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¦ LOCAL COMMISSIONERS MEMORANDUM ¦
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DSS-4037EL (Rev. 9/89)

Transmittal No: 91 LCM-156

Date: August 30, 1991

Division: Medical Assistance

TO: Local District Commissioners

SUBJECT: Survey of Department of Social Services and Department of Health Home Care Regulations

ATTACHMENTS: Attachments 1-2: Department of Social Services Regulations 505.14 and 505.21 (available on-line).
Attachment 3: Department of Health Regulations, Parts 763-764; 766-767; 770-771; 772 (not available on-line).
Attachment 4: Questionnaire (available on-line).

Chapter 165 of the Laws of 1991 adds a new section 367-m to the Social Services Law requiring the Department and the State Department of Health to conduct certain activities related to State regulations for the provision of home care services. One of the required activities is a review of all regulations affecting the organization and delivery of home care services to determine the need for repeal or modification.

As part of this review, I am requesting your assistance in completion of the attached questionnaire concerning possible changes in the following regulations:

1. Department of Social Services Regulations

   a. 505.14: Personal Care Services
   b. 505.21: Long Term Home Health Care Program

2. Department of Health Regulations

   a. Parts 763-764: Certified Home Health Agency
   b. Parts 766-767: Licensed Home Care Services Agency
   c. Parts 770-771: Long Term Home Health Care Program
   d. Part 772: AIDS Home Care Programs

Department of Social Services regulations governing Personal Emergency Response Services and Home Health Care Services, sections 505.33 and 505.23 respectively, are not included in this particular review. Section 505.33 is a recent regulation, effective May 1, 1991, and is expected to be implemented in September for the first time. Section 505.23 is currently under total revision to reflect fiscal assessment requirements specified in Chapter 165. You will have an opportunity for review and comment when the regulations are published at the end of September.

For your reference, a copy of each regulation included in the present survey is attached to this memorandum. The regulations are current as of this date. Section 505.14 does not include proposed revisions implementing the fiscal assessment requirements of Chapter 165 and other proposed cost containment measures.

Instructions for completion of the questionnaire are found on page 1 of the instrument. Your comments must be specific. For example: if you believe that paragraph 505.14(a)(2)(i) of the regulations for personal care services should be modified, you should cite this provision exactly, indicate your recommendation that the provision be modified, and explain why and how you believe the modification should be made.

The attached questionnaire is also being sent to associations representing the provider community. Survey findings from all sources will be analyzed by the Department and used to prepare a formal report to the Governor as required by the statute.

Questionnaires should be completed and returned to the Department by October 11, 1991. As an alternative to use of the attached form, you may use the questionnaire format to compile and submit your comments on a document you create.

You may mail or fax your completed questionnaire to:

Mr. Barry T. Berberich
Director
Bureau of Long Term Care
Division of Medical Assistance
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
Fax Number: (518) 473-4232

Thank you for your cooperation. If you have any questions about completion of the questionnaire, you may call Anne Church of my staff at 1-800-342-3715, extension 3-5615 or (518) 473-5615.

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

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
PERSONAL CARE SERVICES REGULATIONS
505.14

(a) Definitions and scope of services.

(1) Personal care services shall mean some or total assistance with personal hygiene, dressing and feeding; nutritional and environmental support functions and health-related tasks. Such services shall be essential to the maintenance of the patient's health and safety within his/her own home, ordered by the attending physician, based on an assessment of the patient's needs, 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, shall be provided only if the patient's health and safety in the home can be adequately assured by the provision of such services.

(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 three 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 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 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) The initial authorization for Level II services shall not exceed four hours per day or 28 hours per week. An exception to this requirement may be made under the following conditions:

(1) The patient requires total assistance with toileting and/or walking, and/or transferring, and/or feeding as a result of the following:

(i) short-term assistance is required due to an acute medical episode; and/or

(ii) more intensive service is required during a post-hospitalization period; and/or

(iii) assistance provided by informal caregivers is unavailable, withdrawn, reduced or unacceptable to the patient; and/or

(iv) adaptive equipment, self-help devices, and structural modifications in the patient's residence are unavailable or lacking; and/or

(v) monitoring of the patient's safety is required as part of a plan of care for a nonself-directing patient under the conditions specified in clauses (a)(4)(ii)(a)-(c) of this section; and/or

(vi) additional hours of services for routine, supportive assistance are required by the patient because of the degree of his/her physical disability.

(2) Under the circumstances specified in subclause (a)(6)(ii)(b)(1) of this section, the local social services department may authorize additional hours of services per week up to, but not including, continuous 24-hour care.

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

(iii) Level III services shall include the performance of nutritional and environmental support functions, personal care functions, as specified in clauses (a)(6)(i)(a) and (b) of this section, and health-related tasks.

(a) Health-related tasks shall mean tasks performed by an individual, acting as an extension of a self-directing patient, as defined in paragraph (a)(5) of this section, or as part of a plan of care for a nonself-directing patient who has a self-directing informal caregiver living within the same household or a self-directing informal caregiver living outside of the household who has substantial daily contact with the patient in the patient's household. Health-related tasks shall include some or total assistance with certain activities, as specified in guidelines issued by the Department, involved in the following:

(1) performing simple measurements and tests to routinely monitor the patient's medical condition, including the taking of vital signs;

(2) preparing meals in accordance with complex, modified diets;

(3) performing a maintenance exercise program;

(4) using prescribed medical equipment, supplies and devices;

(5) changing dressings of stable surface wounds;

(6) caring for an ostomy after the ostomy has achieved its normal function; and

(7) providing special skin care.

(b) Under special circumstances, and as specified in guidelines issued by the department, the individual providing Level III services may perform additional activities associated with these health-related tasks, or may perform additional health-related tasks for a particular

patient in accordance with the judgment of the assessing nurse. Such special circumstances shall mean that:

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

(2) The patient needs assistance with the task or activity for routine maintenance of his or her health; and

(3) The patient cannot physically perform the task or activity because of his or her disability; and

(4) The patient has no informal caregiver available at the time the task or activity must be performed, or the caregiver is unwilling or unable to perform the task or the caregiver's involvement is unacceptable to the patient.

(c) The initial authorization for Level III services shall not exceed four hours per day or 28 hours per week. An exception to this requirement may be made under the following conditions:

(1) The patient requires total assistance with toileting and/or walking, and/or transferring, and/or feeding as a result of the following:

(i) short-term assistance is required due to an acute medical episode; and/or

(ii) more intensive service is required during a post-hospitalization period; and/or

(iii) assistance provided by informal caregivers is unavailable, withdrawn, reduced or unacceptable to the patient; and/or

(iv) adaptive equipment, self-help devices and structural modifications in the patient's residence are unavailable or lacking; and/or

(v) monitoring of the patient's safety is required as part of a plan of care for a nonself-directing patient under the conditions specified in clauses (a)(4)(ii)(a)-(c) of this section; and/or

(vi) additional hours of service for routine, supportive assistance are required by the patient because of the degree of his/her physical disability.

(2) Under the circumstances specified in subclause (a)(6)(iii)(c)(1) of this section, the local social services department may authorize additional hours of services per week up to, but not including, continuous 24-hour care.

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

(d) Each individual providing Level III services shall have demonstrated his/her ability in performing personal care functions for patients. Such ability shall be documented in the individual's personnel record.

(e) Each individual providing Level III services shall meet the following basic training requirements:

(1) the individual shall have successfully completed a basic training program approved by the State Department of Health for home health aide training; or

(2) the individual shall have successfully completed an approved basic training program for personal care services or an approved equivalent competency testing methodology in accordance with the requirements specified in subdivision (e) of this section. In addition, the individual shall successfully complete a supplementary classroom training program according to a curriculum established by the department. Such instruction shall be

provided prior to each individual's assignment to cases requiring the performance of any health-related task.

(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, personal care functions, or health-related tasks for each personal care services recipient who resides with other personal care services recipients in a designated geographical area, such as in the same apartment building, and a personal care services provider completes the authorized functions or health-related tasks 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 Levels I, II and III services shall be based upon a physician's order, a social assessment and a nursing assessment.

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

(i) The local social services department shall inform the patient and/or the patient's representative of the need for a physician's order for services and shall provide the necessary form for obtaining the required order.

(a) The order shall be based on the patient's current medical status as determined by a medical examination within 30 days of the request for services. The order for all Level III services shall identify the specific functions and tasks required by the patient.

(b) A copy of the physician's order shall be forwarded to the local social services department for a social assessment.

(c) A copy of the physician's order shall be forwarded by the local social services department to the person or agency responsible for completion of the nursing assessment.

(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) 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 and nursing 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 physician's order shall reflect the patient's current medical condition and disabilities.

(2) 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.

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

(ii) The local professional director, or designee, shall review the physician's order and the social and nursing assessments in accordance with the standards for levels of services set forth in subdivision (a) of this section, and shall be responsible for the final determination of the level and amount of care to be provided. The final determination shall 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 request 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 is in immediate need of Level I or Level II services as defined in subdivision (a) of this section to protect his/her health and safety, and the nursing assessment cannot be completed within five working days, the local social services department may authorize the services based on the physician's order and the social assessment; however,

(a) The nursing assessment shall be obtained within 30 calendar days; and

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

(v) The local social services department shall notify the patient in writing of its decision to authorize or deny services on forms required by the State Department of Social Services. The patient shall be entitled to a fair hearing in accordance with the requirements outlined in Part 358 of this Title if services are denied.

(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 and Level III 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. Based on the evaluation, reauthorization may exceed four hours per day or 28 hours per week.

(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 services being provided during the authorization period, the local social services department shall be 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 with 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.

(6) The social services district must include in each contract or other written agreement the rate or rates at which it will reimburse the provider agency for the provision of personal care services. The social services district must submit such rates to the department on forms the department requires to be used. The social services district must not implement such rates until the department and the director of the budget approve them pursuant to paragraph (h)(5) 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 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 or the State Department of health, as provided in subdivision (e) and clause (a)(6)(iii)(e) of this section, respectively;

(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. The provider agency's fiscal practices must include an annual audit, conducted by a certified public accountant, of the provider agency's fiscal records relating to personal care services provided to MA recipients.

(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 State Department of Social Services 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 State Department of Social Services 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 State Department of Social Services 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 State Department of Social Services 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 State Department of Social Services 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 State Department of Social Services 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 State Department of Social Services;

(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 cases 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.

(e) Required training.

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

(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 semi-annually 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 State Department of Social Services 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 State Department of Social Services for approval. The State Department of Social Services 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 State Department of Social Services 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 State Department of Social Services 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 Level I, II or III 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 evaluations;

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

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

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

(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 paragraph.

(iv) Nursing supervision includes the following activities:

(a) orienting the person providing Level I, II or III 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 Level I, II or III personal care services, except Level III services involving a task or activity performed under special circumstances, as provided in subdivision (a)(6)(iii)(b) of this section, the nurse supervisor must conduct an orientation visit within seven calendar days after the person providing personal care services is assigned to the patient. For all initial authorizations involving a Level III task or activity performed under special circumstances, the nurse supervisor must conduct an orientation visit the first day the person providing personal care services is assigned to the patient.

(ii) Scheduling of orientation visits for all initial authorizations of Level I, II, or III personal care services, except Level III services involving a task or activity performed under special circumstances, 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) Level I, II or III 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

subdivision (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

(a) 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; or

(b) the person providing a Level III task or activity under special circumstances as defined in subdivision (a)(6)(iii)(b) of this section has documented training in performing such task or activity for that specific patient.

(4) The nurse supervisor must continue to perform the functions specified in items (i) and (ii) of subclause (iv)(a)(2) of this paragraph when an exception is made to the requirement for an 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 subdivision (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 subdivision (b)(3)(iii) of this section, must recommend the frequency of nursing supervisory visits for a Level I, II or III 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 subdivision (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 Level I, II or III 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 subdivision (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 Level I, II or III 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) 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 subdivision (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 subdivision (b)(3)(iii) of this section;

(v) forwarding the physician's order and the social and nursing assessments for an independent medical review according to subdivision (b)(4)(i) of this section;

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

(vii) 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;

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

(ix) 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 subdivision (b)(5)(v) of this section;

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

(xi) 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;

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

(xiii) 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 (3)(vi) and (vii) of subdivision (f) of this section;

(xiv) 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;

(xv) 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;

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

(xvii) 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;

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

(xix) 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;

(xx) 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; and

(xxi) 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.

(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 patient's plan of care;

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

(v) the authorization for personal care services;

(vi) 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;

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

(viii) the orientation visit and nursing supervisory reports;

(ix) the case narrative notes; and

(x) 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 subdivision (a)(4)(ii) of this section; or

(2) is self-directing, as defined in subdivision(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) If the services are provided by or under arrangements with a voluntary or proprietary homemaker/home health aide organization or a certified home health agency, payment to the provider agency shall be based upon a rate negotiated between the local department of social services and the provider agency or upon the local prevailing rate, whichever is lower. Such rates shall be approved by the State Department of Social Services and the State Director of the Budget pursuant to paragraph (5) of this subdivision. The provider agency is responsible for payment of the provider of service, including withholding of applicable income taxes and payment of FICA, Workers' Compensation, Unemployment Insurance, and other benefits covered under that agency's labor management contracts.

(iii) If the services are provided by or under arrangements with an individual provider of personal care services, payment shall be made directly to the provider of service at a rate approved by the State Department of Social Services and the State Director of the Budget pursuant to paragraph (5) of this subdivision. The local social services department shall be 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 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 had 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.

(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.

(1) 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 socialk 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 exist 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 with 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.

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
LONG TERM HOME HEALTH CARE PROGRAM REGULATIONS
505.21

(a) Definitions.

(1) Long term home health care program means a coordinated plan of care and services provided at home to invalid, infirm, or disabled persons who are medically eligible for placement for an extended period of time in a hospital or residential health care facility if the LTHHCP were unavailable. Such program can be provided in the person's home, including an adult care facility other than a shelter for adults, or in the home of a responsible relative or other responsible adult.

(2) Government funds means funds provided under the provisions of title 11 of article 5 of the Social Services Law (medical assistance to needy persons).

(b) Assessment and authorization.

(1) If a long term home health care program, as defined under article 36 of the Public Health Law, is provided in the social services district for which he has authority, the local social services official, before he authorizes care in a nursing home or intermediate care facility, shall notify the person in writiing of the availability of the long term home health care program.

(2) If a person who has been assessed in accordance with section 505.9(b) of this Part by a long term home health care program, a physician or discharge planner or, at the option of the local department of social services, another certified home health agency, as needing care in a skilled nursing or health-related facility, desires to remain and is deemed by his or her physician able to remain in his/her home or the home of a responsible relative or other responsible adult or an adult care facility other than a shelter for adults if the necessary services are provided and, for purposes of an adult care facility, the person meets the admission and continued stay criteria for such facility, the local social services department must authorize a home assessment of the appropriateness of long term home health care services. The assessment must include, in addition to the physician's recommendation, an evaluation of the social and environmental needs of the individual. The assessment will serve as a basis for the development of an appropriate plan of care for the individual.

(i) If the person is in a hospital or residential care facility, the home assessment shall be performed by the person's physician, the discharge coordinator of the hospital of residential health care facility referring the patient, a representative of the local department of social services, and a representative of the long term home health care program that will provide services for the patient.

(ii) If the person is in his/her own home, the home assessment shall be authorized by the local social services department and shall be performed by the patient's physician, a representative of the local social services department, and a representative of the long term home health care program that will provide services for the person.

(iii) The assessment shall be completed prior to or within 30 days after the provision of services begins. Payment for services provided prior to completion of the assessment shall be made only if it is determined, based upon such assessment, that the recipient qualifies for such services.

(iv) If the person is in an adult care facility, the home assessment must be performed by representatives of the long term home health care program and the local social services district in consultation with the operator of the adult care facility.

(v) Persons provided long term home health care program services in adult care facilities must meet the admission and continued stay criteria for such facilities.

(vi) For individuals requesting long term home health care program services in adult care facilities, assessments must be completed prior to the provision of services.

(vii) No person residing in an adult care facility will be deemed eligible for the long term home health care program authorized under this section until he or she has resided in one or more adult care facilities for a total of at least six continuous months.

(viii) Services provided by the long term home health care program must not duplicate or replace those which the adult care facility is required by law or regulation to provide.

(ix) The commissioner shall prescribe the forms on which the assessment will be made.

(3) Insofar as there is disagreement among the persons performing the assessment, or questions regarding the coordinated plan of care, or problems in implementing the plan of care, the issues shall be reviewed and resolved by a physician designated by the Commissioner of Health.

(4) At the time of the initial assessment, and at the time of each subsequent assessment performed for a long term home health care program, or more often if the person's needs require it, the local social services district must establish a monthly

budget in accordance with which payment will be authorized. The local social services district will provide the operator of the adult care facility with a copy of the completed assessment, the plan of care and the monthly budget.

(i) For all clients other than those receiving care in an adult care facility:

(a) The budget shall include all of the services to be provided in accordance with the coordinated health plan of care by the long term home health care program.

(b) Total monthly expenditures made for a long term home health care program for an individual who is the sole member of his/her household in the program must not exceed a maximum of 75 percent of the average monthly rates payable for nursing home services or health-related services in a skilled nursing or health-related facility in the social services district, whichever is the appropriate level for the individual. Total monthly expenditures made for a long term home health care program for two members of the same household must not exceed a maximum of 75 percent of the average monthly rates payable for both members of the household for nursing home services or health-related services in a skilled nursing or health-related facility in the social services district, whichever is the appropriate level for each person.

(c) When the monthly budget prepared for an individual who is the sole member of his/her household in the program is for an amount less than 75 percent of the monthly rates payable for nursing home services or health-related services, a "credit" may be accrued in behalf of the individual. If a continuing assessment of the individual's needs demonstrates that he/she required increased services, the local social services department may authorize any amount accrued during the past 12 months over the 75-percent maximum. When the monthly budget prepared for two members of the same household is for an amount less than 75 percent of the monthly rates payable for nursing home services or health-related services, "credit" may be accrued in behalf of the household. If a continuing assessment of the household's needs demonstrates that he/she/they require increased services, the local social services department may authorize any amount accrued during the past 12 months over the 75-percent maximum.

(d) When the monthly budget prepared for an individual or a household is for an amount less than 75 percent of monthly rates payable for nursing home services or related services, and the continuing assessment of the person's needs demonstrates that he/she/they require increased services in an amount less than 10 percent of the prepared monthly budget, but totaling no more than 75 percent of the monthly rates payable for nursing home services or health-related services, the long term home health care program may provide such services without prior approval of the local department of social services.

(e) If an assessment of the person's or household's needs demonstrates that he/she/they require services, the payment for which would exceed such monthly maximum, but it can be reasonably anticipated that total expenditures for required services for such person or household will not exceed such maximum calculated over a one-year period, the social services official may authorize payment for such services.

(ii) For clients residing in adult care facilities:

(a) The budget must include all of the services to be provided in accordance with the coordinated plan of health care by the long term home health care program.

(b) Total montly expenditures for long term home health care program services provided to an individual residing in an adult care facility must not exceed a maximum of 50 percent of the average monthly rates payable for nursing home services or health-related care and services provided in a skilled nursing or health-related facility in the social services district, whichever is the appropriate level of care for the individual.

(c) When the monthly budget prepared for an individual residing in an adult care facility is for an amount less than 50 percent of the average of the monthly rates for nursing home services or health-related care and services provided in a skilled nursing or health-related facility, a "credit" may be accrued on behalf of the individual. If a continuing assessment of the individual's needs demonstrates that he/she requires increased services, the social services district may authorize the expenditure of any amount accrued during the past 12 months so long

as such amount, when added to the amount previously expended, does not exceed the 50 percent maximum.

(d) When the monthly budget prepared for an individual residing in an adult care facility is less than 50 percent of the monthly rates payable for nursing home services or health-related care and services provided in a skilled nursing or health-related facility, and the continuing assessment of the person's needs demonstrates that he/she requires increased services in an amount less than 10 percent of the prepared monthly budget, but totaling no more than 50 percent of the montthly rates payable for nursing home services or health-related care and services, the long term home health care program may provide such services without the prior approval of the local social services district.

(e) If an assessment of the needs of an adult care facility resident demonstrates that services are required, the payment for which would exceed the monthly maximum specified in clause (b) of this subparagraph, but it can be reasonably anticipated that total expenditures for required services for such person will not exceed such maximum calculated over a one-year period, the social services official may authorize payment for such services.

(5) If a joint assessment by the local social services district and the provider of services under this paragraph indicates that the maximum expenditure permitted under paragraph (4) of this subdivision is not sufficient to provide long-term home health care program (LTHHCP) services to individuals with special needs, social services officials may authorize, pursuant to the provisions of section 367-c(3-a) of the Social Services Law, maximum monthly expenditures for such individuals, not to exceed 100 percent of the average skilled nursing or health-related facility rate established for that district. In addition, if a continuing assessment of a person with special needs demonstrates that he/she requires increased services, a social services official may authorize the expenditure of any amount which has accrued under this section during the past 12 months as a result of the expenditures for a person participating in the LTHHCP not having exceeded such maximum. If an assessment of a person with special needs demonstrates that he/she requires increased services, the payment for which would exceed such monthly maximum, the social services official may authorize payment for such services if it can reasonably be anticipated that the total expenditures for the required services for such a person will not exceed the maximum calculated over a one-year period.

(i) As used in this subdivision, the term person with special needs means a person for whom a plan of care has been developed pursuant to subdivision 2 of section 367-c of the Social Services Law:

(a) who needs care including but not limited to respiratory therapy, tube feeding, decubitus care or insulin therapy which cannot be appropriately provided by a provider of personal care services as defined in section 505.14(d) of this Part; or

(b) who has one or more of the following conditions: a mental disability as defined in section 1.03 of the Mental Hygiene Law, acquired immune deficiency syndrome, or dementia, including Alzheimer's disease.

(ii) The number of persons with special needs for whom a social services official may authorize payment for services pursuant to this paragraph is limited to 25 percent of the total number of LTHHCP clients which a social services district is authorized to serve; provided that in any district containing a city having a population of one million or more, such limit is 15 percent.

(iii) In the event that a district reaches the limitation specified in this subparagraph, the social services official may, upon approval by the commissioner, authorize payment for services pursuant to this subdivision for additional persons with special needs.

(iv) The social services official must seek approval for authorization to serve additional persons with special needs by submitting a written request to the commissioner which demonstrates that the provisions of this paragraph have (a) met the needs of individuals who could not otherwise be served through the LTHCCP; (b) diverted clients from residential health care facility admission; or (c) permitted the admission of clients on alternate care status into the LTHHCP.

(v) Social services districts are responsible for the retention of information deemed necessary by the department to evaluate the effectiveness of raising the limitation on expenditures for delivery of long term home health care services, and for compliance with reporting requirements established by the department.

(vi) The provisions of this paragraph remain in effect until June 30, 1989.

(6) When a person who is in a hospital or residential health care facility is identified as being medically eligible for skilled nursing or intermediate care, and who desires to return to

his/her own home and is deemed by his/her physician as able to be cared for at home, an assessment shall be completed, and authorization for long term home health care program services or notification that the person is ineligible for such program shall be made timely with respect to ensuring continued Federal reimbursement.

(7) The local social services district shall be responsible for the general casework management of the overall needs of the patient. Case management shall include:

(i) facilitating determination of financial eligibility for medical assistance;

(ii) involvement in the assessment and reassessment of the social and environmental needs of the individual;

(iii) preparation of the monthly budget; and

(iv) coordination of long term home health care program services and other social services which may be required to keep the individual in his/her own home.

(8) No single authorization for long term home health care program services shall exceed four months.

(i) A reassessment shall be performed at least every 120 days, and shall include evaluation of the medical, social and environmental needs of the individual, and shall include a representative of the long term home health care program, a representative of the local social services department, and a physician designated by the Commissioner of Health. If there is a change in the individual's level of care, he/she shall be notified in writing of such change.

(ii) If a change in the patient's level of care occurs between assessment periods as recommended by the long term home health care program, the local social services district shall be notified and a new assessment shall be authorized.

(c) Requirements for provision of care.

(1) Home health aide services may be provided directly by a long term home health care program, or through contract arrangements between the long term home health care program and voluntary agencies and proprietary agencies.

(2) Personal care services may be provided directly by a long term home health care program, or through contract arrangements between the long term home health care program and the local social services district or voluntary and proprietary agencies.

(3) In addition to providing nursing services for the individual receiving long term home health care services, the long term home health care program's registered professional nurse or professional therapist shall also be assigned responsibility for the supervision of the person providing personal care services to evaluate the person's ability to carry out assigned duties, to relate well to patients, and to work effectively as a member of a team of health workers. This supervision shall be carried out during periodic visits to the home in accordance with policies and procedures established by the Department of Health.

(4) Services of a registered professional nurse or professional therapist and supervision of persons providing personal care services may be carried out concurrently. The frequency of periodic visits shall be determined by the coordinated plan of care, but in no case shall they be less frequent than every 120 days.

(d) Payment.

(1) Payment for a long term home health care program shall be at rates established for each service for each agency authorized to provide the program. Rates will be on a per-visit basis, or in the case of home health aide services and personal care services, on an hourly basis.

(2) (i) When personal care services are directly provided by a long term home health care program, or when they are provided through contract arrangements with an agency that does not have a rate negotiated with the local social services department, the Department of Health shall establish the rate of payment with the approval of the Department of Social Services and the Director of the Budget.

(ii) When personal care services are provided by a long term home health care program through contract arrangements with a local social services district, computation of the budget shall be based on the local department's salary schedule, but no payment will be made to the long term home health care program.

(iii) When personal care services are provided by a long term home health care program through contract arrangements with an agency that has a rate negotiated with the local social services district, the long term home health care program rate must be no higher than that locally negotiated rate.

(3) Payment for assessment for a long term home health care program:

(i) is included in the hospital rate for staff participation in discharge planning;

(ii) is included in the physician's visit fee if the physician is not on the hospital staff, and performs the initial assessment while the patient is in the hospital;

(iii) is included in the physician's home visit fee when the initial assessment or reassessment is performed in the patient's home;

(iv) is included in the physician's office visit fee when the initial assessment or reassessment is performed in a nonfacility-related physician's office; and

(v) is included in the clinic fee when the initial assessment or reassessment is performed in a clinic or outpatient department.

(4) Long term home health care program participation in initial assessment and reassessment shall be included in the administrative costs of the program.

(5) No social services district shall make payments pursuant to title XIX of the Federal Social Security Act for benefits available under title XVIII of such act without documentation of the following:

(i) that the long term home health care program has prepared written justification for not having made application for Medicare because of the patient's apparent technical ineligibility; or

(ii) that application for Medicare benefits has been rejected by either the Bureau of Health Insurance or its fiscal intermediary.

(6) No social services district shall make payment for a person receiving a long term home health care program while payments are being made for that person for inpatient care in a residential health care facility or hospital.

(e) Reimbursement. State reimbursement shall be available for expenditures made in accord with the provisions of this section.

ATTACHMENT 4
September, 1991

QUESTIONNAIRE
NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
REVIEW OF REGULATIONS RELATED TO HOME CARE

Name of Agency/Organization: _____

Address: _____

_____

Name of Person Completing Questionnaire: _____

Telephone Number: (_ _ _) _ _ _ - _ _ _ _, extension _ _ _ _

Date: _ _/ _ _/ _ _

Review each of the following:

Department of Social Services Regulations

505.14: Personal Care Services
505.21: Long Term Home Health Care Program

Department of Health Regulations

Parts 763-764: Certified Home Health Agency
Parts 766-767: Licensed Home Care Services Agency
Parts 770-771: Long Term Home Health Care Program
Part 772: AIDS Home Care Programs

Then complete the chart on page 2 of this questionnaire by identifying each specific regulatory provision you believe needs change and checking the type of change needed (Repeal or Modification). Explain why you think the change is needed, and, if the type of change checked is modification, describe how you would modify. If you need more space to record your comments, duplicate and attach additional page twos.

Mail or fax your completed questionnaire by October 11, 1991 to:

Mr. Barry T. Berberich
Director
Bureau of Long Term Care
Division of Medical Assistance
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
Fax Number: (518)473-4232

Thank you for your cooperation.

Regulatory Provision (specific citation)	Type of Change Needed R	M	Why?	How to Modify?