§ 505.14 Personal care services

(a) Definitions and scope of services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) making and changing beds;

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

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

(4) dishwashing;

(5) listing needed supplies;

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

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

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

(9) preparing meals, including simple modified diets.
(b) The initial authorization for Level I services shall not exceed eight hours per week. An exception to this requirement may be made under the following conditions:

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

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

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

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

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

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

(8) feeding;

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

(10) providing routine skin care;

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

(12) changing of simple dressings.

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

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

(b) Criteria and authorization for provision of services. (1) When the local social services department receives a request for services, that department shall determine the applicant's eligibility for medical assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. number and kind of informal caregivers available to the patient;
2. ability and motivation of informal caregivers to assist in care;
3. extent of informal caregivers' potential involvement;
4. availability of informal caregivers for future assistance; and
5. acceptability to the patient of the informal caregivers' involvement in his/her care.

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

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

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

1. a license and current registration to practice as a registered professional nurse in New York State; and
2. at least two years of satisfactory recent experience in home health care.

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

1. a review and interpretation of the physician's order;
2. the primary diagnosis code from the ICD-9-CM;
3. an evaluation of the functions and tasks required by the patient;
4. the degree of assistance required for each function and task in accordance with the standards for levels of services outlined in subdivision (a) of this section;
5. development of a plan of care in collaboration with the patient or his/her representative; and
6. recommendations for authorization of services.
(iv) Assessment of other services. (a) Before authorizing or reauthorizing personal care services, a social services district must assess each patient to determine the following:

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

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

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

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

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

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

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

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

(b) If a social services district determines that a patient can be served appropriately and more cost-effectively through the provision of services described in subclauses (a)(2) through (8) of this subparagraph, and the social services district determines that such services are available in the district, the social services district must first consider the use of such services in developing the patient's plan of care. The patient must use such services rather than personal care services to achieve the maximum reduction in his or her need for home health services or other long-term care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) No authorization for personal care services shall exceed six months. The local social services department may 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 needs Level I or Level II services immediately to protect his or her health or safety and the
nursing assessment cannot be completed in five business days, the social services district may authorize the services based on the physician's order and the social assessment, provided that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Each social services district must have contracts or other written agreements with all agencies or persons
providing personal care services or any support functions for the delivery of personal care services. As used in this
subdivision, support functions for the delivery of personal care services include, but are not necessarily limited to,
nursing assessments, nursing supervision and case management, when provided according to subdivisions (b), (f) and
(g) of this section, respectively.
(2) The social services district must use the model contract for personal care services that the department requires to be used, except as provided in paragraph (4) of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

(iii) The department will notify the social services district in writing of its approval or disapproval of the contract or agreement within 60 business days after it receives the contract or agreement. If the department disapproves the contract or agreement, the social services district may submit revisions to the contract or agreement. The department will notify the social services district in writing of its approval or disapproval of such revisions within 60 business days after it receives the revisions.
(6) The social services district must include in each contract or other written agreement with a provider of personal care services the rate at which the provider will be reimbursed for the provision of personal care services or for any support functions for the delivery of personal care services. The rate at which the provider will be reimbursed will be determined in accordance with subdivision (h) of this section.

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

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

   (i) the provider agency is certified in accordance with 10 NYCRR Parts 760 and 761, licensed in accordance with 10 NYCRR Part 765 or exempt from licensure in accordance with 10 NYCRR Subpart 765-2 because it provides personal care services exclusively to persons who are eligible for medical assistance (MA);

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

   (iii) the provider agency is fiscally sound;

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

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

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

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

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

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

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

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

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

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

(12) The social services district must maintain a record of its monitoring activities. The district must include a report of such monitoring activities in the annual plan the district submits to the department pursuant to subdivision (j) of this section.

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

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

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

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

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

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

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

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

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

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

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

(c) in each case where an individual provider of personal care services is used, the individual provider shall receive on-the-job instruction and on-going nursing supervision from a nurse on staff of the local department of social services or a nurse from a certified home health agency. When such supervision is provided under contract with a certified home health agency, the local social services department shall monitor the case to assure that the service is delivered as authorized;

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

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

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

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

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

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

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

(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; and

(v) a criminal history record check to the extent required by 10 NYCRR Part 402.

(e) Required training. (1) Each person performing personal care services other than household functions only shall be required as a 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 Department.

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

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

(a) Include content related to:

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

(2) the family and family relationships;

(3) the child in the family;

(4) working with the elderly;

(5) mental illness and mental health;

(6) body mechanics;

(7) personal care skills;

(8) care of the home and personal belongings;
(9) safety and accident prevention;

(10) family spending and budgeting; and

(11) food, nutrition and meal preparation.

(b) Total 40 hours in length.

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

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

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

(ii) In-service training shall be provided, at a minimum, for three hours 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
Department and shall meet the following minimum requirements:

(i) Be designed for persons having:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Administrative supervision includes the following activities:

(a) receiving initial referrals from the case management agency, including its authorization for the level, amount, frequency and duration of personal care services to be provided;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) meets either of the following qualifications:
(1) has at least two years satisfactory recent home health care experience; or

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

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

(iv) Nursing supervision includes the following activities:

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

(1) Except as otherwise provided in subclause (3) of this clause, the nurse supervisor must conduct an orientation visit in the patient's home when the person providing personal care services is also present.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) The registered professional nurse who provides direction to nurse supervisors without the home health care experience specified in clause (3) (iii) (c) of this subdivision is responsible for the following activities:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Case management includes the following activities:

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

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

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

(a) the potential contribution of informal caregivers to the patient's plan of care, as specified in subparagraph (b) (3) (ii) of this section;
(b) the patient's physical environment, as determined by a visit to the patient's home; and

(c) the patient's mental status;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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;

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

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

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

(i) the physician's orders;

(ii) the nursing and social assessments;

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

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

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

(vi) the patient's plan of care;

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

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

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

(xi) the orientation visit and nursing supervisory reports;

(xii) the case narrative notes; and

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

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

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

(b) mechanisms exist to discuss individual patients;

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

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

(ii) Professional staff responsible for adult protective services have primary responsibility for case management for a patient who:

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

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

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

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

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

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

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

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

(i) is not residing in the patient's home; or
(ii) is residing in the patient's home because the amount of care required by the patient makes his presence necessary.

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

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

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

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

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

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

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

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

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

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

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

(b) an administrative and operating component; and

(c) a clinical component.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) the applicable minimum wage laws;

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

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

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

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

(i) Providers' submission of required cost reports.

(a) Providers with cost experience.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Each new provider must complete and submit to the department such cost report as the department may require.
Each new provider must complete the cost report by reporting such of the provider's estimated operating costs of
providing personal care services as the cost report may require for the full rate year specified in the cost report.
(3) The department will furnish each new provider with the cost report form. The cost report form will specify the date by which the provider must submit the completed report to the department; however, no provider will have fewer than 90 calendar days to submit the report after its receipt. The department may grant a provider an additional 30 calendar days to submit the cost report when the provider, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the provider cannot submit the report by the date the report is due for reasons beyond the provider's control.

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

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

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

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

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

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

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

(ii) Determination of payment rate.

(a) Providers with cost experience.

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

(i) the rate the provider charges the general public for personal care services; or
(ii) the rate determined by the department in accordance with subclauses (2) through (7) of this clause.

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

(3) Allowable costs.

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

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

(iii) Allowable costs include the following:

(A) a monetary value assigned to services provided by religious orders and for services rendered by an owner or operator of a provider;

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

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

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

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

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

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

(iv) Allowable costs do not include the following:

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

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

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

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

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

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

(G) the amount of the personal care services provider assessment required by section 367-i of the Social Services Law or section 36l4-b of the Public Health Law; or

(H) such other costs as are determined to be unallowable in accordance with reimbursement principles specified in the Medicare Provider Reimbursement Manual.
(4) Recoveries of expenses. The provider must reduce its reported operating costs by the costs of services or activities that are not properly chargeable to patient care. When the department determines that it is not practical to establish the costs of such services or activities, the provider will reduce its reported operating costs by the income that the provider receives from such services or activities. Examples of such income include, but are not limited to, the following:

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

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

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

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

(5) Trend factors.

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

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

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

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

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

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

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

(6) Ceilings on payment for allowable costs.

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

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

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

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

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

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

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

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

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

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

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

(F) The department will establish the following ceilings:

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

(ii) (Effective January 1, 1994, to December 31, 1994) Payment for a provider's administrative and general
expenses, excluding capital costs, will not exceed 28 percent of the provider's total allowable costs, as reported by the
provider in its cost report. The department will reduce payment for a provider's administrative and general expenses in
accordance with the following schedule: when a provider's reported administrative and general expenses, expressed as a
percentage of the provider's total allowable costs, are greater than 26 percent, but do not exceed 31 percent, of the
provider's total allowable costs, the department will reduce payment for the provider's administrative and general
expenses by four percent; when a provider's reported administrative and general expenses, expressed as a percentage of
the provider's total allowable costs, are greater than 22 percent, but do not exceed 26 percent, of the provider's total
allowable costs, the department will reduce payment for the provider's administrative and general expenses by three
percentage points; and when a provider's reported administrative and general expenses, expressed as a percentage of
the provider's total allowable costs, are greater than 20 percent, but do not exceed 22 percent, of the provider's total
allowable costs, the department will reduce payment for the provider's administrative and general expenses by two
percentage points; however, no provider's administrative and general expenses will be reduced to less than 20 percent of
the provider's total allowable costs.

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

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

(7) Adjustments for profit or surplus.

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

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

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

(b) New providers.

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

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

(ii) the rate determined by the department in accordance with subclause (2) of this clause.
(2) (i) The department will determine a new provider's payment rate based on the cost report the provider submits. Each provider must report its estimated personnel and non-personnel operating costs as specified in the cost report.

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

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

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

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

(iii) Revisions to rates.

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

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

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

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

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

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

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

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

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

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

(iv) Audits, hearings and recoveries of overpayments.

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

(v) Exemptions.

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

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

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

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

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

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

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

(a) the number of shared aide sites the social services district plans to establish and the projected implementation date at each site;
(b) the number of nurse supervisors, case managers, provider agency coordinators, and other personnel who will serve personal care services recipients under the district's shared aide plan;

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

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

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

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

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

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

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

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

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

(i) A social services district that seeks an exemption from the shared aide plan requirement must submit an exemption request to the department for its review and approval or disapproval. The social services district must submit its exemption request to the department on forms the department requires and within 60 business days after the department issues an administrative directive to all social services districts regarding the districts' development and implementation of shared aide plans.

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

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

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

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

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

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

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

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

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

Section statutory authority: Education Law, § T8A131, § T8A131-B, § T8A139; Social Services Law, § 365-F, § 367-I; Public Health Law, § 3614-B; Social Services Law, § 368-A
