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

Transmittal No: 92 LCM-73

Date: May 1, 1992

Division: Medical Assistance

TO: Local District Commissioners

SUBJECT: Chapter 41 Of The Laws Of 1992: Changes To The Medical Assistance Program

ATTACHMENTS: Psychotropic Drugs Which Are Exempt From Co-Payment (available on-line)

Dear Home Relief Recipient letter #920944 (including Medical Care Coordinator Program MCCC Provider Selection Form (not available on line)

Dear Medicaid Recipient letter #920943 (not available on line)

Applicable sections of Chapter 41 of the Laws of 1992 (not available on-line)

This Local Commissioners Memorandum (LCM) is to inform you of changes to the Medical Assistance (MA) Program resulting from the recently enacted State budget legislation (Chapter 41 of the Laws of 1992). A brief summary of the most significant changes and their associated implementation dates follows. Letters to recipients (attached) explaining the changes to the MA Program specified in items I. through VII. are in the process of being mailed out. Letters to providers regarding items I. through VII. will be mailed in the near future.

NOTE: Given the reductions in coverage and benefits available to federally nonparticipating (FNP) MA recipients, districts are encouraged to enhance current procedures for the identification of individuals appropriate for disability reviews/determinations. Additionally, recipients are being advised to contact their local district if they believe they are disabled so that such determinations can be made.

I. CHANGE IN DEFINITION OF MEDICAL ASSISTANCE

Effective April 2, 1992 the official definition of "Medical Assistance" has been amended. The new definition will have impact on future determinations of exactly what is or what is not a covered service, supply or care under the MA Program. The amended Social Services Law (SSL) will provide the Department with the necessary authority to pay for only medically necessary medical, dental and remedial services that are provided for in law or regulation.

II. CHANGES IN COVERAGE OF PODIATRY SERVICES

Effective July 1, 1992 fee for service podiatry payments will only be made for services provided to the following individuals:

- o Medicaid eligibles who are under twenty-one years of age and only by written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.
- o Those who are identified as Qualified Medicare Beneficiaries (QMBs). Until further notice podiatrists will be reimbursed for care provided to all Medicare beneficiaries.

For all other MA eligibles: As of July 1, 1992 podiatry services provided by independent practitioners will no longer be covered. Podiatry care provided by clinics and nursing homes is covered if podiatry service is included in the MA reimbursement rate.

III. CHANGES IN BENEFITS AVAILABLE TO FEDERALLY NONPARTICIPATING (FNP) RECIPIENTS AGED TWENTY-ONE THROUGH SIXTY-FOUR YEARS WHO HAVE NOT BEEN CERTIFIED AS BLIND OR DISABLED FOR MEDICAID PURPOSES

A. Eligibility For Full Benefits

Effective July 1, 1992 recipients who are twenty-one years of age through sixty-four years of age and who have not been certified as blind or disabled for Medicaid purposes and are eligible for or in receipt of Home Relief (FNP recipients) may receive the full range of MA covered services only if they are enrolled in one of the following programs:

1. A health maintenance organization (HMO) or other entity which provides comprehensive health services;
2. A managed care program or other primary provider program, as specified by the Department;
3. The Recipient Restriction Program; or

4. A voluntary Medical Care Coordinator (MCC) Program. A brief description of the MCC Program follows in section VII of this correspondence; a more descriptive Administrative Directive (ADM) will be sent in the near future.

Note : If there is no provider affiliated with any of such programs defined above who is sufficiently accessible to a recipient as to reasonably provide services to the recipient then the recipient will be eligible for the full range of benefits.

B. Eligibility For Reduced Benefits Only

Effective July 1, 1992 the following services are ELIMINATED from coverage for FNP recipients who do not qualify for the full range of benefits:

- o Transportation
- o Home Health (except Tuberculosis Directly Observed Therapy)
- o Personal Care (except Tuberculosis Directly Observed Therapy)
- o Private Duty Nursing
- o Speech, Occupational, and Physical Therapies provided by independent practitioners
- o Sickroom Supplies (except family planning items)
- o Orthotic Devices, including Hearing Aids and Prescription Footwear
- o Clinical Psychology provided by independent practitioners
- o Audiology provided by independent practitioners
- o Nursing Facilities

Note: Payments to nursing facilities for recipients receiving nursing facility services on July 1, 1992 will continue to be made. Eligibility for Home Relief recipients in these settings should be reviewed to determine whether they should be in a federally participating aid category.

IV. THIRTY-TWO DAY HOSPITAL INPATIENT LIMITATION FOR FNP RECIPIENTS AGED TWENTY-ONE THROUGH SIXTY-FOUR YEARS WHO HAVE NOT BEEN CERTIFIED AS BLIND OR DISABLED FOR MEDICAID PURPOSES

Effective May 1, 1992 payment for hospital inpatient services (per diem days, alternative level of care days and for Diagnosis Related Groups claims, the actual number of days of the hospital stay) for FNP recipients, except those who are covered under a full capitation program, will be limited to a maximum of thirty-two days of care per year. For calculation purposes the year referred to begins on May 1 and ends on April 30. Recipients who become MA eligible after May 1st are eligible for 32 days of care for the time period beginning with the first day of MA eligibility and ending on April 30 (e.g. A recipient who becomes MA eligible on July 1, 1992 will be eligible for 32 days of care during the time period beginning July 1, 1992 and ending April 30, 1993).

The Department is developing a system, which hospitals will be able to access through the Electronic Medicaid Eligibility Verification System (EMEVS), to identify the approximate number of service days available for a recipient and to obtain an authorization to provide service. As this system will not be in place until after May 1, 1992 providers are being notified that, when the system is in place, retroactive adjustments in payments will be made to recoup MA payment for HR recipients who have exceeded the 32 day stay limitation.

Hospitals are prohibited from discharging an inpatient solely as a result of his or her having received the maximum number of service days for which MA payment is available.

V. CHANGES TO THE UTILIZATION THRESHOLD PROGRAM

A. Changes Affecting FNP Recipients

1. Effective July 1, 1992 the following thresholds will apply:

Physician/clinic - ten (10) visits per benefit year
Pharmacy - twenty-eight (28) items per benefit year

2. Effective September 1, 1992 psychiatric services provided by either psychiatrists, clinical psychologists or outpatient clinics will be subject to a threshold of forty (40) visits per benefit year.

B. Changes Affecting All Other MA Recipients In Federally Participating Aid Categories Regardless Of Age

Effective September 1, 1992 pharmacy services will be subject to a threshold of forty (40) items per benefit year.

C. Changes Affecting Recipients Covered By The Restricted Recipient Program

Effective September 1, 1992 restricted recipients will no longer be exempt from utilization thresholds.

VI. CO-PAYMENT FOR SELECTED SERVICES

Effective June 1, 1992 co-payments will be instituted for most MA recipients for selected services listed in section VI.C. of this correspondence.

In anticipation of the need to respond to recipient concerns the Department has established a toll free hotline for recipients to report providers who may be inappropriately denying services due to co-payment issues. The hotline number is 1-800-541-2831. This hotline should only be used to report co-payment problems; recipients will be instructed to contact their local social services office if they have any questions about the other program changes detailed in this correspondence.

A. Exempt recipients include the following:

- o Recipients under the age of twenty-one
- o Pregnant women
- o Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in a nursing facility and Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- o Recipients enrolled in HMOs and Managed Care programs

B. Exempt services include the following:

- o Emergency services
- o Family planning services
- o Tuberculosis Directly Observed Therapy

C. Co-payments will apply to the following services:

- o Inpatient hospital services provided by Article 28 facilities, hospitals with dual certification, and out of state hospitals
- o Outpatient hospital and Clinic (except Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, alcohol and substance abuse clinic services , Tuberculosis Directly Observed Therapy)
- o Nonemergency/nonurgent visits to emergency rooms (ER)
- o Drugs (Exceptions: 1. psychotropic drugs, to be defined by the Department, 2. family planning drugs)
- o Enteral and Parenteral formulae/supplies
- o Medical/surgical supplies (except family planning items)
- o Home health services; including long term home health services and home health nursing
- o Laboratory services (except when provided by physicians who bill directly and are not licensed as a provider of laboratory services)
- o X-ray services (except when service provided by physicians)

D. Co-payment amounts are as follows:

<u>Service</u>	<u>Amount (\$)</u>
Inpatient Hospital	25.00 per stay upon discharge
Outpatient Hospital and Clinic	3.00 per visit
Nonemergency/Nonurgent ER Visits	3.00 per visit
Prescription Drugs, Generic	0.50 per prescription
Brand	2.00 per prescription
Psychotropic	NO CO-PAYMENT
Nonprescription Drugs	0.50 per order
Enteral/Parenteral Formulae/Supplies	1.00 per order/prescription
Medical/Surgical Supplies	1.00 per order
Laboratory	0.50 per procedure code
X-ray	1.00 per procedure code
Home Health (Including LTHHC and Home Health Nursing)	Depending on rate code either 0.25 per hour or 3.00 per visit up to a maximum of 3.00 per claim

The following rate codes REQUIRE a \$3.00 per visit co-payment:

- 2787 - Nursing Assessment
- 2619 - HHA, AIDS, Nursing Services (Episodic, RN)
- 2677 - HHA, AIDS, Physical Therapy, 1 Client, 1 Visit
- 2678 - HHA, AIDS, Occupational Therapy, 1 Client, 1 Visit
- 2679 - HHA, AIDS, Speech Therapy, 1 Client, 1 Visit
- 2518 - RHCF (HB) Home Hlth Aide (Hr or Visit) Seco
- 2620 - HHAS (FS) Nursing
- 2621 - HHAS (FS) Long Term Nursing
- 2640 - HHAS (FS) Occupational Therapy
- 2641 - HHAS (FS) Long Term Occupational Therapy
- 2650 - HHAS (FS) Physical Therapy
- 2651 - HHAS (FS) Long Term Physical Therapy
- 2652 - HHAS (FS) Audiology (LTHHCP)
- 2660 - HHAS (FS) Spch Therapy (Obs-Replaced by 2662)
- 2661 - HHAS (FS) Long Term Speech Therapy
- 2662 - HHAS (FS) Speech Pathology
- 2680 - HHAS (FS) Spch Eval (Obs-Replaced by 2662)
- 2686 - RHCF (HB) D.HHAS Nursing - AIDS
- 2687 - HHAS (FS) HHA, AIDS - Nursing
- 2688 - HHAS (FS) Community LTHHC PRI+Screen
- 2811 - RHCF (HB) D.HHAS Long Term Nursing (Hospit)
- 2812 - RHCF (HB) D.HHAS Long Term Occupational Therapy
- 2813 - RHCF (HB) D.HHAS Long Term Physical Therapy
- 2814 - RHCF (HB) D.HHAS Long Term Speech Therapy
- 2842 - RHCF (HB) D.HHAS Nursing
- 2844 - RHCF (HB) D.HHAS Occupational Therapy
- 2845 - RHCF (HB) D.HHAS Physical Therapy
- 2846 - RHCF (HB) D.HHAS Speech Therapy (Obs Replaced)
- 2847 - RHCF (HB) D.HHAS Speech Pathology
- 2848 - RHCF (HB) D.HHAS Spch Eval (Obs-Replaced)
- 2849 - RHCF (HB) D.HHAS Physical Therapy Evaluation
- 3830 - RHCF (FS); C.HRF Nursing LTHHC, PRI Screening

- 3851 - RHCF (FS); C.HRF Long Term Nursing (RHCF)
- 3852 - RHCF (FS); C.HRF Long Term Occupational Therapy
- 3853 - RHCF (FS); C.HRF Long Term Physical Therapy
- 3854 - RHCF (FS); C.HRF Long Term Speech Therapy
- 9980 - MISC Hosp. LTHHC, PRI & Screen

The following rate codes REQUIRE a \$.25 per hour (unit of service) co-payment:

- 2617 - HHA, AIDS, Home Nursing, Private Duty, LPN, Ho
- 2618 - HHA, AIDS, Home Nursing, Private Duty, RN, H
- 2668 - HHA, AIDS, Home Health Aide, Hourly
- 2515 - HHAS (FS) Home Health Aide (Hrly) Secondary
- 2516 - RHCF (HB) Home Health Aide (Hrly) Secondary
- 2517 - HHAS (FS) Home Health Aide Secondary Cod
- 2519 - RHCF (FS) Home Health Aide Secondary Cod
- 2610 - HHAS (FS) Home Health Aide
- 2611 - Long Term Home Health Aide
- 2631 - HHAS (FS) Long Term Homemaker
- 2669 - HHAS (FS) Home Health Aide (Per Hour)
- 2671 - HHAS (FS) Long Term Housekeeper
- 2695 - HHAS (FS) Respite Long Term Home Health AI
- 2696 - HHAS (FS) Respite Long Term Home Health Hom
- 2697 - HHAS (FS) Respite Long Term Home Health Hou
- 2810 - RHCF (HB); D.HHAS Long Term Home Health Ai
- 2815 - RHCF (HB); D.HHAS Long Term Homemaker
- 2816 - RHCF (HB); D.HHAS Long Term Housekeeper (H
- 2825 - RHCF (HB); D.HHAS Respite Long Term Home Health
- 2826 - RHCF (HB); D.HHAS Respite Long Term Home Care
- 2841 - RHCF (HB); D.HHAS Home Health Aide (Per Visit)
- 2878 - RHCF (HB); D.HHAS Home Health Aide (Per Hour)
- 3850 - RHCF (FS); C.HRF Long Term Home Health Aid
- 3855 - RHCFS (FS); C.HRF Long Term Homemaker (RHCF)
- 3856 - RHCFS (FS); C.HRF Long Term Housekeeper (RHCF)
- 3865 - RHCFS (FS); C.HRF Respite Long Term Home Health
- 3866 - RHCFS (FS); C.HRF Respite Long Term Home Care
- 3867 - RHCFS (FS); C.HRF Respite Long Term Care Housing
- 3876 - RHCFS (FS); C.HRF Home Health Aide

VII. MEDICAL CARE COORDINATOR PROGRAM (MCC)

Effective July 1, 1992 Home Relief recipients will have the option to choose enrollment in the MCC Program. Home Relief recipients who choose the MCC Program will select a primary medical provider (physician or clinic) and a primary pharmacy. A form to be used by the recipient to identify his/her choice of primary medical provider and primary pharmacy will be sent to recipients in the notification mailing. This draft version of the form can be used until the final version is sent (see attached). These providers will function as the recipient's medical care coordinators. Functionally, the MCC Program will operate in a manner identical to the Recipient Restriction Program (RRP). The most significant difference in the RRP and the MCC

Program is that restricted recipients have a history of abusive utilization of Medicaid services while recipients participating in the MCC Program do not. HR recipients who volunteer for the MCC Program are eligible for the full range of Medicaid covered services.

All of the policy requirements governing the RRP remain in effect for the MCC Program. Under both programs, the recipient's primary physician or clinic must order all ancillary services such as prescription drugs, laboratory tests, durable medical equipment, and non-emergency transportation, and make all necessary referrals. Providers to whom a recipient is referred by his/her primary physician or clinic may also order these ancillary services, with the exception of nonemergency transportation which must always be ordered by the recipient's primary provider.

Recipients who have been assigned to a primary physician or clinic and primary pharmacy under the MCC Program are required to receive all care within the provider's scope of practice from the selected caregiver except under the following circumstances:

- o in cases of documented emergencies;
- o in cases where the primary physician or clinic has referred the recipient to another provider; or
- o in cases where the service provided is either methadone maintenance, or a service provided in an inpatient setting.

To encourage office based physician participation in the MCC Program, a \$10.00 monthly management fee to be paid to primary physicians has been established. This monthly fee is payable, provided the recipient remains eligible, even though the recipient may not have visited the physician during the month.

New values have been added to the restriction subsystem of WMS to accommodate the MCC Program. The codes will be available to the local agencies sometime before July 1, 1992; more descriptive information will be included in an ADM in the near future. These codes, which are effective on July 1, 1992, are as follows:

- 53 Client lives in underserved area
- 55 Primary pharmacy
- 56 Primary physician
- 58 Primary clinic

The current procedures in effect under the RRP for entering restriction data into WMS apply to the MCC Program. These include provider type, provider number, and begin date.

The Department will assist local districts to identify providers participating in the MCC Program. However, if a client lives in an area that is underserved by the Medicaid provider community, as determined by the local district in conjunction with the Department, and no primary providers are available to serve as his/her medical care coordinator, that recipient is eligible to receive the full range of Medicaid covered services without participating in the MCC Program. When this occurs the local district should enter code 53 for that recipient in the WMS restriction subsystem.

An ADM which will provide more detailed information on this new program will be sent to local social services agencies. This ADM will include instructions on how recipients choose their primary providers and the form that will be used in the selection process.

VIII. CHANGE TO ESTATES, POWERS AND TRUSTS LAW

Section 86 of Chapter 41 adds a new paragraph (c) to section 7-3.1 of the Estates, Powers and Trusts Law (EPTL). Section 7-3.1(c) provides that any provision in a trust (other than a testamentary trust) which directly or indirectly suspends, terminates or diverts the beneficial interest of the creator or the creator's spouse when the creator or the creator's spouse applies for MA or requires "medical, hospital or nursing care or long term custodial, nursing or medical care" is void, without regard to the irrevocability of the trust or the purpose for which the trust was created.

As defined in section 369.3 of the SSL, the beneficial interest of the creator or the creator's spouse includes the income and principal of the trust to which the creator or the creator's spouse would have been entitled under the terms of the trust.

Therefore, a provision in a trust established on or after April 2, 1992 which suspends, terminates or diverts the beneficial interest upon application for MA is void. The total beneficial interest to which the creator or the creator's spouse would have been entitled with the full exercise of discretion by the trustee is considered available despite any language in the trust document which limits or excludes the availability of such interest for medical care.

IX. CHANGE TO SOCIAL SERVICES LAW REGARDING TRUSTS

Section 85 of Chapter 41 adds a new subdivision 3 to section 369 of the SSL to authorize the Department and any social services district to recover through Surrogate's Court the amount of MA paid on behalf of a creator or the creator's spouse from their beneficial interest in any trust (other than a testamentary trust).

SSL 369.3 clarifies the authority of a social services district to pursue recovery from the trustee(s), creator, or creator's spouse when MA is authorized in cases where, for example:

1. no individual is empowered to act on behalf of an applicant/recipient (A/R) who is unable to act on his or her own behalf;
2. a nonapplying legally responsible relative living in the community refuses to make his or her income and resources available to the A/R; or
3. where the spousal impoverishment undue hardship provision is met.

X. LIENS AND RECOVERIES

Section 85 of Chapter 41 also amends subdivisions 1 and 2 of section 369 of the SSL relating to liens, recoveries and adjustments for Medical Assistance (MA) correctly paid. In addition to the ability to recover for MA correctly paid from the estate of an individual who was 65 years of age or older when he or she received MA, SSL 369.1 and 369.2 now allow the placement of a lien on the property of an institutionalized individual who is not reasonably expected to be discharged and return home. (Any such lien dissolves if the individual does return home.) However, a lien cannot be imposed on the individual's home while any of the following relatives of the individual lawfully reside in the home:

1. spouse;
2. child under twenty-one years of age;
3. blind or permanently and totally disabled child of any age; or
4. sibling who has resided in the home for at least one year immediately preceding the date of the individual's admission to a medical institution and who has an equity interest in the home.

Further, recovery from a lien on an individual's home must not be made while any of the following persons continue to reside in the home:

1. a sibling of the individual who resided in the home for at least one year preceding the date of the individual's admission to a medical institution; or
2. a son or daughter of the individual who resided in the home for at least two years immediately preceding the date of the individual's admission to a medical institution, and who provided care which permitted the individual to reside at home rather than in a medical institution.

The son, daughter or sibling must have resided in the home on a continuous basis since the date of the individual's admission to a medical institution.

XI. UNCLAIMED RESOURCES OF DECEASED RECIPIENTS

As detailed in 88 INF-12 "Disposition of the Estate, Including the Personal Incidental Allowance Account, of a Deceased MA Only Recipient", the most common settlement of the estate of a deceased MA recipient is made by appointing a voluntary administrator under section 1303 of the Surrogate's Court Procedure Act (SCPA). This is an abbreviated estate settlement when the gross estate is less than \$10,000 and does not include real property. If no relative of the deceased is willing or able to act as the voluntary administrator, upon notification, the chief fiscal officer or public administrator of the locality must seek the appointment of a voluntary administrator. The voluntary administrator is the only duly appointed fiduciary with the legal right to receive or distribute estate property. Possessors of estate property (e.g., nursing homes, medical institutions or facilities, banks) are legally liable for wrongfully withholding or disposing of estate property to other than the duly appointed fiduciary.

Section 87 of Chapter 41 adds a new subdivision 8 to section 1310 to the SCPA allowing the possessor of monies belonging to the estate of a deceased recipient to pay to the Department or a social services district the amount of MA furnished to or on behalf of the deceased creditor, without a formal estate proceeding or the appointment of a fiduciary.

SCPA 1310.8 applies when at least six months have passed since the death of the recipient. The social services district must provide an affidavit showing:

1. the date of the decedent's death;
2. that no executor or administrator has been appointed to administer the estate;
3. the decedent was not survived by a spouse or minor child;
4. that the social services district is entitled to be paid; and
5. that the deposit does not exceed \$5,000.

Sections 85 - 87 of Chapter 41 of the Laws of 1992 are attached for your reference.

XII. TECHNICAL CORRECTIONS AND AMENDMENT TO SSL 366.5(c)(4)

Attached also are sections 64, 65, and 90 of Chapter 41 of the Laws of 1992. Section 64 is a technical correction to SSL 366.2(a) to support the current procedures for determining the amount of an institutionalized individual's income available for his or her cost of care, in accordance with 18 NYCRR 360-4.9. Section 65 is a technical correction to SSL 366.2(a)(4), which clarifies that the MA resource standard is one-half of the annual MA income standard. These technical corrections will not require any action.

Section 90 amends SSL 366.5(c)(4) by adding the word "total" before "uncompensated value" in clause (ii) to conform the SSL with section 1917(c) of the Social Security Act. An ADM will be forthcoming detailing the implementation of changes to the treatment of multiple transfers of resources.

Chapter 41 further provides that, notwithstanding the absence of implementing regulations, sections 85 and 87 (items IX., X. and XI. of this LCM) are effective upon enactment, and section 86 (item VII.) is effective for trusts created on or after the date of enactment. Therefore, social services districts should track all potentially affected cases pending the issuance of the ADM.

XIII. EFFICIENCIES IN THE FISCAL ASSESSMENT AND MANAGEMENT OF HOME CARE SERVICES.

This provision is found in Section 70 for home health services and Section 73 for personal care services.

(A) Hospice

Hospice is removed from the list of efficiencies required by Chapter 165 of the Laws of 1991. Social services districts will be required to have written agreements with any hospice(s) in the district or service area. The agreement must specify procedures for notifying recipients who are believed to be eligible, unless hospice is medically contraindicated by a recipient's physician, of the availability of hospice services. Also the agreement must specify the procedure for referring recipients to such hospice(s), if a recipient so chooses. This will assure that there is communication between social services districts and hospices and that the hospice benefit is used when appropriate to meet the client's needs.

A model agreement which can be used by social services districts will be developed and included in a forthcoming directive. In planning for the implementation of this provision, social services districts should identify all hospices in the district. If information is needed about the availability of hospices, contact Al Roberts at 1-800-342-3715, extension 3-5539, or directly at (518) 473-5539.

(B) Addition of Patient Managed Home Care as an Efficiency

Patient managed home care exists when the patient or client assumes responsibility for some aspect of the arrangement for or the management of the home care service(s) provided. Several social services districts have developed this service delivery model in accordance with Chapter 386 of the Laws of 1990 and have found that the cost of a unit of service is less than in the traditional service delivery model because the client is assuming responsibility for specific portions of the management of the service.

The current demonstration project, outlined in 91 LCM-35, is not filled to capacity. Any social services district interested in developing patient managed home care should contact Fred Waite at 1-800-342-3715, extension 3-5498 or directly at (518) 473-5498.

C) Mandate the Use of the Efficiencies

The previous statute (Chapter 165 of the Laws of 1991) required that the efficiencies must be considered in the development of a care plan. The change in Chapter 41 of the Laws of 1992 requires that the client must use such efficiencies for maximum reduction in the need for home care services. This will assure that clients whose needs can be met by the use of personal emergency response services, shared aide, or another home care service must accept the most efficient service delivery model or service.

Social services districts which have not completed the development of plans for personal emergency response systems, required in 91 ADM-42, and for shared aide, required in 92 ADM-4, are reminded that those plans should be submitted for approval in order that these efficiencies are available in the district.

XIV. EXCEPTION CRITERIA IN THE FISCAL MANAGEMENT PROCESS FOR HOME CARE SERVICES

This provision is found in Section 71 for home health services and Section 74 for personal care services.

Chapter 165 of the Laws of 1991 included six exception criteria which are used to determine whether home care services are appropriate for a client for whom the cost of care exceeds 90 percent of the average monthly cost of residential health care facility (RHCF) services in the district. The provisions of Chapter 41 of the Laws of 1992 changes these exception criteria as follows:

- (1) Previously, the fourth criteria read as follows:

"Home health or personal care services are most appropriate for the recipient's functional needs, living arrangements, and working arrangements; can be provided cost effectively; or based on the recipient's medical history, the recipient's ability to perform the activities of daily living would diminish if he or she were institutionalized"

The revised criteria is as follows:

"Home health or personal care services must be appropriate for the recipient's functional needs and institutionalization is contraindicated based on a review of the recipient's medical case history which must include a certified statement from the recipient's physician describing the potential impact of institutionalization. Further, the physician's certified statement on a form required by this Department and the Department of Health must be reviewed by a residential health care facility to determine if institutionalization would result in a diminishing of the recipient's ability to perform the activities of daily living."

Included in the upcoming directive implementing this provision will be a form which will be used to obtain the necessary certifications from the recipient's physician and the RHCF.

- (2) The fifth exception criteria included that a placement at the level of institutional care for which the recipient is appropriate is not available. Since this exception criteria was not pertinent to determining whether a recipient is eligible for home care services, the exception has been removed. The requirement that home care services can be continued until the appropriate level of RHCF is available is considered in a latter portion of the process.

XV. INSTRUMENTS FOR HOME CARE ASSESSMENT

This provision, found in Section 78 of Chapter 41, amends the Social Services Law by adding a new section 367-o, which requires that a new home care assessment instrument must be developed by this Department and the Department of Health. The purpose of this form is as follows:

- (1) Assess the recipient's characteristics and service needs and determine whether home care services are appropriate and can be safely provided to the recipient;
- (2) Refer the recipient to the home care services which will most appropriately and cost-effectively meet the recipient's needs or to other appropriate long-term care services; and
- (3) Consider factors including but not limited to the following:
 - a. recipient's ability to perform activities of daily living;
 - b. recipient's health and rehabilitation needs; and
 - c. recipient's mental and physical ability to direct care and summon assistance and the availability, willingness and ability of others to provide care.
- (4) Specify the maximum number of hours per month that will be paid by the Medical Assistance program, providing that the recipient's health and safety is not jeopardized.
- (5) Serve as the basis for the recipient's plan of care; and
- (6) Consider the relationship between or among all the services provided by the home care providers to which the recipient is referred, all other home care services available in the area, the availability of informal supports to provide care, the sources of informal support suggested by the recipient or the recipient representative and potential Medicare coverage of the recipient's care needs.

All recipients who are expected to receive care for more than 60 days and are receiving more than 156 hours per month will be reduced to 156 hours per month on July 1 unless the recipient is reassessed using the new instrument. All initial cases and cases being reassessed after July 1 must be assessed using the new instrument.

Currently, the Department and the Department of Health are involved in the field test of an instrument which, with modification, will be used to meet this requirement. It is expected that the instrument will be modified and finalized by mid-May. The Department is sending each district a list of those recipients who are receiving more than 156 hours per month according to the prior approval system.

Since the period for implementing the requirement for the new assessment instrument is short, social services districts are urged to plan ahead for the implementation. Several activities which might be done are as follows:

- (1) Review files to identify all recipients who receive more than 156 hours per month. Also review the list which will be sent to the social services district so that any errors can be reconciled.
- (2) Determine whether the health and safety of recipients who are receiving more than 156 hours per month will be jeopardized by a reduction to 156 hours.

XVI. OTHER LONG TERM CARE ITEMS

The statute also includes several other provisions as follows:

- (1) Administrative Caps for Personal Care Services: There will be a cap on allowable reimbursement for administrative expenses that may be included within the Medicaid rates set for personal care services, including personal care services under the long term home health care program.

For rate periods beginning on or after January 1, 1992, the reimbursement for administrative expenses cannot exceed twenty-eight (28) per cent of the total personal care rate for current service providers. This limitation does not apply to new providers in the first year of operation. The new law further provides that the ratio of administrative and general expenses divided by the total rate of payment, excluding any capital cost reimbursement, will be reduced according to the following scale:

ADMINISTRATIVE/GENERAL PERCENTAGE	PERCENTAGE POINT REDUCTION
26 - 31%	4 percentage points
22 - 26%	3 percentage points
20 - 22%	2 percentage points but not to be lower than 20%

The mandated administrative cap will become part of the 1992 rate setting process for all personal care service rates promulgated by the Department of Social Services for local department of social service personal care contracts and by the Department of Health for personal care rates associated with the long term home health care program.

- (2) Physician Home Visit: Chapter 41 of the Laws of 1992 authorizes a physician fee increase for home visits by a physician or nurse practitioner when transportation costs a patient would otherwise require are avoided. More information about this provision will be available at a later date.

- (3) Social Services District Delegation: The delegation of activities related to home care services, which currently are the responsibility of local districts, to providers or other entities have been authorized by statute. This provision will be discussed in greater detail in a separate Local Commissioners Memorandum.

- (4) Adult Day Health Care: The recently enacted budget also reduced the allowable ceiling for rates paid to nursing facilities (NFs) for day care services provided to non-occupants from 75 percent of the facility's average in-patient rate to 65 percent. These new rates are currently being computed by the Department of Health, which plans to make them available during the first week of May, with an effective date of July 1, 1992. A letter explaining the rate reductions will be sent to all relevant providers by DoH.

Each of the major provisions of Chapter 41 of the Laws of 1992 affecting the delivery of home care services is effective on July 1, 1992.

The Division is in the process of developing implementing regulations and ADMs containing the relevant policy changes and procedures. Regulations regarding implementation of the home care provisions have been developed and will be filed on an emergency basis in May. Two administrative directives will follow. The first describing new assessment requirements will be released in late May. The second will include the fiscal management assessment process which was required by Chapter 165 of the Laws of 1991 and changed in Chapter 41 of the Laws of 1992 and will be released prior to July 1.

In the interim, for more information regarding this correspondence contact the following individuals at 1 800 342-3715:

Items I. through VII.: Rich Nussbaum, extension 3-2160; user-ID DMA041.

Items VIII. through XII.: MA Eligibility County Representative at extension 3-7581 or 212-417-4853 in New York City. Please electronically forward any comments to Elsie Kirk, user ID OME310.

Items XIII. through XVI.: Barry T. Berberich, Director, Bureau of Long Term Care, extension 3-5611 or directly at (518) 473-5611, or by electronic mail at OLT010.

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

Attachment

Psychotropic Drugs Which Are Exempt From
Co-Payment Requirement Effective 6/1/92

Acetophenazine
Amitriptyline
Amoxapine
Benztropine
Biperidine
Bupropion
Buspirone
Chlorpromazine
Chlorprothixene
Clomipramine
Clozapine
Desipramine
Doxepin
Fluoxetine
Fluphenazine
Haloperidol
Imipramine
Lithium
Loxapine
Maprotiline
Mesoridazine
Methylephenidate
Molidone
Nortriptyline
Perphenazine
Phenelzine
Pimozide
Prochlorperazine
Promazine
Protriptyline
Thioridazine
Thiothixene
Tranlycypromine
Trazodone
Trifluoperazine
Triflupromazine
Trihexyphenidyl
Trimipramine