible changes in his/her functioning. However, when changes are noted, the individual is responsible for reporting his/her observations to the appropriate professional for review and decisions about the recipient's plan of care.

If the recipient has no individual or outside formal agency willing to assume responsibility for his/her supervision and direction, a referral should be made to the protective services for adults program for a protective services assessment. Denial or termination of personal care services may be required if the recipient's health and safety cannot be assured by involvement of other individuals, outside formal agencies or the protective services for adults (PSA) program. When district protective services staff determine that legal action is necessary in order to arrange for placement in an alternative setting where the health and safety of the recipient can be assured, it may be necessary to continue to provide personal care services until the legal process is completed. A future administrative directive will discuss further the relationship between personal care services and adult protective services.

Special Note:

The Department of Health is developing regulations addressing health and safety issues in the provision of home care services. When those regulations and subsequent interpretative memoranda are issued, the Department will make any necessary revisions to the health and safety standards contained in this directive.

C. Consideration of Efficiencies

As part of the assessment or reassessment process, the district will now be required to consider for each recipient certain other services or service delivery models which may be more efficient or more cost effective. Consideration of these efficiencies may be performed and documented in conjunction with either the social or the nursing assessment. If the district determines that one or more of these services or service delivery models are appropriate and could be delivered cost effectively, then the district must incorporate use of the options in the development of the recipient's plan of care. Attachment 7 has been developed for documenting in the recipient's case record that use of these efficiencies were considered.

The efficiencies which must be considered to determine if the recipient's needs can be met more appropriately and cost effectively, include the following:

- o Patient Managed Home Care;
- o Personal Emergency Response Services (PERS);
- o Shared Aide;
- o Home Health Services;
- o Adult Day Health Program;

- o Long Term Home Health Program, Assisted Living Program, an Enriched Housing Program; or,

- o Specialized Medical Equipment, such as Insulin Pens.

In addition to consideration of the above efficiencies, unless contra-indicated by the recipient's physician, the district must notify eligible recipients of the availability of hospice services and refer the recipient to hospice services if the recipient chooses to receive them. Generally, recipients with a life expectancy of six months or less and who require supportive or palliative care only, are eligible for hospice services.

Chapter 41 of the Laws of 92 further requires that a written agreement exist between the district and every hospice in the district, in order to assure this referral process. The written agreement, as a minimum, must contain the procedures for notifying recipients believed eligible, of the availability of hospice services and for referring those recipients who are agreeable to the referral. A model Memorandum of Agreement for districts to use has been developed and is included as Attachment 9 of this directive. If the district elects to use a locally developed Memorandum of Agreement, the proposed Memorandum of Agreement must be submitted to the Department for review prior to implementing its use.

Staff involved in conducting the assessment or reassessment must be familiar with the eligibility requirements and restrictions associated with these services and service delivery models. Attachment 6 of this directive is a matrix of these efficiencies which contains recipient eligibility factors and program characteristics for each efficiency. A recipient's eligibility for the efficiencies summarized in Attachment 6 must be determined under the applicable regulations for each particular service, service-delivery model or program listed. The attachment is to be used as a reference, not a substitute, for the eligibility criteria established in regulations for each service, service-delivery model or program. Social service districts may wish to develop a district specific handout that outlines the following:

- o available long-term care resources in the district;

- o eligibility requirements of each program or service delivery model;

- o any program restrictions, i.e., waiting lists; and,

- o names and telephone numbers of individuals to contact to arrange service.

The health and safety of the recipient remains the overriding concern when considering the use of one or more of the efficiencies. If the use of an efficiency would jeopardize the recipient's health and safety, it must not be considered.

In certain cases, it may be possible to use new technology or less labor intensive service delivery models to achieve cost efficiency without any adverse effect on the recipient. For example, an elderly diabetic recipient with poor eyesight and with an unsteady gait due to on-going circulatory problems may have a physician's order completed which identifies that the recipient needs assistance with bathing, walking outside of the home, grocery shopping, and requires safety monitoring and daily nursing visits for an insulin injection. The assessment process may identify that the recipient's safety monitoring needs could be effectively met through the use of Personal Emergency Response Services, and that the pre-set insulin pen, could reduce the recipient's need for a daily nursing visit to bi-weekly nursing visits. If inclusion of the two efficiencies in the recipient's care plan can maintain the recipient's health and safety, the recipient meets the eligibility criteria for each efficiency, and the service(s) are available, then inclusion of the efficiencies in the recipient's care plan is appropriate.

At times it may be necessary to verify whether certain specialized medical equipment is reimburseable under Medical Assistance or how a provider should bill a particular item. In such instances, district staff should contact Linda Miller in the Division of Medical Assistance's Bureau of Primary Care at 1-800-342-3715, Ext.3-5881, in order to obtain the required information.

D. When The District Must Conduct Fiscal Assessments

This section discusses when social services districts must conduct initial or subsequent fiscal assessments for personal care services applicants or recipients.

1. Initial fiscal assessments:

The social services district must conduct initial fiscal assessments of personal care services applicants and recipients in accordance with the following:

- (a) Applicants who are expected to require more than 60 continuous days of personal care services:

The social services district must conduct an initial fiscal assessment of each applicant who is not currently receiving personal care services but who the social services district reasonably expects will need personal care services for more than 60 continuous days during the initial authorization period, regardless of the number of hours per day or days per week that the applicant would need services during the initial authorization period. This does not mean that the applicant must need personal care services for each day of a continuous 60 day period. Rather, this requirement means that the

applicant would be authorized to receive personal care services for more than 60 continuous days regardless of the number of hours per day or days per week that the applicant would actually receive services during this 60 day period.

- (b) Applicants who are expected to require 60 or fewer continuous days of personal care services:

The social services district is not required to conduct a fiscal assessment of a personal care services applicant who the district reasonably expects will require personal care services for 60 or fewer continuous days. When the social services district determines, based on the physician's order, the social assessment and the nursing assessment, that personal care services are medically necessary and the district reasonably expects that the services can maintain the recipient's health and safety in the home, the district must authorize services without conducting a fiscal assessment. A fiscal assessment will be required only if the district later reasonably expects that the recipient will actually require personal care services for more than 60 continuous days, as explained in (c) below.

- (c) Recipients who are expected to require more than 60 continuous days of personal care services:

The social services district must conduct an initial fiscal assessment for each recipient who is receiving personal care services in accordance with an initial authorization of services and who the district, when it initially authorized services, did not reasonably expect would need services for more than 60 continuous days, but who the district, prior to the 60th continuous day of the initial authorization period, reasonably expects will, in fact, need personal care services for more than 60 continuous days.

An unexpected change in the recipient's social circumstances, mental status or medical condition during the authorization period could be one reason why the district reasonably expects that a recipient will need services for more than 60 continuous days even though the district, when it first authorized services, did not reasonably expect that the recipient would need services for more than 60 continuous days. Such a change in the recipient's social circumstances, mental status or medical condition can affect the type, amount, frequency, or average monthly costs of personal care services and any private duty nursing services and home health services, that the recipient will need. If the district reasonably expects that the average monthly costs of the services the recipient will need for 12 months will exceed 90 percent of the average monthly costs of RHC services in the

district, it must conduct an initial fiscal assessment of the recipient.

2. Subsequent fiscal assessments:

The social services district must conduct subsequent fiscal assessments of personal care services recipients for whom the district has already conducted initial fiscal assessments, in accordance with the following:

(a) Upon reauthorization:

When a social services district has conducted an initial fiscal assessment and authorized personal care services, the district must conduct a subsequent fiscal assessment of the recipient before it reauthorizes services UNLESS:

the district determines there has been no change in the recipient's care plan and the cost of services included in that care plan from the previous authorization period; or

the district determines from the social assessment or the nursing assessment that a recipient who was authorized to receive personal care services because he or she met an exception criterion continues to meet that exception criterion or meets another exception criterion.

(b) Unexpected changes:

The social services district must also conduct a subsequent fiscal assessment when the recipient's social circumstances, mental status or medical condition changes during the authorization period and such change would affect the type, amount, frequency, or average monthly costs of personal care services and any private duty nursing services and home health services, other than medical supplies, equipment and appliances. If the district reasonably expects that the recipient will continue to require personal care services for more than 60 continuous days and that the average monthly costs of the services the recipient will require for 12 months will exceed 90 percent of the average monthly costs of RHCF services in the district, the district must conduct a subsequent fiscal assessment.

E. Cases for Whom the District is Not Required to Conduct a Fiscal Assessment

Recipients receiving services through a Long Term Home Health Care Program (LTHHCP), an AIDS Home Care Program, a foster family care demonstration program, a chronic care management demonstration program, or a model waiver authorized by the Department under SSL Section

366.6 or 366.7 or who is receiving personal care services from a program licensed, operated or certified by OMRDD or OMH are not subject to the fiscal assessment requirement.

Districts are also not required to conduct fiscal assessments on cases receiving only home health services. Certified home health agencies (CHHAs) will be responsible for conducting the fiscal assessment and management activities for home health services cases. Administrative Directive 92-50, Fiscal Assessment and Management of Home Health Services, identifies the responsibilities of both the certified home health agency and the district as they relate to home health services.

However, social services districts are responsible for the fiscal assessment and management activities of all cases which receive a combination of personal care services and/or home health services and/or private duty nursing services. A directive on the Fiscal Assessment and Management of Private Duty Nursing Services will be released at a future date.

On occasion, a district having responsibility for the fiscal assessment and case management activities of a case authorized to receive personal care services in combination with home health services, but not private duty nursing services, will be reassessed and determined to be inappropriate for, or no longer require, personal care services. In those instances, the district must notify the certified home health agency within 10 calendar days of the determination and provide to the certified agency the following documentation:

- o a copy of the recipient's current social and nursing assessments; fiscal assessment, if any; and the assessments of the appropriateness and cost-effectiveness of the efficiencies listed on pages 7-8 of this directive;
- o a copy of the recipient's most current physician order; and
- o a copy of the recipient's current plan of care;

The district must notify the recipient of the district's determination to discontinue personal care services and of the recipient's right to request aid continuing and a fair hearing. If the recipient disagrees with the district's determination to discontinue personal care services and requests a fair hearing and aid continuing, the district immediately must contact the CHHA and make arrangements for the district's continued responsibility and management of the recipient's care pending the fair hearing determination.

F. Fiscal Assessments

The fiscal assessment is a comparison of the estimated average monthly costs of the home care services a recipient is reasonably expected to require over 12 months to 90 percent of the average monthly costs of RHCFS services in the district. The 90 percent target figures have been calculated for each social services district and are listed in Attachment 1. The 90 percent target figures will be calculated annually and transmitted to the districts by the Department.

Fiscal assessment, in effect, means costing out all those services included in the recipient's care plan that can be identified as home care services, i.e., personal care, home health services, nursing assessments, nursing supervision visits, private duty nursing services, or therapies. It does not include: durable medical equipment, drugs, physician visits, Personal Emergency Response Services (PERS), or medical transportation. In cases where a portion of the services can be billed to Medicare or other third-party payors, it is important to note that only those costs which will be billed to the MA program must be included in the fiscal assessment calculation.

To determine the estimated average monthly costs of the personal care services needed singly, or in conjunction with home health services and/or private duty nursing services, that the district expects a recipient will require over a 12 month period, the district must:

1. Estimate the number of hours or visits of personal care services (PCS) and any needed home health service (HHS), other than medical devices, equipment and supplies, and/or private duty nursing services (PDNS) that the recipient is expected to receive for 12 months prospectively from the date services would be authorized or reauthorized.
2. Delete from consideration any of those services that during the course of that 12 month period would be paid for by a third-party payor or by Medicare;
3. Multiply the total number of hours or visits of expected personal care services, home health services and private duty nursing services that would be reimbursed only by the MA program during that 12 month period, by each services' respective average MA rate, as provided by the Department in Attachment 8, Schedules D, E, and F of this directive;
4. Add together the products obtained as a result of step 3 and divide the sum of the combined products by 12.
5. If applicable, subtract from this total the amount of the recipient's monthly excess income and excess resources;

6. The amount derived at after completing step 5 represents the average monthly total cost of all MA only reimbursed home care services that is to be compared to 90 percent of the district's average monthly RHCF cost.

Attachment 5 of this directive is the Fiscal Assessment Worksheet which was developed to simplify the fiscal assessment process and which must be completed for each recipient with service needs likely to exceed 60 continuous days. For social services districts with access to a personal computer, the Department is designing a Lotus 123 spreadsheet for each district. The spreadsheet, when it becomes available, will include protected fields which contain the district specific rate information to be used in calculations for the fiscal assessment. The district staff will be required to enter recipient identifying information and the units of service for each service included in the care plan. All mathematical calculations and comparison to RHCF costs in the district will be computed automatically. Districts will be notified in writing upon the availability of the spreadsheet.

District specific rate information used in calculating the fiscal assessments will be periodically updated and transmitted by the Department to the districts.

G. Time-Frame for Fiscal Assessments

The fiscal assessment must be completed prior to the authorization or reauthorization of services. The district of fiscal responsibility must complete the fiscal assessment within 30 calendar days after the district receives the initial request for personal care services or the request for reauthorization of personal care services.

Implementation of the fiscal assessment process will be phased-in. On the effective date of this directive all new cases will be required to comply with the provisions of this directive. Existing cases will be subject to the fiscal assessment process at the time of reassessment or when a change in the recipient's condition necessitates a change in service delivery. Cases which are currently receiving a combination of home health and personal care services will immediately be assessed by the district upon receipt of the recipient's comprehensive assessment from the CHHA.

The fiscal assessment should be conducted prior to the authorization of services but after the district is in receipt of the following: the recipient's physician's order; the nursing assessment and social assessment; the plan of care and assessments of the appropriateness and cost-effectiveness of the efficiencies. When the recipient immediately needs Level I or Level II services to protect his or her health and safety and the nursing assessment and the fiscal 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 and fiscal assessments are obtained within 30 calendar days; and
- (b) the recommendations of the nursing and fiscal assessments are reviewed and changes made in the authorization as required.

H. Action Required As A Result of the Fiscal Assessment

1. Cost is Equal to OR Less Than 90% of RHCF Placement Costs

If the estimated average monthly costs of personal care services that the district reasonably expects a recipient to require for 12 months, combined with the average monthly costs of any home health services and private duty nursing services that the district reasonably expects a recipient will require for 12 months, is equal to or less than 90 percent of the average monthly RHCF placement cost in the district, as defined by the Department, the district must:

- o Authorize or reauthorize personal care services for the recipient, provided the services are medically necessary, and the social services district reasonably expects that personal care services can maintain the recipient's health and safety in the home; or
- o Deny or discontinue personal care services and refer the recipient to other appropriate long-term care services if the district determines that personal care services are not medically necessary or no longer medically necessary or when it cannot be reasonably expected that such services can maintain or continue to maintain the recipient's health and safety in the home.

It is important to remember that even in situations where the cost is less than 90 percent of the average monthly RHCF placement cost, the case must include documentation that the efficiencies were considered as part of the care plan development. Use of one or more of the efficiencies may result in significant cost reductions even in these cases.

2. Costs Exceed 90% of RHCF Placement Costs

If the district estimates that the average monthly costs of the personal care services that the district reasonably expects a recipient will require for 12 months combined with the average monthly costs of any home health care services and private duty nursing services that the district reasonably expects a recipient will require for 12 months, will exceed 90 percent of the average monthly costs for 12 months, as determined by the Department, of RHCF services in the social services district, the district must determine:

- o Whether the recipient meets at least one exception criteria and must be authorized or reauthorized for personal care services, provided that personal care services are, or continue to be medically necessary and the district reasonably expects that personal care services can maintain, or continue to maintain, the recipient's health and safety in his or her home; or
- o Whether the recipient does not meet at least one exception criteria and must be referred to other appropriate long-term care services.

I. Exception Criteria

When the results of the fiscal assessment indicate that the average monthly costs of the personal care services that the district reasonably expects a recipient will require for 12 months, combined with the average monthly costs of any home health services and/or private duty nursing services that the district reasonably expects a recipient will require for 12 months, will exceed 90 percent of the average monthly costs for 12 months, as determined by the Department, of RHCF services in the social services district, the district must review the recipient against five exception criteria to determine whether he/she is entitled to receive personal care services. The exception criteria are as follows:

1. the recipient is not medically eligible for RHCF services or other long-term care services, including other residential long term care services or other non-residential long-term care services;
2. personal care services are cost-effective when compared to the costs of other long-term care services appropriate to the recipient's needs as described below:
 - (a) for a recipient who would otherwise be placed in a general hospital, the assessor must compare the average monthly costs of the personal care services that the assessor reasonably expects the recipient will require for 12 months to the average monthly costs of care in a general hospital. The average monthly costs of care in a general hospital are determined by the Department of Health by adding the payments made to all general hospitals in the region for the diagnostic-related group (DRG) in which the recipient would be classified, dividing such result by the sum of the group mean lengths of stay for persons classified in such DRG, multiplying such result by 365 and further dividing such result by 12. The figures to be used in this comparison are listed in Attachment 8, Schedule A of this directive;

- (b) for a recipient who would otherwise be placed in an intermediate care facility for the developmentally disabled, the assessor must compare the average monthly costs of the personal care services that the assessor reasonably expects the recipient will require 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 OMRDD. The figures to be used in this comparison are listed in Attachment 8, Schedule B of this directive;
 - (c) for a recipient who would otherwise be placed in an RHCF, the assessor must compare the average monthly costs of the personal care services that the assessor reasonably expects the recipient will require for 12 months to the average monthly costs of RHCF services in the social services district, provided to recipients classified in the same resource utilization group (RUG) in which the recipient would be classified. The figures to be used in this comparison are listed in Attachment 8, Schedule C of this directive;
 - (d) for a recipient who would otherwise be placed in other residential long-term care services or other non-residential long-term care services, the assessor must compare the average monthly costs of the personal care services that the assessor reasonably expects the recipient will require 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. The figures to be used in this comparison will be determined by the social services district on a case by case basis;
3. the recipient is:
- (a) employed, which means that he or she is engaged in a work activity that involves significant physical or mental activities for pay or profit or is doing the type of work usually done for pay or profit, regardless of whether a profit is actually realized. Whether a patient is employed for purposes of this item is determined in accordance with the federal regulations for determining substantial gainful activity under Title II of the federal Social Security Act, as codified at 20 CFR 404.1571 through 404.1576 (20 CFR Parts 400-499, revised annually as of April 1, is published by the Office of the Federal Register, National Archives and Records Administration, and is available for public use and inspection at the Department of Social Services, 40 N. Pearl St., Albany, New York 12243);
 - (b) enrolled in an educational program approved by a committee on pre-school 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; or

(c) the parent or legal guardian of a dependent child, defined as a child who lives with the recipient and who is:

(i) younger than 18 years of age;

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

(iii) 18 years of age or older and blind or disabled, as determined in accordance with Subpart 360-5 of Part 360 of this Title; or

(d) blind or disabled, as determined in accordance with Subpart 360-5 of Part 360 of this Title, and would remain hospitalized or require long-term hospitalization without personal care services;

4. personal care services are appropriate for the recipient's functional needs, and institutionalization is contraindicated, based on a review by the social services district of the recipient's medical history. The review must include a certified statement from the recipient's physician, on a form required by the Department and the Department of Health (Attachment 10), that describes the potential impact of institutionalization. The form must be reviewed by an RHCF to determine if institutionalization would result in a diminishing of the recipient's ability to perform the activities of daily living. (The social services district is responsible for sending Attachment 10 to the recipient's physician. If the physician has certified that institutionalization will diminish the recipient's ability to perform the activities of daily living, the district is then responsible for sending Attachment 11 and DSS-4359 to the reviewing residential health care facility.); or

5. the recipient lives with another person who the district determines would need services if the recipient were institutionalized, and the district determines that the costs of services for the recipient and the costs of services for such other person, if either or both were institutionalized, would equal or exceed the costs of personal care services for the recipient and the costs of any services for such other person.

J. Results of the Exception Criteria Review

1. Recipient Meets at Least One of the Exception Criteria

If the district determines that the recipient meets at least one exception criterion, the district must authorize or reauthorize

personal care services for the recipient even though the average monthly cost of the services, together with the average monthly cost of any home health services and/or private duty nursing services the recipient will require, is expected to exceed 90 percent of the average monthly cost of RHC placement, provided that:

- o the social services district determines that personal care services are medically necessary; and
- o the social services district reasonably expects that personal care services can maintain the recipient's health and safety in the home.

Districts only need to determine that a recipient meets one of the five exception criteria. In situations where it appears that a recipient would likely meet more than one exception criteria, the district should pursue validation of the exception criteria which has the least cost and or administrative burden associated with it. For instance, exception criteria #2 requires completion of a PRI, which has significant cost associated with it, and exception criteria #4 requires coordination of multiple supporting documentation from various sources, whereas a determination of exception criteria #3 has minimal time involvement and no additional cost associated with the determination.

2. Recipient Does Not Meet at Least One of the Exception Criteria

If the district determines that the recipient does not meet at least one exception criterion and the recipient is not currently in receipt of personal care services, the district must deny personal care services and refer the recipient to other appropriate long-term care services for which the recipient is medically eligible.

If the recipient is currently receiving personal care services, the district must provide a notice to the recipient of its determination in accordance with section M. Fair Hearings, 2. Discontinuances based on Chapter 165 of this directive, and continue authorizing personal care services until such time as other appropriate long-term care services are available to the recipient provided that:

- o the social services district determines that personal care services are medically necessary; and
- o the social services district reasonably expects that personal care services can maintain the recipient's health and safety in the home.

K. Role of the Local Professional Director

When there is a disagreement between the physician's order and the social, nursing, fiscal and other required assessments or there is a

question about the level and amount of services to be provided or the case involves the provision of continuous 24 hour personal care services, the district must transmit the following documentation to the local professional director or his/her designee for review:

- o the physician's order,
- o the social and nursing assessments,
- o the fiscal assessment, if required, and
- o the assessment of efficiencies.

The local professional director must review the documentation and transmit to the social services district within five working days of the request, the final determination of the level and amount of care to be provided.

L. Referral To Other Appropriate Long-Term Care Services

When the district determines, or it is the final determination of the local professional director or his or her designee, that the recipient must be referred to other appropriate long term care services including services in a RHCF, the district must:

1. complete all required admission documentation for each recipient awaiting referral to other appropriate long term care services; such other appropriate long-term care services include RHCF services, other residential long-term care services, or other non-residential long-term care services;
2. file such documentation with all long term care services providers that provide the level of care appropriate for the recipient and which are located within 50 miles of the recipient's home;
3. provide each long term care services provider with the names and telephone numbers of district professional staff available to provide additional information to such providers regarding the recipient's medical conditions or services needs;
4. contact weekly, by telephone, at least three RHCFs, other residential long-term care services or other non-residential long-term care services that provide the level of care appropriate for the recipient and that are located within 50 miles of the recipient's home. The district must rotate these contacts weekly among all such long-term care services and document the contacts in the recipient's case record.
5. inform the recipient when other appropriate long-term care services become available to the recipient and assist the recipient to obtain the services.

Districts which have more than 25 RHCFS within a 50 mile radius may prioritize or stagger the application process. Admission applications should be sent to the five RHCFS most preferred by the recipient. If after 10 days those facilities have not admitted the recipient, applications must be sent to five additional facilities. This process must continue every 10 days until all appropriate facilities have been contacted.

The fiscal assessment and management of personal care services policies may impact on the district's and hospital's current discharge planning procedures. Districts should work cooperatively with hospital discharge planners to develop procedures which will help facilitate the recipient's discharge from the hospital to the appropriate long term care setting.

M. Fair Hearing Rights

1. Denials based on Chapter 165:

The social services district must notify a personal care services applicant of the district's determination to deny personal care services when the district reasonably expects that the average monthly costs of the personal care services, in addition to any home health services and private duty nursing services, that the applicant will require for 12 months would exceed 90% of the average monthly costs for 12 months of RHCFS care and the applicant does not meet any exception criteria. The applicant is entitled to a fair hearing. The district must notify the applicant of its determination to deny services and of the applicant's right to a fair hearing by using the notice attached to this directive as Attachment 3. The district must photocopy this notice and issue it as a two-sided rather than a two-paged notice. The Exception Criteria For Denial of Personal Care Services should then be appended to the denial notice.

2. Discontinuances based on Chapter 165:

The social services district must notify a personal care services recipient of the district's determination to discontinue personal care services when the district reasonably expects that the average monthly costs of the personal care services, in addition to any home health services and private duty nursing services, that the recipient will require for 12 months would exceed 90% of the average monthly costs of RHCFS care and the recipient does not meet any exception criteria. At the time the district determines that the recipient does not meet at least one exception criterion and must be referred to other appropriate long-term care services, the district, using the notice attached to this directive as Attachment 4, must notify the recipient of the following:

- a. that the district is referring the recipient to other appropriate long-term care services;

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- b. that the district intends to discontinue the recipient's personal care services authorization when such services become available to the recipient;
 - c. that the recipient has a right to request a fair hearing to appeal the district's determination that the recipient does not meet any exception criteria and to appeal the appropriateness of the other long-term services; and
 - d. of the recipient's right to have personal care services continue unchanged until the fair hearing decision is issued (aid continuing), in accordance with Part 358 of the Department's regulations.

The district must photocopy the discontinuance notice, included as Attachment 4, and issue it as a two-sided rather than a two-paged notice. The Exception Criteria for Discontinuance of Personal Care Services should then be appended to the discontinuance notice.

Note: Regardless of whether the recipient requests a fair hearing and aid continuing, section 367-k of the SSL and 505.14 require the district to continue the provision of personal care services to the recipient until other appropriate long-term care services become available to the recipient.

3. Non-Chapter 165 notices:

The social services districts must continue to notify personal care services applicants and recipients when the district denies or discontinues personal care services for reasons unrelated to the fiscal assessment process required by Chapter 165. A social services district must also notify personal care services applicants and recipients when it determines to authorize, reauthorize, increase or decrease personal care services. Until further notice, the district must use the fair hearing notices attached to 89 ADM-21 for all social services district determinations to deny or discontinue personal care services for reasons unrelated to Chapter 165 and for all authorizations, reauthorizations, increases and decreases.

N. Case Management Activities

The district continues to have responsibility for providing case management services to all recipients receiving personal care services. In addition to existing case management activities, the district or its Department approved designee is responsible for the following:

- o assessing the recipient's eligibility for hospice services;
- o assessing the recipient's appropriateness for and cost-effectiveness of any of the efficiencies identified on pages 7-8, IV. C., of this directive; and

- o if required, obtaining or completing the fiscal assessment described on page 13, section F. of this directive.

O. Recordkeeping Requirements

Documentation must be maintained in the recipient's record to assure that the management and fiscal assessment procedures contained in 505.14 and required by Chapter 165 of the Laws of 1991 and Chapter 41 of the Laws of 92 are followed. In addition to existing documentation requirements identified in 505.14(g)(4), the recipient's case record must include the following additional documentation:

1. documentation of the assessments of the appropriateness and cost-effectiveness of the efficiencies listed on pages 7-8 of this directive;
2. documentation of the amount, duration and scope of any home health services and private duty nursing services being provided in combination with personal care services;
3. documentation of the assessment of the recipient's eligibility for hospice services, unless medically contra-indicated by the recipient's physician;
4. a copy of the fiscal assessment, if required;
5. documentation of the district's referral, when applicable, of the recipient's case to the local professional director or designee, which must include a copy of the physician's order; the social assessment; the nursing assessment; the fiscal assessment, if a fiscal assessment is required; and, the assessment of the appropriateness and cost-effectiveness of the efficiencies;
6. for each case referred to the local professional director or designee, a copy of the local professional director's or designee's final determination;
7. a copy of the recipient's referral to the certified home health agency when the district determines that a recipient of personal care services and home health services, but not private duty nursing services, no longer requires personal care services but may continue to require home health services; and
8. documentation to support the districts' weekly contact with at least three RHCF's, other residential long-term care services or other non-residential long-term care services that provide the level of care appropriate for the recipient and that are located within 50 miles of the recipient's home.

P. Social Services District Reporting Requirements

The social services district is required to submit annually to the Department statistical data on the fiscal assessment and management

process. This information must be submitted on Attachment 2, the District Fiscal Assessment Annual Report Form for Personal Care Services Recipients. The first report must be submitted to the Department by 03/31/93. Subsequent reports will be incorporated into the districts' Personal Care Services Program's Annual Plan report.

V. SYSTEMS IMPLICATIONS

None.

VI. EFFECTIVE DATE

The effective date for implementation of the requirements identified in this directive is January 1, 1993.

Gregory M. Kaladjian
Executive Deputy Commissioner

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90 PERCENT OF RHCFC COSTS BY DISTRICT CY 1991

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CODE	COUNTY NAME	90 PERCENT TARGET
01	ALBANY	\$2,717.00
02	ALLEGANY	\$2,193.00
03	BROOME	\$2,337.00
04	CATTARAUGUS	\$2,269.00
05	CAYUGA	\$2,485.00
06	CHAUTAUQUA	\$2,166.00
07	CHEMUNG	\$2,659.00
08	CHENANGO	\$2,834.00
09	CLINTON	\$2,344.00
10	COLUMBIA	\$2,463.00
11	CORTLAND	\$2,200.00
12	DELAWARE	\$2,769.00
13	DUTCHESS	\$2,622.00
14	ERIE	\$2,407.00
15	ESSEX	\$2,598.00
16	FRANKLIN	\$2,518.00
17	FULTON	\$2,869.00
18	GENESEE	\$2,166.00
19	GREENE	\$2,601.00
20	HAMILTON	\$2,196.00
21	HERKIMER	\$2,730.00
22	JEFFERSON	\$2,825.00
23	LEWIS	\$2,598.00
24	LIVINGSTON	\$2,405.00
25	MADISON	\$2,738.00
26	MONROE	\$2,551.00
27	MONTGOMERY	\$3,050.00
28	NASSAU	\$3,492.00
29	NIAGARA	\$2,261.00
30	ONEIDA	\$2,289.00
31	ONONDAGA	\$2,881.00
32	ONTARIO	\$2,831.00
33	ORANGE	\$2,874.00
34	ORLEANS	\$2,212.00
35	OSWEGO	\$2,259.00
36	OTSEGO	\$2,679.00
37	PUTNAM	\$2,942.00
38	RENSSELAER	\$2,378.00
39	ROCKLAND	\$3,482.00
40	ST. LAWRENCE	\$2,036.00

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90 PERCENT OF RHCFC COSTS BY DISTRICT

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CODE	COUNTY NAME	90 PERCENT TARGET
41	SARATOGA	\$2,825.00
42	SCHENECTADY	\$2,609.00
43	SCHOHARIE	\$3,362.00
44	SCHUYLER	\$3,421.00
45	SENECA	\$2,302.00
46	STEUBEN	\$2,467.00
47	SUFFOLK	\$3,363.00
48	SULLIVAN	\$2,579.00
49	TIOGA	\$2,472.00
50	TOMPKINS	\$2,290.00
51	ULSTER	\$2,802.00
52	WARREN	\$2,453.00
53	WASHINGTON	\$2,266.00
54	WAYNE	\$2,665.00
55	WESTCHESTER	\$3,311.00
56	WYOMING	\$2,522.00
57	YATES	\$2,569.00
58	NYC	\$3,751.00

SOCIAL SERVICES DISTRICT FISCAL ASSESSMENT REPORT FORM
FOR PERSONAL CARE SERVICE RECIPIENTS

1. District Name: _____ 2. District Code: _____

3. Period Covered: FROM _____ TO _____

4. Fiscal Assessment Statistics:

(a) Total number of personal care services cases: _____

(b) Number of Fiscal Assessments completed for Personal Care Services cases: _____

(c) Number of Fiscal Assessments with costs equal to or less than 90% of the average monthly RHCF costs: _____

(d) Number of Fiscal Assessments with costs greater than 90% of RHCF costs and NOT meeting any exception criteria: _____

(e) Number of Fiscal Assessments with costs greater than 90% of the average monthly RHCF costs and meeting one or more exception criteria: _____

(f) Number of Fiscal Assessments meeting the following exception criteria:

exception exception exception
criterion #1 _____ criterion #2 _____ criterion #3 _____

exception exception
criterion #4 _____ criterion #5 _____

Note: If a recipient meets more than one exception criteria, please count each exception criteria he or she meets. For example, if a person meets exception criteria #3 and #5, count that person twice in #4(f) above.

(g) Number of Fiscal Assessments referred to the local professional director or designee for final determination: _____

5. On what number of cases did the Local Professional Director's or designee's decision result in:

(a) Recipient being referred to RHCF services? _____

(b) Amount, duration or scope of services being modified? _____

(c) Recipient requesting a fair hearing? _____

6. On what number of fiscal assessments did the district do the following:

- (a) consult with recipient's physician? _____
- (c) conduct a second fiscal assessment? _____
- (d) request additional information from the assessor _____
(below list information most frequently requested)

7. Identify any problems you have experienced in implementing the fiscal assessment and management of home care services process:

Prepared by: _____
Title: _____
Date: _____