

Medicaid Personal Care or Home Attendant Services

The Medicaid program in New York State covers a type of home care services called Personal Care services (aka PCS or "home attendant"). This is a service under NYS's "State Medicaid Plan," which means that the rules described here apply whether the consumer receives it under fee-for service from the local Medicaid program (such as for Immediate Need) or from an MLTC or managed care plan.

MAJOR CHANGES in Personal Care Eligibility and Assessment were ENACTED IN STATE LAW APRIL 2020 that will be implemented beginning Nov. 8, 2021- and later because of postponements. Read about the changes here.

- DOH adopted regulations to implement these changes, some of which went into effect on Nov. 8th. On this DOH webpage, click on "Long Term Care" dropdown to find links to the amended regulations and DOH documents explaining which parts are in effect and which are delayed. These include a DOH webinar (Recording) - (Web) - (PDF).
- The INDEPENDENT ASSESSOR changes go into effect on May 16, 2022, and for Immediate Need and expedited mainstream managed care on Dec. 1, 2022. See this article.
- New rules allowing MLTC reductions after a Transition Period ends went into effect Nov. 8, 2021. See this Fact Sheet.
- Restrictions on eligibility for Personal Care requiring assistance with 2 or 3 ADLs are delayed until March 2025. See more here.

Covered in this article:

* Law and regulations

1. What are Personal Care Services?

2. Eligibility

3. Scope of Tasks

4. How does one Obtain Personal Care Services?

5. How Much Personal Care? How are Hours Determined?

A.. Standards for 24-Hour Care - Definition of Live-in and Split Shift

B. Standards for Assessing Need and Determining Amount of Care

6. Who Can be Hired as a Personal Care Aide?

7. Procedural rights in Reductions, Discontinuances -- Notice and Hearing with Aid Continuing - Mayer, Granato, etc.

8. Articles on Demographics & Service Patterns of Personal Care Service Population

i. LAW AND REGULATIONS:

Social Services Law sec. 365-a, subd. 2(e), 18 NYCRR 505.14. This regulation was amended effective Dec. 23, 2015. See notice published in State Register. New language is posted here.

- **MAJOR CHANGES in Personal Care Eligibility and Assessment were ENACTED IN STATE LAW APRIL 2020 that will be implemented in Oct. 2020 or after. Read about the changes here.**
 - ♦ **DOH proposed regulations to implement these changes here. Comments are due on Sept. 14, 2020.**
- â December 2015 Changes in regulations are described in this NYS Dept. of Health GIS 15 MA/024 - Changes to the Regulations for the Personal Care Services Program (PCS) and the Consumer Directed Personal Assistance Program (CDPAP) (PDF)
 - ♦ NOTICE OF ADOPTION
 - ♦ Scope of the CDPAP Benefit
 - ♦ Scope of the Personal Care Services Benefit
- **Key litigation, statutes and regulations** on Medicaid personal care and other home care services in New York State are listed in this document.

1. What are Personal Care Services?

Personal care services are assistance of a personal care aide with nutritional, environmental support, and personal care functions. "Such services must be essential to the maintenance of the patient's health and safety in his or her own home" ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness" of services. 18 NYCRR 505.14(a).

There are two "levels" or types of PCS in New York State.

1. **HOUSEKEEPING or "Level 1"** - for those who because of disability need assistance with housekeeping, cleaning, meal preparation, grocery shopping, and laundry, but they do not need help with "personal care" tasks such as bathing or

dressing. These services are limited by state law to EIGHT hours per week. 18 NYCRR 505.14(a)(5)(as amended 12/2015). **NOTE** - Adults who have Medicare, who would otherwise be required to enroll in an Managed Long Term Care plan, but who only need Housekeeping services may NOT enroll in MLTC. They obtain these Housekeeping services by applying at the local district/ HRA.

2. **PERSONAL CARE or "Level 2"** -- includes all of the Housekeeping (Level 1) tasks PLUS assistance with personal needs - bathing, dressing, grooming, toileting, walking, feeding, assisting with administering medications, preparing meals with special diets, and routine skin care. In amendments in December 2015, "turning and positioning" was specifically added as a task, as needed by bedbound individuals who cannot turn themselves, putting them at risk of bed sores.

2. Eligibility

PCS 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 regulation." 18 NYCRR 505.14(a)(3). Individual must be:

- **Self-directing** or have someone able to direct their care. NYS Admin. Directive 92 ADM-49 clarifies that the person directing care does not need to reside with the consumer but must have "substantial daily contact."
- The patient's **condition must be stable**, meaning that it may be chronic and degenerative but is not expected to exhibit sudden deterioration or improvement; AND does not require skilled professional or frequent medical or nursing judgment to determine changes to the plan of care. 18 NYCRR 505.14(a)(4)(i). See below regarding the "scope of tasks" that personal care aides may perform - generally they may not perform "skilled" nursing tasks, though these can be performed by CDPAP aides or family.
- Person's need for assistance cannot be met by **voluntary** assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, such as a commode, walker, etc. 505.14(a)(3)(iii)(as amended Dec. 2015). Note also that under State Dept. of Health directive, "The MLTC plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party." MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care."
- *The need for assistance with 2 or 3 ADLs was enacted in the State budget in 2020 as an eligibility requirement, but is postponed until March 2025. See more [here](#).*

A common basis for denial of eligibility is that the consumer allegedly needs a "higher level of care" than personal care. If the two above criteria are met, and the consumer does not need the aide to perform tasks beyond the personal care *scope of tasks* described above, then eligibility should be established -- it may require a hearing. Moreover, now that MLTC

plans and managed care plans are responsible for authorizing not just personal care services but also consumer-directed personal assistance services, private duty nursing and certified home health services, it would be improper for a plan to deny a request for PCS on this ground, without first assessing whether a different service could meet the client's needs, such as private duty nursing.

In NYC, a family member, friend, or guardian who agrees to "direct care," or to perform any skilled task such as pre-pouring a medication box, should indicate this agreement on Form HCSP-2131 Agreement to Participate in Plan of Care.

3. Scope of Tasks

Personal Care Aides / Home Attendants may perform tasks that are not "skilled." They differ slightly from "home health aides" who provide care in Certified Home Health agencies (CHHA), in that CHHA home health aides are permitted to perform care in some cases that is semi-skilled, especially for consumers who are "self-directing." The reason is that the "certification" of a CHHA requires that the visiting nurses employed by the CHHA closely supervise the home health aides.

- This 1994 NY State document describes the Scope of Tasks for Personal Care Aides.
- The DOH updated the Scope of Tasks for Certified Home Health Aides in March 2009
- Selfhelp's "Q-Tips" document (also in Spanish) has a chart comparing the scope of tasks of Personal Care Aides (PCAs) to that of CHHA Home Health Aides (HHA) at pages - see pp. 5-7.
- Aides in the Consumer Directed Personal Assistance Program are not bound by these restrictions, and may perform tasks that would otherwise be considered "skilled" and could only be performed by nurses or unpaid family or friends.

4. How does one Obtain Personal Care Services?

First, one must apply for and become eligible for Community Medicaid. Those under 65 and not on Medicare apply for Medicaid on the NYS of Health Exchange, and those 65+ or who have Medicare apply through their local Medicaid office. See this article for where to apply in New York City. See info about Medicaid applications.

Second, *how* a Medicaid recipient accesses Personal Care services depends on their age, whether they have Medicare, and some other factors.

1. **Under 65 and not on Medicare** - Most people in this category are automatically assigned to a "mainstream Medicaid managed care plan" when Medicaid is approved. Since August 2011, members of these plans must request Personal Care - including Housekeeping Level I and Personal Care Level II, Consumer-Directed Personal Assistance, private duty nursing, and other home care services through these plans. The plans assess the need for services, contract with home care agencies, and authorize services. The State Department of Health (DOH) has issued guidelines that include instructions on how consumers should request PCA services from their plans. NYSDOH Guidelines to Personal Care Services in Medicaid Managed Care.
- **Medicaid recipients over age 18 and not on Medicare, who are not yet enrolled in a mainstream Medicaid managed care plan** have the option of enrolling instead in a Managed Long Term Care plan, which would provide the personal care services. Once they are in a mainstream Medicaid managed care plan, however, they may not switch to an MLTC plan unless they need a special service not available from the managed care plan, such as adult day care or home modifications. See MLTC Policy 14.01: Transfers from Medicaid Managed Care to Managed Long Term Care. If they applied on the Exchange, they will need to transfer their Medicaid case to the local Medicaid office (HRA in NYC) in order to enroll in an MLTC plan.
2. **Medicare beneficiaries age 21+ who are not in hospice or OPWDD waiver** - most must first request a Conflict-Free Eligibility assessment from NY Medicaid Choice, and then enroll in a Managed Long Term Care plan in order to obtain PCA or CDPAP services. See some exceptions here.
- **IMMEDIATE NEED** - See this article for how to obtain temporary PCA services through local Medicaid program where there is an immediate need, and individual needs services to bridge the gap before enrolled in an MLTC plan.
3. A Few Still apply for PCS at Local Medicaid Office - (in NYC - the HRA Home Care Services Program)(or see procedures outside NYC)
- Medicare beneficiaries over age 21 may apply who are:
 - ◆ in a **home hospice** program,
 - ◆ in an **OPWDD waiver**, Nursing Home Transition & Diversion waiver, or Traumatic Brain Injury waiver,
 - ◆ who **need only Housekeeping** (Level I) services
- Those who do not have Medicare may apply if:
 - ◆ they are in an **OPWDD waiver**, Nursing Home Transition & Diversion waiver, or Traumatic Brain Injury waiver, or
 - ◆ they are over not yet in a mainstream managed care plan,

5. How Much Personal Care? How are Hours Determined?

A.. Standards for 24-Hour Care

NYS has two types of 24-hour care available when medically necessary. The definitions of these levels were just amended by regulation effective December 23, 2015. The amendments were adopted in part to comply with a settlement in *Strouchler v. Shah*, a lawsuit that was settled in federal court in Oct. 2014, after the court **issued a Preliminary Injunction against NYC HRA in Reducing 24-hour Split-Shift Medicaid Personal Care Services** (Sept. 4, 2012). The regulation published Dec. 22, 2015 is the final version after the State Dept. of Health issued a series of emergency and proposed regulations since 2011. Here are the new definitions effective Dec. 23, 2015 - also see GIS 15 MA/024 - Changes to the Regulations for the Personal Care Services Program (PCS) and the Consumer Directed Personal Assistance Program (CDPAP) (PDF)â Scope of the Personal Care Services Benefit

- **"Live-in 24-hour personal care services** means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep." 18 NYCRR 505.14(a)(4).
 - ♦ "In cases involving live-in 24-hour personal care services, the social assessment **shall also evaluate whether the patient's home has sleeping accommodations for a personal care aide**. When the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient's circumstances change and sleeping accommodations for a personal care aide become available in the patient's home, the district must promptly review the case. If a reduction of the patient's continuous personal care services to live-in 24-hour personal care services is appropriate, the district must send the patient a timely and adequate notice of the proposed reduction." 18 NYCRR 505.14(b)(4)(i)(c)(1)(as amended 12/2015).
- **Split-shift or "Continuous personal care services** means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning or positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep." 18 NYCRR 505.14(a)(2).

NOTE about definitions of live-in and split-shift care.

- The old regulation distinguished between the need for TOTAL and SOME assistance, allowing only those who need TOTAL assistance to qualify for split-shift or continuous care. The Dec. 2015 final regulation eliminates this distinction entirely for all personal care assessment, which is a positive change. It takes the same time for the aide to assist whether an individual needs some or total assistance with a particular activity.
- Before, split-shift continuous care was only for people with "unscheduled" needs, while live-in was for predictable needs. The amended regulation eliminates these concepts, emphasizing instead the frequency of need.
- The new regulation implements NYS Dept. of Labor guidance that says live-in aides are entitled to five hours of uninterrupted sleep during an eight-hour period of sleep. See NYS DOL Request for Opinions - Live-in Companions, March 11, 2010.
- The regulation no longer requires an assessment of "whether, where live-in 24-hour assistance is to be authorized, the consumer could be safely left alone without care for a period of one or more hours in a calendar day." This criteria had allowed for wrongful denial of care to some people.

B.. Standards for Assessing Need for Care, including 24-hour Care

Personal care services must be authorized in amounts that are medically necessary. While there are specific standards for determining the need for 24-hour care, above, the regulations are not as specific for people who need less than 24-hour care. Local Medicaid programs as well as managed care and MLTC plans that authorize PCS are permitted to use "task-based assessment" to determine needs, with important restrictions. The policies listed below were developed when PCS were administered by the local district Medicaid offices. They apply equally to managed care and MLTC plans when they administer these services, since The Federal Medicaid statute requires that all managed care plans make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. Â§ 1396b(m)(1)(A)(i); 42 C.F.R. Â§Â§ 438.210(a)(2) and (a) (4)(i). The NYS DOH Model Contract for MLTC Plans also includes this clause: "Managed care organizations may not define covered services more restrictively than the Medicaid Program." Appendix J.

- **Safety Monitoring** -- "Safety monitoring" does not have to be authorized as a "stand alone" task if no other personal care assistance is needed, as held in Rodriguez vs. City of New York, 197 F.3d 611 (2d Cir. Oct. 6,1999), However, local Medicaid districts [and MLTC and managed care plans] must authorize "the appropriate monitoring of the patient while [a personal care aide is] providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed." NYS DOH GIS 03 MA/003 . This policy was again clarified in MLTC Policy 16.07--

"...When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and

cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring,

NOTE If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions...".

- **"Mayer-Three" -Where there are 24-Hour Needs, Plan or district may not use Task-Based Assessment-** Statewide, no local district (or managed care or MLTC plan) may use task-based assessment if the individual needs 24-hour care, even if some of that care is provided by family or other informal caregivers. This aspect of *Mayer v. Wing* is codified in regulation at 18 NYCRR 505.14(b)(4)(viii)(d). This is known as the **"Mayer-3"** exception to task-based assessment. Mayer -3 applies to MLTC, e.g. FH No. 7145223P. This is reiterated in **MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services**. This guidance is a very important tool for advocacy with MLTC plan, local districts, and at fair hearings.
- **INFORMAL CARE must be VOLUNTARY** - PCS, including 24-hour live-in or split shift, may only be authorized after "alternative arrangements for meeting the patient's medical needs have been explored and are infeasible including, but not limited to, the provision of personal care services in combination with other formal services or in combination with **voluntary contributions** of informal caregivers," 18 NYCRR 505.14(b)(4)(i)(c)(1)(as amended 12/2015).(emphasis added). The regulations do not change the longstanding requirement that the "social assessment" evaluate:

- (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.

18 NYCRR 505.14(b)(3)(ii)(b). Family cannot be assumed to be available, and should be specific as to whether and when they can assist - which days, at what times, etc. See also 97MA033 - Clarifying instructions regarding *Mayer v. Wing* (S.D.N.Y.,1996).

- **Span of Time of unscheduled or recurring needs must be considered - 2016**

MLTC Guidance clarified that MLTC plans must consider the "span of time" during which the needs for assistance with ambulation, toileting, and transfer arise. **MLTC Policy 16.07:** *Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services.*

This guidance is a very important tool for advocacy with MLTC plan, local districts, and at fair hearings. MLTC Policy 16.07 states:

â "All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and **whether needed assistance can be scheduled or may occur at unpredictable times during the day or night.** All plans must assure that the plan of care that is developed can **meet any unscheduled or recurring daytime or nighttime needs** that the enrollee may have for assistance." (emphasis added)

A January 2019 Dear Health Plan Administrator Letter from the Department of Health also clarifies that the plan of care must address all of the enrollee's scheduled and unscheduled needs, and provides guidance about the Person Centered Services Plan (PCSP).

"Span of time" was long required in New York City and Nassau counties - in the NYC HRA Nurse's Assessment form (M-27r) (page 4) and its accompanying HRA instructions, used in NYC before MLTC became mandatory. These forms were adopted pursuant to an agreement with the NYC defendant in *Rodriguez*, which culminated in a *Stipulation of Settlement and Order of Dismissal*, dated January 9, 2003, in which NYC agreed to consider unscheduled and recurring needs and the span of time during which they occur. (available in WNYLC Online Resource Center Benefits Law database (must log-in, registration is free). Since managed care plans must make services available to the same extent they are available to recipients of fee-for- service Medicaid, these same standards should apply in MLTC. 42 U.S.C. Â§ 1396b(m)(1)(A)(i); 42 C.F.R. Â§Â§ 438.210(a)(2) and (a) (4)(i) In Nassau County, the County agreed in *Rodriguez* to revise certain assessment forms and instructions "to identify clients with unscheduled needs (such as toileting, transferring, and/or ambulating) and/or recurring needs (such as feeding, assistance with medication, etc.) to ensure a plan of care that will meet these needs." (Departmental Memo to all assessing and reviewing nurses and medical directors from Rita Nolan, Dir, Medical Services, dated May 24, 2004).

6. Who Can be Hired as a Personal Care Aide?

State regulations allow certain relatives to become the personal care aide, which in this program means being hired by the licensed home care services agency (LHCSA) that has a contract with the MLTC plan, certified home health agency, managed care plan, or local district. These relatives MAY NOT BE the personal care aide: spouse, parent, son, son-in-law, daughter or daughter-in-law. Another relative may be the aide "...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."

18 NYCRR 505.14(h)(2)(posted at [this link](#)). Note that the Consumer-Directed Personal Assistance Program will expand in April 2016 to allow a parent of an adult child in addition to a son or daughter, their spouse, or any other adult relative to be the aide, provided the individual does "...not reside with the consumer or ... who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary...." 18 NYCRR 505.28(b)(3). See more in [this article](#).

7. Procedural rights - Notice and Hearing with Aid Continuing

Protections established in litigation, law, regulation, and DOH State Policy include:

- **Right to have personal care services reinstated after a hospital stay, in the same amount provided prior to the hospital stay.** *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996). Should also apply to reinstatement inpatient rehabilitation -- there is no "30-day" limit to the length of the hospital or rehab stay. NYS DSS 99 OCC-LCM-2 (Apr. 20, 1999), reaffirming effectiveness of 96-MA-023 - New Notice, Aid-Continuing and Related Procedures Applicable to Hospitalized MA Recipients Who Received Personal Care Services Immediately Prior to Hospitalization (*Granato v. Bane; McCoy v. Schimke; Burland v. Dowling*) established by *Granato* and *Burland* cases. Cites in list of cases. This applies to MLTCs and managed care plans, which must provide services in the same amount, duration and scope as available in fee for service system.
- **MAYER v WING -Personal Care Services may not be reduced or terminated without a justification, which must be stated in the notice.** The agency reducing services (local district, MLTC or managed care plan) has the burden of proof to show a change in the individual's medical condition or circumstances justifies the reduction, or that a mistake was made in the original authorization, and certain other limited reasons. 18 NYCRR 505.14(b)(5)(c). (page 9-b of link) . This regulation implements *Mayer v. Wing*, 922 F. Supp. 902, 911 (S.D.N.Y. 1996). .

MLTC Policy 16.06 - Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services makes clear that this rule applies equally to MLTC and managed care plans. See, also FH No. 7061248Y, dated 9/29/15

ALERT: EFFECTIVE NOV. 8, 2021 - Amended Regulation takes effect which essentially says that Mayer and MLTC Policy 16.06 does not apply to MLTC plans after a "Transition Period" has Expired. See this Fact Sheet. In all other cases, MLTC Policy 16.06 applies -- including when an MLTC plan proposes to reduce hours for a member to less than the hours the same MLTC plan authorized previously.

Where MLTC Policy 16.06 and Mayer v. Wing do apply --

- **It is not enough to merely say in notice a mistake was made, or that medical condition improved, or that the proposed services are what is "medically necessary" - must specify facts justifying a change. See, MLTC Policy 16.06 eg FH No. 7059615J --**
- **MLTC Policy 16.06** says it is not a "mistake" just because a plan's assessment now determines a different number of hours than a past assessment. A mistake must be a material error that resulted in the higher hours in the prior assessment.
- **MLTC Policy 16.06 and state regulations specifically require "**The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change..." 18 NYCRR 505.14(b)(5)(v)(c)(2)(i), or if a mistake is alleged, "The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake..." 18 NYCRR 505.14(b)(5)(v)(c)(2)(ii),
- **EXHAUSTION REQUIREMENT for managed care and MLTC - see [this article](#) --**
 - ◆ Since 2018, member must request a PLAN APPEAL first, and only if that is denied, may request a Fair Hearing. See [this article](#)
 - ◆ Aid continuing is required if plan proposed to reduce services and Plan Appeal, and then Fair hearing are timely requested, even if the "authorization period" for the services has expired. Soc. Services Law Sec 365-a, subd. 8, as amended L. 2014.
 - ◆ Notice must be specific about the specific change in condition or mistake that occurred. See [above](#).
 - ◆ **MODEL NOTICES** - MLTC Plans must Use [These Templates](#)
- See **"Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans,"** a Report on findings of a study of fair hearing decisions on reductions of personal care and Consumer Directed Personal Assistance services hours posted during a seven-month period ending December 31, 2015. Decisions are posted in an [online fair hearing archive](#) of the state Office of Temporary & Disability Assistance (OTDA). The report makes specific policy recommendations to address the need for better oversight and monitoring of plan activities. The report was featured in a [story in the NYTimes](#) on July 21, 2016 and can be downloaded here - on [MMNY site](#). See the MMNY press release on the report [here](#).
- The right to a determination on Medicaid personal care eligibility in 30 days (NYC), in [Miller v. Bernstein settlement](#).

FAIR HEARINGS -- Hearings are often required to obtain an increase in hours of personal care/home attendant services, to contest denials of applications based on the alleged need for a "higher level of care," etc. [MLTC Policy 16.07](#) can be useful in these hearings and [see above re standards of assessment of hours.](#)

- IN 2011, NYS Office of Temporary & Disability Assistance began posting all fair

hearing decisions, in redacted, format on a searchable website at <http://www.otda.ny.gov/oah/FHArchive.asp>.

- Many fair hearing decisions are posted by advocates on the WNYLC [Online Resource Center](#) on the Western New York Law Center website. For access, register and "log in" and select "Fair Hearings" tab to access the database. The database is partly searchable -- by keywords used by advocates when the post decisions, but not by the entire decision.
- This [Digest of Medicaid Fair Hearing Home Care Decisions](#) is another way of identifying hearing decisions that may be helpful to show a roadmap for preparing for a hearing, or to cite as precedent at a fair hearing.

8. Articles on Demographics & Service Patterns of Personal Care Service Population

[Medicaid Personal Care in New York City: Service Use and Spending Patterns](#), (Medicaid Institute at United Hospital Fund, December 2010)

<http://www.uhfnyc.org/publications/880720> -- takes two distinct looks at one group of personal care recipients, elderly dual Medicare-Medicaid beneficiaries in New York City

[Medicaid Long-Term Care in New York: Variation by Region and County](#), (Medicaid Institute at United Hospital Fund, December 2010)

<http://www.uhfnyc.org/publications/880719> -- analyzes rates of service use and levels of spending per recipient across New York State, documenting variation by region and by county. It also examines four interrelated factorsâ demographics, reimbursement policies, availability of service, and local administrationâ to begin to explain regional variation.

Alene Hokenstad, *[An Overview of Medicaid Long-Term Care Programs in New York](#)*, (Medicaid Institute at United Hospital Fund, May 2009) A comprehensive report on Medicaid long-term care programs in New York, which serve 247,000 Medicaid beneficiaries each month and account for roughly one quarter of all Medicaid spending. Care for these beneficiaries can be intensive and costly. Created to inform discussions among New York's policymakers, health care stakeholders, and community advocates, the report provides an overview of the current organization of long-term care services under New York's Medicaid program, a September 2007 snapshot of program enrollment and associated annual spending, and a summary of the rules that govern how each program operates. The report also identifies policy options for addressing the key challenges facing the state as it looks at options to better serve New York's frail seniors and adults with physical disabilities through its 12 long-term care programs.

<http://www.uhfnyc.org/publications/880507>

HISTORY -

Regulation changes beginning in October, 2011. As authorized by the 2011 statute quoted above, DOH has issued a series of emergency regulations which change the standards for authorizing 24-hour care, both sleep-in care and split-shift "continuous" care

in 18 NYCRR 505.14. Because the regulations are issued as emergency regs, they must re-file them every 60 days. See n 1 on State Administrative Procedure Act. Note that all of the emergency re-filings have been identical in language except for one thing -- whether the Local Medical Director must consult with the treating physician. The substance of the changes are discussed below. Here are the emergency reg cites in chronological order -- See full regulation at 18 NYCRR Â§ 505.14 - updated with changes through March 29, 2012, which are unchanged as of July 23, 2012).

1. Oct. 4, 2011 (published in NYS Register Oct. 19. 2011 p. 33), which expired 90 days after filing
2. December 30, 2011- emergency regulation again scheduled to expire
3. March 29, 2012 - emergency regulation published in State Register on April 18, 2012. Again scheduled to expire. This one made a substantive change from the earlier emergency regs, no longer requiring the Local Medical Director to consult with the treating physician.
4. July 18, 2012 -- emergency reg will expire in 60 days or September 24, 2012. No changes from Mar. 29, 2012 regulation publication. See full regulation at 18 NYCRR Â§ 505.14 incorporating all changes.
5. Sept. 24, 2012 - emergency reg again filed -- September 24, 2012 - Personal Care Services Program (PCSP) and Consumer Directed Personal Assistance Program (CDPAP) . \
6. March 14, 2014 - Personal Care Services Program (PCSP) and Consumer Directed Personal Assistance Program (CDPAP) --emergency regulation -- will be published in the State Register on the third Wednesday following the effective date. Initial emergency regulations are generally effective from the date of filing for 90 days.

FN 1. Note on State Administrative Procedure Act

Info provided courtesy of Gene Doyle, LMSW
People Organized for Our Rights, Inc. (P.O.O.R.)

When regulations are filed on an emergency basis, they have an initial life span of 90 days. When, as in this case, regulations are repeatedly filed on an emergency basis, each subsequent filing is good for only 60 days. See State Administrative Procedure Act (SAPA) Â§ 202[6].

In order to adopt regulations on a permanent basis, a Notice of Proposed Rule Making must be published in the New York State Register and must afford a minimum 45 day period for submission of public comments.

In each of the Notices of Emergency Rule Making that the New York State Department of Health (DOH) has filed, there is a paragraph immediately following the regulatory text which reads:

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of

proposed rule making in the State Register at some future date. The emergency rule will expire [by x date]

DOH will continue this 60-day emergency rulemaking dance until a Notice of Proposed Rulemaking and a Notice of Adoption are published. Once the Notice of Proposed Rulemaking is published, the 45-day comment period will begin. See SAPA Â§ 202[1](a).

DOH website posts its emergency regulations at:<http://www.health.ny.gov/regulations/emergency/> and its [proposed regulations here](#). Recently adopted regulations (within the last six months) can be found at: http://www.health.ny.gov/regulations/recently_adopted/ .

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