Draft Analysis and Comments of Proposed Amendments to 18 NYCRR 505.14 and 505.28 - Valerie Bogart, NYLAG, draft 8/19/20

Page	Cite - 505.14 black 505.28 is purple	Proposed Language	Comment
All	All 505.14	"patient" or "individual" should be changed to "consumer"	Reg impact statement says modernizing language but uses antiquated medicalized term -- "patient." "Consumer" within 505.28 would refer to CDPAP consumer, and within 505.14 refer to a personal care services [PCS] consumer. In 505.28, the proposed language uses "the individual" sometimes to refer to the consumer. It would be clearer if all references to the individual applying for or receiving PCS or CDPAP services is the "consumer."
		Update Terms to IADLs and ADLs instead of "nutritional and environmental support functions" and "personal care functions" – These changes would bring the regulations up to date with the terminology used nationally in the field of rehabilitation assessment. The UAS, UAS Reference Manual, DOH MLTC Policy 16.07, Community First Choice Option [CFCO] law, regulations and NYS CFCO SPA, and other guidance all use these terms.	
	505.14(a)(5)(i)(a)	Change "nutritional and environmental support functions" to "**Instrumental Activities of Daily Living" ("IADL)"**	Further to align the regulation with the UAS, the list of IADL's in 505.14(a)(5)(i)(a) should also include: ● Use of telephone or other communication devices ● Management of medications ● Assisting with transportation Clarify that the 8-hour/week limit for Level 1 services does not apply to individuals also receiving personal care services in MMCO and LDSS. MLTC Policy 16.07.
	505.14(a)(5)(i)(a)	Change "personal care functions" to **"Activities of Daily Living" (ADL)** Also change "grooming" to "personal hygiene" to be consistent with UAS.	The regs add a definition of "ADL" for purposes of defining the new statutory 2- or 3-ADL minimum requirement. Instead of defining "ADL" separately, it will be clearer to replace the existing term "personal care functions" with the term "ADL" and modify the definition there. See suggested edit below. If ADL is separately defined as proposed, must add: 1. **Transfer** is included in the proposed reg solely for toilet use.

			Transfer is a basic ADL for other purposes – getting up and down from a chair or bed, getting in and out of a car, etc. 2. **Toileting** must include incontinence care, including catheter use to the extent permitted by scope of tasks (ie PCS and CDPAP differ).
	505.14(a)(5)(i)(a)	**Proposed Edit – Rename "personal care functions" as activities of daily living and update that list:** (ii) Level II shall include the performance of ~~nutritional and environmental support functions~~ instrumental activities of daily living specified in clause (i)(a) of this paragraph and ~~personal care functions~~ activities of daily living. (a) ~~Personal care~~ Activities of daily living (ADL) functions include assistance with the following: (1) bathing of the ~~patient~~ consumer in the bed, the tub or in the shower; (2) dressing; (3~~) grooming~~, personal hygiene, including care of hair, shaving and ordinary care of nails, teeth and mouth, and routine skin care; (4) toileting; this may include assisting the~~ patient~~ consumer on and off the bedpan, commode or toilet, and incontinence care; (5) walking, ~~beyond that provided by~~ including use of durable medical equipment such as walkers and wheelchairs, within the home and outside the home; (6) transferring from bed to chair or wheelchair; (7) turning and positioning; ~~(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;~~ ~~(9)~~ (8) feeding; ~~(10)~~(9) administration of medication by the consumer ~~patient~~, including prompting the consumer ~~patient~~ as to time, identifying the medication for the consumer ~~patient~~, bringing the medication and any necessary supplies or equipment to the consumer ~~patient~~, opening the container for the consumer ~~patient~~, positioning the consumer ~~patient~~ for medication and administration, disposing of used supplies and materials and storing the medication properly, and changing of simple dressings; ~~(11) providing routine skin care;~~ ~~(12) using medical supplies and equipment such as walkers and wheelchairs; and~~ ~~(13)~~ (moved)	
12 68 72	505.14(a)(3)(iv)(a) 505.28(b) 505.28(b)(13)	(a) for patients with a diagnosis by a physician of dementia or Alzheimer's, being assessed in accordance with subdivision (b) of this section as needing at least supervision with more than one activity of daily living.	The regulation arbitrarily denies PCS to others who, because of a cognitive impairment other than dementia or Alzheimer's, or because of a vision impairment, need supervision with more than one ADL but not physical maneuvering with more than 2 ADLs.

		(b) for all other patients, being assessed in accordance with subdivision (b) of this section as needing at least limited assistance with physical maneuvering with more than two activities of daily living.	"The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." 42 C.F.R. §440.230(c). Additionally, these regulations will be applied to those eligible for CFCO services, whether through FFS PCS/CDPAP or, once available, through MLTC plans. The CFCO regulations similarly prohibit discrimination based on diagnosis. " States must provide Community First Choice to individuals ...[i]n a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and *without regard to the individual's age, type or nature of disability*, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life." 42 C.F.R. § 441.515. To align the regulation with these federal requirements, section (a) should be amended as follows: (a) for patients with a diagnosis by a physician of dementia or Alzheimer's, traumatic brain injury, developmental disability, or other cognitive impairment, or visual impairment, being assessed in accordance with subdivision (b) of this section as needing at least supervision with more than one activity of daily living.
13	505.14(a)(5)(iii)	(iii) The personal care aide may perform nutritional and environmental support functions and personal care functions for the recipient and may also assist the recipient to perform such tasks themselves. Assistance may include supervision and cueing to help the recipient perform a nutritional and environmental support function or personal care function if the recipient could not perform the task without such assistance. **Supervision and cueing are not standalone personal care services and may not be authorized, paid for or reimbursed separately from or in addition to the performance of**	In 1999, a federal court held that the NY Medicaid program was not required to provide stand-alone safety monitoring as a service separate from personal care services. *Rodriguez vs. City of New York*, 197 F.3d 611 (2d Cir. 1999). When that decision was misinterpreted to ban personal care aides from assisting a consumer to safely perform ADLs, in 2003 the State issued guidance to clarify that personal care does include "...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 . In 2016, DOH again reiterated the same in DOH MLTC Policy 16.07:

		nutritional and environmental support functions or personal care functions. Recommended edits of 2nd sentence above Supervision and cueing are not standalone personal care services and may not be authorized, paid for or reimbursed ~~separately from or in addition to the performance of nutritional and environmental support functions or personal care functions.~~ If no assistance with an activity of daily living or instrumental activity of daily living is being provided, but must be authorized for the appropriate monitoring of the consumer while providing assistance with the performance of activity of daily living or instrumental activity of daily living such as transferring, toileting, or walking, to assure the task is being safely completed. Also see recommendation in TERMINOLOGY section above to change "nutritional and environmental support functions" to "Instrumental Activities of Daily Living" and "personal care functions" to "Activities of Daily Living."	"...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. ... Example of supervision and cognitive pairing A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly." The proposed regulation is not as clear as either the 2003 GIS or MLTC Policy 16.07. The second sentence of 505.14(a)(5)(iii) highlighted in **bold** is confusing and could be misinterpreted to improperly deny authorization of personal care or CDPAP services to provide supervision or cueing assistance with ADLs or IADLs. We recommend using the clearer language from the longstanding guidance cited above.
68	505.14(a)(9) 505.28(b)(1) 505.14(a)(5)(ii)(a)	**Definition of ADLs** (9) Activities of daily living means bathing, personal hygiene, dressing, walking, locomotion, transferring on to and off the toilet and toilet use, bed mobility, and eating.	See suggested edit in TERMINOLOGY section above changing the term of "Level II "personal care functions" to "Activities of Daily Living," with a slight edit of the list of tasks. This avoids confusion from having different lists in the same regulation of personal care tasks and aligns these lists using the standard term of "ADLs" as used in federal regulations, for CFCO, in the UAS, and in the professional vocabulary. Whether ADL is separately defined as proposed, or is the new terminology for "personal care functions" as we propose, the proposed ADL list omits incontinence care, transfer to and from chair or bed, and medication administration. Not all assistance with

			elimination involves using a toilet. It may also include incontinence care. Transfer is included only pertaining to toileting, which will exclude some consumers who require assistance with transfer to and from bed or chair but may use a catheter so not need assistance in transferring to a toilet. An individual may be able to walk independently with a walker but not be able to stand up (transfer) without assistance.
15 et seq. 75	505.14(b)(1) et seq. 505.28(d)	**Under federal regulations, the member's provider(s) must be able to request or recommend services, and the various assessors must consult with the member's providers. Under the proposed scheme, the member's providers are cut out of the process, which potentially violates the federal Medicaid managed care regulations. We recommend that that any consumer requesting personal care or CDPAP services have the opportunity and right to submit the new *physician's statement of need* form that the regulations propose to be used for the Immediate Need applications.** Proposed 505.1**4**(b)6)(i)(a)(2)(i) (p. 52) The entire authorization scheme for managed care services set forth in 42 CFR §438.210 is based on requests for services being made by the member's treating provider, and require consultation with the "providers caring for the enrollee" in developing the treatment or service plan. 42 C.F.R. 438.210(c)(3)(i). For example, "[f]or the processing of requests for initial and continuing authorizations of services, each [managed care plan] contract must require—… that the MCO.. [c]onsult with the **requesting provider** for medical services when appropriate…" § 438.210(b)(2)(ii)(Emphasis added). Similarly, "each contract must provide for the MCO. . . to notify the **requesting provider**, and give the enrollee written notice…" of any adverse benefit determination. §§ 438.210(c) and (d) (Emph. added). The regulation also defers to the requesting provider on whether an authorization must be expedited. "For cases in which **a provider indicates**… that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO …must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service." § 438.210(d)(2)(i). The "Definitions" section of the federal regulation defines "provider" as meaning "any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. § 438.2. This broad definition would include an enrollee's physician. The member has the right for their physician to request services on their behalf, to recommend that the authorization should be expedited, and to receive notice of any adverse determination. Moreover, the federal regulation imposes time limits for a plan to authorize services, calculated from the date the service was requested by the provider or member, discussed further below. Additionally, the federal regulation contains specific requirements for plans providing Long Term Services and Supports (LTSS) which include personal care and CDPAP services. The regulation provides in part, "The treatment or service plan must

		be: (i) Developed by an individual meeting LTSS service coordination requirements with enrollee participation, **and in consultation with any providers caring for the enrollee**…." § 438.208(c)(3) The federal regulations set a time limit for a plan to authorize services from the date a service is requested by the member's provider (time limits discussed more below). By effectively banning the member's physician from initiating a request for services, the proposed scheme violates the federal Medicaid managed care regulations. **For these reasons, the regulations must provide an opportunity for the consumer's physician to submit a request for services or information regarding the consumer's medical diagnoses, functional impairments, and service needs**. Not only is this required by federal regulations, but this information is needed for the Independent Assessment. Otherwise, it is unclear how the nurse assessor obtains information about the medical condition, other than from the consumer, who may not be the best reporter of their medical history and status. **We recommend that that any consumer requesting personal care or CDPAP services have the opportunity to submit the same new *physician's statement of need* form that the proposed regulations propose to be used for the Immediate Need applications.** Proposed 505.14(b)6)(i)(a)(2)(i) (p. 52).

15 75	505.14(b)(1) 505.28(d)	(b)(1) The assessment process includes an independent assessment, a medical exam and physician order, an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required under paragraph (2) of this subdivision, a referral to a clinical review panel. When the social services district or MMCO receives a request for services, that social services district or MMCO shall refer the applicant for an independent assessment and physician order, provide assistance to the individual in making contact with the independent assessor designated by the Department of Health to begin the assessment process and, if needed, the MMCO shall refer the applicant to the social services district and the social services district shall begin to determine the applicant's financial eligibility for medical assistance services, including community based long term care services.	**Medicaid eligibility determination.** The last clause in proposed 505.14(b)(1) requires an MMCO to refer an applicant for services to the local district to determine Medicaid financial eligibility. This referral should never be necessary or even possible. An individual cannot enroll in either a mainstream plan or an MLTC plan unless they have been determined financially eligible for Medicaid, so there would be no occasion for the MMCO to refer an individual who is not a member for the functional assessments. However, with a small tweak, this clause is still important: ...and, if needed, the ~~MMCO shall refer the applicant to the social services district and the~~ social services district shall begin to determine the applicant's financial eligibility for medical assistance services, including community based long term care services. This modification requires the LDSS to simultaneously determine financial eligibility for Medicaid while the functional assessments are scheduled and conducted. This is not a change to the current system, at least as implemented in NYC. Moreover, if an individual who does not yet have Medicaid requests a Medicaid service at a LDSS office, this is implicitly a request to file a Medicaid application, with which the LDSS must assist, and then determine eligibility within the 45/90 day time limits. 42 C.F.R. Sec. 435.911. Any individual must be given the opportunity to apply for Medicaid without delay. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906; 42 C.F.R. § 435.914
		INDEPENDENT ASSESSMENT (Nurse)	
15, 75-77	**505.14(b)(1)** **505.28(d)(1)**	(b)(1) When the social services district or MMCO receives a request for services, that social services district or MMCO shall refer the applicant for an independent assessment and	This assessment by a nurse apparently combines into one the former social and nursing assessments in the existing regulations.

		physician order, provide assistance to the individual in making contact with the independent assessor designated by the Department of Health to begin the assessment process**….**	
16 19-21		505.14(b)(2) The initial assessment process shall include the following procedures in all cases:	1. Assessment must elicit extent of night-time needs, skilled needs, and assess sleeping accommodations if needed for live-in aide. Since the physician assessor is given a copy of and relies on the independent assessment for information about functional needs and their frequency, this assessment must elicit specific information that the LDSS/MMCO will consider to determine if 24-hour care is required. 505.14(b)(2)(iii)(e). See details in discussion of Physician's Order below – the same questions must be asked in the independent assessment. It is the nurse, more than the physician, who has expertise in assessing functional needs.
76	**505.14.(b)(2)(i)** **505.28(d)(1)(ii)(b)**	SUGGESTED EDIT in RED (i) (b) The independent assessment shall include the following: (1) an assessment of the functions and tasks required by the patient, including:	
34	**add from** 505.14(b)(2)(iii)(a)and more	(i) need for frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding; (ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day; (iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day; (iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and (v) whether, were live-in 24-hour personal care services to be authorized, the 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.; (vi) Whether there are sleeping accommodations for an aide; (vii) whether there are any skilled needs, with the frequency when needed	This assessment must specifically identify any skilled needs that are beyond the scope of tasks of a personal care aide and the times and frequency with which those needs arise. This information is necessary for the LDSS/MMCO's development of the plan of care, as well as for the consumer's right to know the basis of any subsequent finding that they cannot be safely cared for at home with personal care services or CDPAP. MMCO plans should also be required to assess whether other services in the service package can meet any skilled needs. Also, should assess whether home has sleeping accommodations for an aide. Since this is a factor for the LDSS/MMCO to determine need for live-in vs. continuous 24-hour care, this must be included. The UAS does NOT ask specifically about night-time ADL needs, which is a glaring omission.

20 76	**505.14.(b)(2)(i)(b)(2)** **505.28(d)(1)(ii)(b)**	(2) a discussion with the patient to determine perception of his/her circumstances and preferences]; and Suggested edit: (3) an assessment of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and shall consider all of the following: (i) number and kind of informal caregivers available to the patient; (ii) ability and motivation of informal caregivers to assist in care; (iii) extent of informal caregivers' potential involvement at specific times each day of the week; (iv) availability of informal caregivers for future assistance; and (v) acceptability to the patient of the informal caregivers' involvement in his/her care; and (v) if the consumer is not self-directing, as defined in section 505.14(a)(3)(ii),the assessment	2. The assessment should specifically elicit the consumer's preferences for **how many hours of personal care or CDPAP services they are requesting and their daily schedule**, along with related services in the MMCO benefit package (adult day care, nursing, etc), and the **consumer's preferences regarding informal care**. For example, the consumer may prefer her adult son does not assist with incontinence care or bathing. The consumer's specific preference as to the amount and schedule of services should be included in the assessment so that it is available to the independent medical examiner, the LDSS/MMCO in forming the plan of care, and, where needed, in the independent review for high-needs cases. **Without a clear indication of the care sought by the consumer and its amount (ie. 24/7 live-in PCS), etc. it is impossible for subsequent reviewers, including in appeals, to review the adequacy of a care plan or a determination that the consumer cannot be safely cared for at home.** 3. We support the incorporation of the longstanding requirements of the former "social assessment" to assess the availability of voluntary informal care – copied in the adjacent box -- and recommend that the assessment also: a. elicit specific details as to the availability of potential informal caregivers, including the days of the week and the times of day they are available and willing to provide care. We frequently see MLTC plans authorizing services only on weekdays, assuming that family is available on the weekend, or authorizing weekday services only until 5 PM, assuming that a working family member is available at that time. The UAS just asks if family is involved, with no detail, leading to mistakes and assumptions.
20-21 77	**505.14.(b)(2)(i)(b)(3)** **505.28(d)(1)(ii)(c)**		

		shall identify any informal caregiver or other person or entity who is willing able to direct care for the consumer;	b. contact the informal caregivers identified in the assessment to ascertain their availability and willingness to provide voluntary informal care, if they are not present during the assessment. c. include an assessment of whether the consumer is "self-directing," and if not, determine which person or entity will "direct care" pursuant to 505.14(a)(3)(ii). The nurse is qualified to assess whether consumer is self-directing. Since the person directing care is most commonly an informal caregiver, the nurse is already assessing their availability to provide care, and this is an extension of that assessment.
		SCHEDULING & PROCEDURES of INDEPENDENT ASSESSMENT – Regulations must specify the following 1. The procedures for scheduling the assessment are unclear and appear to place the burden on the consumer to schedule. Once the consumer has made a request for services, arrangement of any required assessments should be done by the LDSS or MMCO. The LDSS or MMCO is only required to "provide assistance to the individual in making contact with the independent assessor" and "coordinate with" the assessment entity "to minimize patient disruption and in-home visits." 2. The regulation must give time limits for the LLDS or MMCO to refer for the assessment, for the contract entity to schedule, conduct, and submit the assessment, taking into account availability of the consumer and their designated representative. Discussed further below in **505.14(b)(3) (**p. 23 below). 3. The independent assessment must be conducted in the consumer's residence – whether a home or a nursing home. If the consumer is temporarily in a hospital or rehab setting the regulation should require that assessment must be conducted there. 4. Relationship with Conflict-Free assessment –The regulation should clarify that the CFEEC assessment serves as the independent assessment for a new MLTC enrollee, obviating the need for a duplicate assessment after enrollment.	

		5. <u>The regulation must state the consumer's right to have a family member or other representative present for the assessment, in order to comply with federal person-centered planning requirements</u>. The LDSS or plan must notify any designated representative or family member of the time of the assessment, and take into account the individual's availability for scheduling. This is especially necessary for individuals who are non-self-directing, but also for others who may want someone present. Federal person-centered planning requirements require the individual's representative to have a participatory role in care planning, as needed and as defined by the individual 42 CFR § 441.301(c)(1), which is incorporated by reference in the managed care regulations at 42 CFR § 438.208(c)(3). The independent assessment and all of the other assessments are part of the person-centered planning process. See more about TIMING of the entire process below p. 23.	
23-25 77-80	505.14(b)(2)(ii) **505.28(d)(2)**	**Independent medical exam and physician order**	
23-25 78	505.14(b)(2)(ii)(b) **505.28(d)(2)(ii)**	(ii)(b) The medical professional who examines the patient must be a physician licensed in accordance with article 131 of the Education Law, a physician assistant or a specialist 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. <u>Qualifications</u> – The amended statute requires personal care services to be "...prescribed by **a** qualified independent physician selected or approved by the department of health." N.Y. Soc. Serv. Law §365-a, subd. 2(e). DOH lacks authority under this law to authorize a physician assistant, specialist assistant, or nurse practitioner to conduct the exam upon which the physician would prescribe services. Alternatively, if non-physicians are permitted to do the examination, both the examiner and the physician, like the nurse conducting the independent assessment who must have two years of "satisfactory recent experience in home health care," 505.14(b)(2)(i)(a)(2) at p. 20, the medical examiner and prescribing physician should have specialization in and/or two years of satisfactory recent experience in geriatrics, rehabilitation medicine, or a related field.
26	505.14(b)(2)(iii)(a)	(iii)(a) The social services district or MMCO must review the independent assessment and physician order and must coordinate with the entity or entities designated by the Department of Health to provide independent assessment and physician order services, as appropriate, to minimize patient disruption and in-home visits.	2. <u>Scheduling</u> - The regulation 505.14(b)(1) states the local district or MMCO shall provide assistance to the individual in making contact with the independent assessor, but is silent on providing the consumer with assistance to schedule the independent medical exam. Sec. 505.14(b)(2)(iii)(a) says the LDSS or MMCO "must coordinate" with the entity conducting the independent assessment
24 79	505.14(b)(2)(ii)(d) **505.28(d)(2)(iv)**	(d) The medical professional must examine the patient and accurately describe the patient's	

24 79	505.14(b)(2)(ii)(e) **505.28(d)(2)(v)**	medical condition and regimens, including any medication regimens and the patient's need for assistance with personal care services tasks. (ii)(e) "... The medical professional must review the independent assessment and may review other medical records and consult with the patient's providers and others involved with the patient's care if available to and determined necessary by the medical professional....	and medical exam "to minimize patient disruption and in-home visits." This is not enough to ensure timely scheduling of assessments and ensure that the burden is not on the consumer to schedule this mandatory assessment. In the Medicaid Matters NY meeting on 7/28/20, the DOH flowchart slide indicated that the referral would be done internally by NY Medicaid Choice after the independent assessment. This makes sense, but a time limit is still needed, and scheduling must take into account availability of the consumer and their designated representative. 2. <u>The consumer's representative – whether family member, social worker or other person – must be given the opportunity to be present for this examination</u>. Under federal person-centered planning requirements, the "representative should have a participatory role, as needed and as defined by the individual... "42 CFR § 441.301(c)(1) and (2), as cross referenced from § 438.208(c)(3)(ii). 3. The proposed regulation states that the medical professional ***may*** review other medical records and consult with the patient's providers and others involved with the patient's care. The word "may" should be change to "***must***." The **consumer must be given the opportunity for their treating physician to submit a statement or additional medical records.** This is a required part of the person-centered planning process in managed care. § 438.208(c)(3)(i). The consumer's provider's records must be reviewed at all steps of the assessment process - in the independent assessment, the independent medical exam, and in the high-need medical panel review. This must be added to the regulation.
		<u>Physician Order Form</u>	
25 79	505.14(b)(2)(ii)(f) **505.28(d)(2)(vi)**		1. <u>Form must elicit frequency of needs and Night-time needs</u>: In the section of the proposed regulation on LDSS/MMCO responsibilities

		(f) The medical professional must complete a form required or approved by the Department of Health (the "physician order form").	(505.14(b)(2)(iii)(e) and 505.28(d)(3)(v)) , copied in the adjacent column, the LDSS/MMCO must review whether the physician's order indicates a medical condition that causes the need for frequent assistance during a calendar day, the frequency of assistance needed with specific ADLS during a "calendar day," whether similar assistance is needed during waking and sleeping hours, and if not, why not, and whether a live-in aide would be likely to obtain 5 hours of uninterrupted sleep during the aide's 8-hour period of sleep. Neither the DOH-4359 Physician's Order form or the NYC M11q form elicit specific information about night-time needs and frequency. The forms must be revised to specifically ask the physician about each and every one of these factors. Otherwise, the LDSS/MMCO's review will always find that the physician's order did not indicate the presence of these factors – simply because the physician was not asked. Additionally, as said above, the <u>same questions must be added to the Independent Assessment by the nurse</u>. Many of these questions involve assessment of the consumer's functional impairments and needs, which may be more appropriately assessed by the nurse who is trained in home care assessment. Since the physician must review the independent assessment, the nurse assessor's observations about these factors is critical in order for the physician to indicate the night-time needs.
34 92	505.14(b)(2)(iii)(e) **505.28(d)(3)(v)**	Form should also include these factors since the LDSS/MMCO must review whether the physician's form documents these items: (iii)(e)For cases involving continuous personal care services or live-in 24-hour personal care services, the social services district or MMCO shall assess and document in the plan of care the following: (1) **whether the physician order indicated a** medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;	
25	505.14(b)(2)(iii)(e)	(2) the specific personal care functions with which the patient needs frequent assistance during a calendar day; (3) the frequency at which the patient needs assistance with these personal care functions during a calendar day; (4) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and (5) whether, were live-in 24-hour personal care services to be authorized, the 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.	
25 79-80	505.14(b)(2)(ii)(g) **505.28(d)(2)(vii)**	(ii)(g)A physician employed or contracted by an entity designated by the Department of Health, **who may be the examining medical professional**, must sign the physician order form, certify that	2. <u>Examining physician must sign the form</u>. The proposed regulation states that the form ***may*** be signed and certified to by the examining

		the information provided in the form accurately describes the patient's medical condition and regimens at the time of the medical examination, and indicate whether the patient is self-directing and whether the patient can be safely cared for at home.	professional. The examining professional must be the one to sign and certify the accuracy of the information in the form. If another physician *also* signs the form, in a supervisory or other administrative role, the examining professional must *also* be required to certify its accuracy and completeness. This is necessary for accountability and for the consumer's appeal rights. 3. **Indication of whether the patient can be safely cared for at home**. It is premature for the medical examiner to make this determination before the LDSS/MMCO has developed a proposed plan of care, including the role of voluntary supports. For example, an individual who needs suctioning of a tracheostomy could not be safely cared for at home if the plan of care was solely a 4-hour/day personal care aide with no informal supports. The same individual could be safely cared for at home with continuous 24-hour split shift CDPAP and/or private duty nursing services, or a combination of these same services and informal care for a total of 24-hour continuous coverage. See more below about "safety." 4. Determination of whether consumer is self-directing. As said above, the independent assessment should assess the consumer's ability to self-direct and, if she cannot, should identify the person or entity that will direct care and describe their availability and the tasks to be performed. Without this information, the physician assessor could not make this determination. 5. Consumer right to receive copy of assessment. A copy should be provided to the consumer, who must have the right to review it and point out any incorrect or missing information to the plan or LDSS.
		Determination of whether the consumer may be safely cared for at home.	

		Various assessors and the LDSS/MMCO are asked to make a determination about whether the consumer can be safely cared for at home. The procedures and standards for making this determination must comply with Olmstead, as specifically required by the amended statute: "... In establishing any standards for the provision, management or assessment of personal care services the state shall meet the standards set forth in Olmstead v. LC by Zimring, 527 US 581 (1999) and consider whether an individual is capable of safely remaining in the community...." Soc. Serv. Law §365-a, subd. 2(e)(personal care) and §365-f, subd. 2 (CDPAP). The ADA regulation 28 CFR §35.13 (h) states, "A public entity may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on **actual risks**, **not on mere speculation, stereotypes, or generalizations** about individuals with disabilities." The federal Medicaid regulations specify that Person-Centered Service Plans for long term services and supports must "[r]eflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed." 42 CFR § 441.301(c)(2)(vi), incorporated by cross reference in § 438.208(c)(3)(ii). This language illuminates the more nuanced determination that is required of whether a consumer can be safely cared for at home, identifying the risk factors that might diminish safety, and the measures that can be put in place to minimize them. Any assessment of risk must be based on an individualized assessment not general assumptions about safety. This individualized assessment must rely on current medical or best available objective evidence to assess (1) the nature, duration and severity of the risk, (2) the probability that the potential injury will actually occur, and (3) whether reasonable modifications of policies, practices or procedures will mitigate or eliminate the risk.[1] This more nuanced process must be specified in the regulations, and will require training of the various assessors, in order to change an outdated view of safety as a black and white matter – the consumer is or is not safe at home. The content of the Independent Assessment and other assessments, and of the final authorization by the LDSS/MMCO must guide the assessor through the consideration of risk factors by listing common ones and ways to minimize them. One of the key factors that any assessor must know to determine if an individual is capable of safely living in the community is the proposed care plan. As stated above, a consumer who requires suctioning of a tracheostomy might be unsafe if the proposed care plan was only 4 hours/day of formal care with no informal supports, but safe with a care plan covering 24/7 needs with a combination of formal and informal care. For this reason, whoever is asked to make a determination about safety must be provided with both (1) the proposed plan of care by the LDSS/MMCO, and (2) the consumer's proposed plan

[1] See, e.g. letter dated May 31, 2013 from David Hickton, U.S. Attorney for W.D. PA and Thomas Perez, Ass't. Attorney General, U.S. DOJ Civil Rights Division, to Gov. Tom Corbett, Governor of Pennsylvania, available at https://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf

		of care. To ask for an opinion without this information invites the assessor to speculate about safety based on assumptions that may be based on stereotypes, rather than the individual's facts. We suggest DOH compose a workgroup of stakeholders to improve the assessment forms and process to incorporate individualized assessment of risk factors and measures that could mitigate the risks, as well as other components required for Person-Centered Service Plans in the federal regulation cited above. One of the most forceful messages of Olmstead is to avoid stereotypes about who is "safe" only in an institution. These regulations must do a better job of ensuring that assessments meet Olmstead standards.	
26 88	505.14(b)(2)(iii) **505.28(d)(3)**		
		Improper Procedures for MMCO or LDSS to address so-called "Factual Inaccuracies"	
27 88-89	505.14(b)(2)(iii)(a)(1) –(2) **505.28(d)(3)(i)-(ii)**	(1) If the social services district or MMCO identifies a factual inaccuracy recorded in the independent assessment, the social services district or MMCO shall advise the independent assessor. (2) If the independent assessor, in consultation with the social services district or MMCO determines that the information is incorrect, the independent assessor shall promptly issue a correction to the assessment.	We adamantly oppose these two paragraphs and urge that they be removed. First, these sections undermine the entire concept of independence of the independent assessment as required by the amended Social Services Law, which states that DOH "shall establish an independent assessor … **to take over from** local departments of social services, Medicaid Managed Care providers, and Medicaid managed long term care plans performance of assessments and reassessments required for determining individuals' needs…" Soc. Serv. L. § 365-a, Subd. 10 (emphasis added). This language stresses the independence of the assessment. For the regulation to require the so-called independent assessor to "promptly issue a correction" to the assessment when the LDSS or MMCO "identifies a factual inaccuracy" seriously undermines the independence of the assessment, and potentially violates the state law being implemented. Since the independent assessment is relied on by the independent medical assessment, the spectre of the LDSS or MMCO tampering with the independent assessor's findings potentially taints the entire process, again eviscerating any "independence" sought by the legislature in enacting these new requirements.

			Second, as written, this colloquy between the LDSS/MMCO and the independent assessor about any alleged factual inaccuracies could potentially be off the record, and not memorialized in the documents. This would violate the consumer's rights to obtain and review a copy of all assessments for an appeal or hearing. Worse, the final determination would be made based on assessments that have been altered and do not represent the actual findings of the so-called "independent assessor." Finally, one might question the basis for the LDSS/MMCO to identify any suspected factual inaccuracy when they are no longer conducting the assessments. If any version of these paragraphs remains, then it must require that all communications between the LDSS/MMCO and independent assessor be memorialized in writing, that the original assessment be retained in the record, with the so-called "corrected" assessment clearly marked as a separate "corrected" document, and both the original and corrected assessments and the communications from the LDSS/MMCO must be forwarded and considered by the other assessors (independent medical review, high-needs review), and must be provided in the record for any appeal or hearing. The consumer must be provided with both the original and corrected assessment and any communications upon request and as part of the evidence packet for any appeal or hearing.
		Review & Authorization Process by LDSS/MMCO In General	
27 89	505.14(b)(2)(iii)(b) **505.28(d)(3)(ii)** 505.14(b)(2)(iii)(b)(1)	Before authorizing or reauthorizing personal care services, a social services district or MMCO shall review the patient's independent assessment, and may directly evaluate the patient, to determine the following: 1) whether personal care services can be provided according to the patient's plan of care,	This section should also require LDSS or MMCO to review the independent physician's order. The proposal says that the DSS/MMCO "may" directly evaluate the patient. If this evaluation is permitted, the results of the evaluation must be written on a standardized state-prescribed form, with the name of the evaluator and the names of any individual from whom information must be obtained. This written evaluation must be made available to the consumer as part of any evidence packet provided in appeal. Also, we have concerns about timing. As stated above, yet another evaluation will delay the determination even further. If the whole idea of these external third party assessments was to enhance standardization, then the additional evaluation by the plan or LDSS defeats that purpose.

	505.28(d)(3)(ii)(a)	whether such services are medically necessary and whether the social services district or MMCO reasonably expects that such services can maintain the patient's health and safety in his or her home, as determined in accordance with DOH regulations.	1) At this point in the process no plan of care has yet been determined.. as written, the development of a plan of care happens later… so this clause does not make sense here. See section on page 13 above on health and safety determination.
	505.14(b)(2)(iii)(b)(2) **505.28(d)(3)(ii)(a)**	(2) **NEW** the frequency with which nursing supervision would be required to support services if authorized;	2) It is not clear what this means. How is frequency of nursing supervision to be taken into account by the LDSS/MMCO? For dual eligibles, the regulation should require MMCO's -- and LDSS as well -- to arrange for Medicare-covered nursing services for skilled nursing tasks or supervision. This is especially true for MLTC plans that are responsible for coordinating services not offered by the plan. Is the regulation suggesting there is so limit to the amount of nursing supervision or tasks that is available? For managed care plans, which also include nursing services – both part-time or intermittent and full-time private duty nursing – this is a separate service, the medical necessity for which should be determined independently. The need for nursing should not impact the determination of need for PCS or CPDPAP. For CDPAP, DOH policy has long been that nursing supervision is not required (Consumer Directed Personal Assistance Program: Clarification of 06 OMM/LCM-1, "Questions and Answers Related to Administration of the CDPAP" GIS 08-LTC-005), but that a CDPAP consumer may also receive CHHA services, which would include intermittent nursing. 06_DOH OMM_lcm-2.pdf
		CONSIDERATION OF "MORE COST-EFFECTIVE" SERVICES that CONSUMER "MUST USE"	
31 **91**	505.14(b)(2)(iii)(c) **505.28(d)(3)(iii)**	*In general – for both PCS & CDPAP reg requires:* (c) IIf a social services district or MMCO determines that a patient can be served appropriately and more cost-effectively through the provision of services described in subclauses (b)(3) through (b)(11) of this subparagraph, and the social services district or MMCO determines that such services are available in the district, the social services district or MMCO must first	**Person-Centered Planning requirements for MMCO's conflict with required use of alternate services instead of personal care or CDPAP.** The regulation requires the LDSS or MMCO to consider whether a long list of alternative services could meet the consumer's needs effectively and more cost-effectively. This requirement has long been in the regulation, but pre-dates the era of managed care, with the duty of both MLTC and mainstream plans to do **person-centered planning** regarding long-term services and supports [LTSS]. The federal Medicaid managed care regulations, which for the first time set standards for plans providing LTSS, cross-reference to HCBS regulations to define person-centered

		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.	planning requirements in managed care. The person-centered care planning process places more emphasis on the consumer's preferences; in fact it must be led by the consumer, and their "representative should have a participatory role, as needed and as defined by the individual...The person-centered service plan [PCSP] must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports." 42 CFR § 441.301(c)(1) and (2), incorporated by cross reference from § 438.208(c)(3)(ii). **The last sentence in** 505.14(b)(2)(iii)(c) and **505.28(d)(3)(iii) stating the patient MUST use alternate services rather than PCS/CDPAP conflicts with the PCSP mandates and must be deleted for MMCO cases.**
28 28 **89**	505.14(b)(2)(iii)(b)(3) 505.14(b)(2)(iii)(b)(4) **505.28(d)(3)(ii)(c)**	**SPECIFIC ALTERNATE SERVICES** LDSS or MMCO must consider whether the patient can be served appropriately and more cost-effectively by: (iii)(3) whether the patient can be served appropriately and more cost-effectively by personal care services provided under **CDPAP** (iii)(4) 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** ... [under] section 505.33;	(3) **CDPAP services are optional**. SSL 365-f refers to "eligible individuals who **elect** to participate in the program...." (emphasis added). Given the responsibility that the consumer must agree to accept in order to participate in CDPAP, this program must be optional whether the care is administered by the LDSS or MMCO. While consumers should be advised of the availability of CDPAP and the option to enroll, this service must not be substituted for personal care regardless of cost-effectiveness unless agreed to by the consumer. MLTC plans that have inadequate networks of PCS aides often pressure consumers to accept CDPAP services. This paragraph should be deleted to prevent such unlawful plan behavior. (4) **PERS -**Given the new minimum ADL requirements for PCS and CDPAP, no one will ever receive PCS "solely for monitoring the medical condition and well-being." Therefore this paragraph should be deleted.

29 90	505.14(b)(2)(iii)(b)(7) **505.28(d)(3)(ii)(d)**	(iii)(7) assisted living or enriched housing program;	(7) Where consumer enrolled in an MMCO plan, determining that the consumer should move out of their home into assisted living or enriched housing because it is more cost-effective would violate person-centered planning principles. Where administered by LDSS, such theoretical options should not be a basis for reducing or denying home care. Historically, when LDSS administered PCS/CDPAP prior to mandatory managed care, the LDSS would sometimes deny or discontinue PCS/CDPAP because some other service was theoretically available (CHHA, nursing, nursing home, etc.). Advocates challenged these determinations in part where there was no evidence that the service or placement was actually immediately available. Even where the individual agrees to the change, services should be denied or discontinued unless immediate admission is secured.
30 **90**	505.14(b)(2)(iii)(b)(8) **505.28(d)(3)(ii)(e)**	(iii)(8) adaptive equipment or supplies such as bedside commode, walkers, insulin pens.	(8) While use of such equipment has always been considered, where MMCO is managing care, whether to use equipment or supplies must be the consumer's option, with their preferences elicited in the person-centered planning process. A plan may not decide unilaterally that the consumer could use a bedside commode – or incontinent pads -- at night instead of providing an aide to assist to and from the bathroom. Aside from the medical contraindication of using incontinent pads all night, if the consumer prefers to go to the bathroom at night, this preference must be considered in person-centered care planning.
30 **90**	505.14(b)(2)(iii)(b)(9) **505.28(d)(3)(ii)(f)**	(iii)(9) whether personal care services can be provided appropriately and more cost-effectively by …Adult day health or social adult day care	(9) In managed care, it must be the consumer's choice to attend either of these programs, with preference elicited in person-centered care planning process. Fee for service Medicaid does not cover social adult day care so that is not an option for those not enrolled in managed care.
30 **90**	505.14(b)(2)(iii)(b)(10) **505.28(d)(3)(ii)(g)**	(iii)(10) whether the patient's needs can by met through the provision of formal services provided or funded by an entity, agency or program other than the medical assistance program; and	(10) It is unclear what these formal services are that are provided outside of Medicaid. If this refers to Medicare services, maximization of Medicare has always been required. If there is a specific service in mind, it should be described to avoid vagueness. If not, this should be deleted. As said above for assisted living, the alternate service must be actually available with approval secured – not just theoretically available, and in managed care must be the consumer's choice.

30 **91**	505.14(b)(2)(iii)(b)(11) **505.28(d)(3)(ii)(h)**	(iii)(11) whether the patient's needs can be met through the voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult, and whether such assistance is available [RECOMMENDED EDIT: ADD] and acceptable to the consumer.	(11) Consideration of the availability of **voluntary care** by informal caregivers, and the acceptability to the consumer, has always been part of the assessment. See comments for Independent Assessment, above, recommending that the assessor gather more specific information as to days and times of actual ability, availability and willingness of informal caregivers to assist. Note that federal person-centered service plan requirements expressly state that "natural supports" (the term used in the federal regulations) are voluntary. § 441.301(c)((2), cross-referenced from 438.208(b)(3).
33	505.14(b)(2)(iii)(d)	**AUTHORIZATION OF 24-HOUR CARE; REFERRAL TO HIGH-NEED CLINICAL REVIEW**	
33 **91**	505.14(b)(2)(iii)(d)	For cases involving live-in 24-hour personal care services the social services district or MMCO shall evaluate whether the patient's home has sleeping accommodations for a personal care aide.	The location of this paragraph doesn't make sense, as the LDSS/MMCO has not yet determined the plan of care at this point in the regulation. It should be moved later. Wherever it goes, see above recommendation that the Independent Assessment evaluate the home for sleeping accommodations, as this would make sense as part of the comprehensive nurse assessment. Also, this should be made independently of the plan or LDSS, to carry out the legislative intent to make the assessment process independent, removed from the LDSS or MMCO.
34 92	505.14(b)(2)(iii)(e) **505.28(d)(3)(v)(a)**	(iii)(e) For cases involving continuous personal care services or live-in 24-hour personal care services, the social services district or MMCO shall assess and document in the plan of care the following: (1) **whether the physician order indicated a** medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding; (2) the specific personal care functions with which the patient needs frequent assistance during a calendar day; (3) the frequency at which the patient needs assistance with these personal care functions during a calendar day;	As commented above in the PHYSICIAN ORDER section, for the LDSS or MMCO to review whether the physician order indicated all of the elements listed in the regulation, the physician order form must specifically elicit all of this information. At present the forms do not ask these questions, so it is unfair for an inference to be drawn that the consumer does not have certain needs at night if the form does not ask about such needs. Also since many of these needs are assessed and identified in the INDEPENDENT ASSESSMENT, which should also be adapted to specifically elicit the information listed in section 505.14(b)(2)(iii)(e).

		(4) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and (5) whether, were live-in 24-hour personal care services to be authorized, the 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.	
36 93 **94**	505.14(b)(2)(iii)(f) **505.28(d)(3)(vi)**	**Referral to High Need Review** (f) The social services district or MMCO shall refer high needs cases, as described in subparagraph (iv) of this paragraph, to the clinical review panel for an independent medical review before authorizing services. When a case is referred to the clinical review panel: (1) the social services district or MMCO shall provide the patient's plan of care and any documentation of the review or evaluation performed pursuant to this paragraph to the clinical review panel (2) the social services district or MMCO shall cooperate with the panel as appropriate to ensure an expedient review of each high needs case; and (3) the social services district or MMCO shall consider the recommendation from the clinical review panel when determining whether to authorize more than 12 hours of personal care services per day.	In addition to providing the Independent assessment, the Physician's Order, and the plan of care to the clinical review panel, the **consumer's treating physician's statement of need must also be given. The same form used as the Physician's Order form could be used** (with our added recommendations above). As stated above, federal regulations require consulting with the treating physician. **Consumer right to request High Need Review if LDSS/MMCO do not refer it for High-Need Review.** If the LDSS/MMCO determines that the consumer needs 12 or less hours, and proceeds to authorize services in 505.14(b)(4), notice of denial would be given to the consumer denying the requested hours exceeding 12 hours/day. Will a consumer who appeals that notice be precluded from winning a reversal of that denial and winning an authorization for > 12 hours/care because they did not have the Independent Medical Review of High Needs Cases? **If so, we propose that where the consumer or their physician has requested more than 12 hours/day, then the LDSS/MMCO must refer the case for the High Need Review**, even if the LDSS/MMCO would not have made the referral, and this review shall be considered by the LDSS/MMCO in its final authorization and service plan. Otherwise, the consumer's right to appeal the denial of > 12 hours/day services is obstructed and delayed.

37 94	505.14(b)(2)(iii)(g) **505.28(d)(3)(vii)**	(g) The social services district or MMCO is responsible for developing a plan of care [**CDPAP ONLY** <u>in collaboration with the individual or, if applicable, the individual's designated representative</u>,] that reflects the assessments and physician order described in this paragraph, identifies the personal care service functions with which the patient needs assistance, and includes at least any descriptions and documentation provided for in this section.	Development of the plan of care must occur before the case is referred to the Clinical Review Panel, since only cases where the plan of care is determined to require 12+ hours will be referred. So this par. (g) should be moved up in this section, either switched with (f) or moved up earlier. Also, the language "includes at least any descriptions and documentation provided for in this section" is not clear. We are glad to see the CDPAP reg specifies that the plan of care must be developed in collaboration with the consumer or their designated representative. The same language must be included in the PCS regulation, at least for MMCO's to comply with person-centered-planning requirements.
37 94		**Independent Medical Review of High Needs Cases**	
       95 96	**505.28(d)(4)(ii)** **505.28(d)(4)(iv)** **505.28(d)(4)(v)**	(b) The independent medical review must be performed by an independent panel of medical professionals, or other clinicians, employed by or under contract with an entity designated by DOH. (d) The lead physician must review the independent assessment, physician order, any other assessment or review conducted by the social services district or MMCO, including any plan of care created. (e) The lead physician may evaluate the individual, or review an evaluation performed by another medical professional on the clinical review panel. (f) The lead physician may consult with or interview other members of the clinical review panel, the ordering physician, the patient's treating or primary care physician, and other individuals that the lead physician deems	It is not clear what DOH envisions for this panel. How many medical professionals will be on a panel? The regulation describes a "panel of medical professionals or other clinicians." What other professionals would be included on the panel beside physicians? The language is vague and lacks any detail as to the composition of the panel. (d) That the lead physician must review "any plan of care created" implies that the LDSS/MMCO may not have created one yet. The case should not be referred to this panel without both (1) the LDSS/MMCO's plan of care AND the (2) consumer's requested plan of care. The panel decision as to whether the consumer's health and safety can be maintained at home must be based on each of these plans of care and specify which, if any, plan can maintain consumer's heath and safety.. (e) We are concerned about more delay with another evaluation by the lead physician or panel member. If they do an evaluation, whether in person or by telehealth/phone, any results must be recorded and available to the consumer in any record for appeal. (f) That the lead physician "may" consult with the patient's treating or primary care physician does not satisfy federal requirements for managed care plans particularly pertaining to LTSS. "The treatment or service plan must be: (i) Developed … with enrollee participation, **and in**

		necessary and who are available, and may request such additional information or documentation as the lead physician deems necessary to perform the review, including medical records of the patient that may be relevant to the clinical determination of whether the plan of care is reasonable and appropriate to maintain the patient's health and safety in his or her own home.	**consultation with any providers caring for the enrollee**…" 42 C.F.R. 438.210(c)(3)(i). As stated above, we strongly urge that the **consumer's treating physician be given an opportunity to provide a statement for review in all of these assessments, including the** high-need medical review panel. See our suggestion above for using the same form proposed for the Immediate Need procedure**.**
96	**505.28(d)(4)(vii)**	(g) The results of the independent medical review shall be signed by the lead physician and shall provide a recommendation on the reasonableness and appropriateness of the plan of care to maintain the patient's health and safety in his or her own home, in accordance with the standards and scope of services set forth in subdivision (a) of this section, whether other Medicaid services may be appropriate, and the clinical rational [sic] for such recommendation. The recommendation must not recommend specific hours of services or an alternative plan of care.	**The prohibition on the independent medical review recommending specific hours of service or an alternative plan of care** does not make sense when the **entire purpose of this review is to determine whether the consumer needs more than 12 hours/day** on average, and if so, whether the proposed care plan reasonably maintains their health and safety. This prohibition on recommending hours presumably has its origins in the long-ago adopted amendment of this regulation 505.14 that banned the treating physician from recommending a specific number of hours in the physician's order. That ban was clearly intended to exclude the treating physician's opinion on the number of hours needed because it was considered biased. Here, the state is going to huge lengths and expense to hire an INDEPENDENT medical panel to review high need cases. There is no risk of bias for the consumer in these assessments; if anything, consumer advocates fear that these assessors will want to please their funder – the State – by not recommending high hours for high needs consumers. These recommendations must be able to agree or disagree with the proposed care plan by the LDSS/MMCO, and recommend whether a different care plan with a specified number of hours was necessary. For example, if the LDSS recommended 24-hour live in, and the independent panel determined that the aide could not get 5 hours of continuous sleep during an 8-hour period of sleep, , the panel must be able to recommend continuous 24-hour split shift care. Otherwise it is unclear what the purpose of this panel is. Also, if the review panel finds the proposed plan of care by the LDSS/MMCO would not maintain health and safety in the home, the

			panel must separately recommend whether the consumer's proposed plan of care would reasonably do so. The panel must be given BOTH plans of care – that proposed by the LDSS/MMCO and that proposed by the consumer.
		TIME FRAMES	
40-41 75 102	505.14(b)(1) 505.14(b)(3) 505.28(d) 505.28(e)(i)(7)	b)(1) The assessment process includes an independent assessment, a medical exam and physician order, an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required under paragraph (2) of this subdivision, a referral to a clinical review panel. When the social services district or MMCO receives a request for services, that social services district or MMCO shall refer the applicant for an independent assessment and physician order, provide assistance to the individual in making contact with the independent assessor designated by the Department of Health to begin the assessment process and, if needed, the MMCO shall refer the applicant to the social services district and the social services district shall begin to determine the applicant's financial eligibility for medical assistance services, including community based long term care services. (b)(3) (i) A social services district must make a determination and provide notice with reasonable promptness, not to exceed seven business days after receipt of both the independent assessment and physician order, or the clinical review panel recommendation if applicable, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding	A big concern for consumers is that this new expanded assessment procedure wlll delay authorization and initiation of services. The regulations require EIGHT steps to be performed before determination is made by the LDSS or MCO. A TIME LIMIT IS NEEDED in the regulation for each of these eight steps: 1. LDSS or MCO to <u>refer</u> the applicant for the independent assessment; 2. For the Independent assessment to be <u>scheduled</u> one the referral is made; 3. For the independent assessment to be <u>completed and filed</u> with the LDSS or MCO; 4. For the LDSS or MCO to <u>refer</u> the individual for a physician assessment and order – since the regulation 515.14(b)(2)(ii) requires the physician to review the independent assessment, this can only be done once that assessment is completed and filed with the LDSS or MCO. 5. For the physician to <u>schedule</u> the assessment; 6. For the physician to <u>complete and file</u> the physician orders with the LDSS or MCO. 7. In cases where the LDSS or MCO determines that 12 or more hours are needed, for the LDSS or MCO to <u>refer</u> the individual for the clinical review panel, and 8. For the clinical review panel to <u>complete and return</u> its recommendation. 9. LDSS must make a determination and provide notice within 7 business days after receipt of the assessments listed above. This is the ONLY time limit stated in the proposal..

		the amount or duration of services to be authorized, or as provided in paragraphs (6) and (7) of this subdivision.	Presumably, the time limits for steps 1-8 listed above -- for scheduling, conducting and returning the independent assessment, the physician's assessment, and the clinical review panel review -- will be included in the contracts between the outside assessor organization(s) and DOH. However**, the consumer has the right to timely referral , scheduling, and completion of these assessments, for which time limits must be specified in the regulations.** **LDSS time limit** – the only specified time limit is for the 9th step in the list above – for the LDSS to make a determination and provide notice within 7 business days after receipt of the independent assessment, physician order, and clinic review panel recommendation if applicable. This limit is meaningless if there are no time limits on referring the applicant for the other assessments and for the outside assessors to conduct and file the assessments. The proposal repeals the current 5-day limit for the LDSS to conduct the nursing assessment (505.14(b)(XX). An analogous time limit must be included for the series of 2-3 assessments. In New York City, the eligibility determination for personal care services must be completed within **30 days** of the request. The Stipulation of Settlement of Discontinuance in *Miller et al. v. Bernstein* (Supreme Ct. N. Y. Co. May 11, 1978) at paragraph 7(a) requires HRA to determine eligibility for personal care services (then known as "home attendant services) within 30 days of the request. (available at http://www.wnylc.com/health/download/1/). This stipulation contains no sunset clause and is still in effect. Time limit rest of state? The only way that the entire process could be completed anywhere near 30 days was if each of the Steps 1-8 in the list above had at most a 3-calendar day turn around time limit. That would span 24 days plus the 7 business days allotted for the LDSS determination after all assessments are received. This would total about 33 days. However, this timeline is unrealistic and the entire process will more likely run two – three months.

41 **102**	505.24(b)(3)(ii) 505.28(e)(i)(8)	(ii) Notwithstanding subparagraph (x) of this paragraph, an MMCO must provide notice to current enrollees within the timeframes provided in the contract between the Department of Health and the MMCO, or as otherwise required by Federal or state statute or regulation.	**TIME LIMITS FOR MMCO DETERMINATIONS.** The proposed regulation appropriately requires the MMCO to provide notice within the timeframes required by federal or state statute or regulations. Standard requests under federal regulations must be decided within 14 calendar days of receipt, with expedited requests decided in just 72 hours. Either time limit may be extended by up to 14 days, as explained below. Since there are 8 steps prior to the final plan determination (see list in box above), it is simply unrealistic for the plan to meet the federal time limits, even for standard appeals let alone expedited appeals. Even if the regulation provided that each of the eight steps listed in the row above must be done in two days, that totals 16 days before a determination is made – which already does not meet the federal time limits. The federal regulations at 42 C.F.R. §438.210(d) require MMCO's to determine: ● Standard requests for services within 14 calendar days of receipt of request, subject to up to 14-day extension, on notice to the consumer, if justified by the need for additional information and if the extension is in the Enrollee's interest. ● Expedited requests –must be decided within 72 hours from the request for service, if criteria are met, subject to the same maximum 14-calendar day extension described above for standard requests. The plan must provide notice if it finds the criteria for expediting the request are not met. ● If the plan does not issue a decision on a request for services within the timeframes specified in § 438.210(d) described above, this constitutes a denial and is thus an adverse action, which can be appealed just as a written decision can be appealed. 42 CF.R. 438.404(c)(5**).**

			New York Insurance Law adds additional requirements - ● A plan's "…utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within <u>three business days of receipt</u> of the necessary information." NY Insurance Law §4903(b)(1). ● If the request is for home health care services following an inpatient hospital admission, the insurer shall provide notice to the insured and provider "…within <u>one business day of receipt</u> of the necessary information except, … within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday." NY Insurance Law §4903(c)(1). For the State to set up a system that, by its design, prevents MCO's from meeting federal and state time limits for authorizing services, potentially violates these federal regulations as well as state Insurance Law. "Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs …in a timely manner." 42 C.F.R. §438.206(a). The specific time frames required by the regulations, of course, provide more detailed standards for timeliness.
41	**505.14(b)(4)**	**Authorization & Reauthorization Criteria & Notices**	
42 **100**	505.14(b)(4)(iv) 505.28(e)(2)	**MEDICAL NECESSITY DEFINITION** The social services district or MMCO may authorize only the hours or frequency of services that the patient actually requires to maintain his or her health and safety in the home. *Suggested edit to conform to the 2016 federal amendments to the managed care regulations*: The social services district or MMCO ~~may~~ <u>must</u> authorize ~~only~~ the hours or frequency of services	The proposed language is more limited than the broader definition of medical necessity in New York, which includes services that are "necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. Soc. Serv. L. § 365-2, subd. 2. Personal care services must be authorized as necessary to prevent a medical impairment from interfering with the person's capacity for normal activity. Thus the aide must be authorized to assist the consumer in participating in desired outside activities, or in engaging in daily activities in the way that the consumer prefers (helping the consumer shop rather than shopping for the consumer).

		that the consumer actually requires to maintain his or her health and safety in the home, that are necessary to prevent the consumer's medical impairment(s) from interfering with their capacity for normal activity, and to enable the consumer to access the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.	The Model MLTC contract definition of medical necessity has not been updated since CMS revised the managed care regulations in 2016. The regulations require the contract to specify what constitutes "medically necessary services'' in a manner that is no less restrictive than used in the state Medicaid program. The model contract partly meets this criterion because its definition of medical necessity incorporates the above language from SSL 365-2, subd. 2. But the 2016 federal regulations require that the contract also address the extent to which the MCO is responsible for covering services that address, in part: "... (C) The ability for an enrollee to attain, maintain, or regain functional capacity. (D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice." The MLTC Model contract fails to address the plan's responsibility to enable members to achieve these goals, but the State should take the opportunity in amending these longstanding regulations to bring the definition up to date with the 2016 federal requirements.
43 44	505.14(b)(4)(vii)(a) 505.14(b)(4)(vii)(c)(1)	**REASONS FOR DENIAL** (a) The social services district or MMCO 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 or MMCO reasonably expects that such services cannot maintain or continue to maintain the client's health and safety in his or her home.	This paragraph (b)(4)(vii)(a) should be deleted. This longstanding paragraph was written before federal court decision in *Mayer v. Wing*, which held in part that due process entitles consumers to additional protections when Medicaid personal care services are reduced than when they are denied. After that court decision was issued and a settlement was entered in the case, DOH amended a later part of this regulation to specify requirements when personal care services are *reduced*. This paragraph (vii)(a) confusingly discusses denial and discontinuance of services together, even though the standards for both actions are very different. Since the regulation later separately identifies the different requirements for when service are denied, and for when they are reduced or discontinued, this introductory paragraph should be deleted.

110 45 110 45 111 45 111	505.28(h)(4)(i)(e) 505.28(h)(4)(i)(f) 505.28(h)(4)(i)(h) compare 505.14(b)(4)(vii)(c)(1)(ix) 505.14.(b)(2)(i)(b)(3) 505.28(h)(4)(i)(i)	(vi) Adds as a reason for denial a technological development such as "the use of **telehealth** services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary." (vii) the client **resides in a facility** or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; (viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify; and Suggested edits: (ix) the client's need(s) can be met either without services or with the current level of services by fully utilizing any voluntary available **informal supports**, or other supports and services, that are documented in the plan of care and identified in the notice, and that are acceptable to the consumer.	We are skeptical that **telehealth** services could reduce the amount of personal care or CDPAP services that are medically necessary. The notice would have to specify exactly which ADLs or IADLs telehealth may reduce the need for, and at which times. At most, telehealth might be used for some nursing supervision or other nursing activities. As to assistive devices, services could only be denied if the consumer was totally independent with use of the assistive device. This grounds for denying services if the consumer resides in a facility must be eliminated, as it violates the ADA as interpreted by Olmstead. This must be clarified especially in light of the new exclusion of individuals who are "Long Term Nursing Home Stay" – in a facility for more than 3 months. If that status PRECLUDES authorization of PCS/CDPAP in order return to the community, this is obviously a potential violation of the ADA. As discussed above, where the services are managed by an MMCO, this ground is not permissible. The MMCO must engage in person-centered care planning and authorize services based on consumer's preference if they are in the benefit package and medically necessary (see above discussion of medical necessity). As stated above, the Independent Assessment assesses not only the availability of informal supports but also their acceptability to the consumer (505.14.(b)(2)(i)(b)(3). Any reliance on informal supports requires that their assistance be voluntary and acceptable to the consumer. These concepts must be stated in the regulation, as shown in the suggested edits. Federal person-centered service plan requirements expressly state that "natural supports" (the term used in the federal regulations) are voluntary. 42 C.F.R. § 441.301(c)(2), cross-referenced from 438.208(b)(3).
		REASONS FOR REDUCTIONS **Preserves existing language, with minor tweaks:** Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following: **Retains existing grounds for reductions (with slight tweak in (iv) but adds new grounds (vii-viii)**	

45 111	505.14(b)(4)(vii)(c)(2) 505.28(h)(4)(ii)	(i) the client's medical or mental condition or 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. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. 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; (ii) a mistake occurred in the previous personal care services authorization or reauthorization. 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; (iii) the client refused to cooperate in the required reassessment; (iv) see next row (v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and (vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify	
45 112	505.14(b)(4)(vii)(c)(2)(iv) 505.28(h)(4)(ii)(g)	(iv) the client's needs may be met, in whole or part, by a technological development, which the notice must identify, that renders certain services unnecessary or less time-consuming, including the use of telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary;	Notice must be required identifying how these technologies reduce the need for personal care or CDPAP services. **Recommended edit** uses the terminology suggested above – ADLs and IADLs. (iv) the client's needs may be met, in whole or part, by a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming, including the use of telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary. The notice must identify the specific activities of daily living or instrumental activities of daily living for which telehealth services or specifically identified and available assistive devices reduce the amount of services

			that are medically necessary, specify the days and times of day in which telehealth services are available, and state why the services should be reduced as a result of these services or devices.
		WE OPPOSE NEW PROPOSED GROUNDS FOR REDUCTIONS: We strongly oppose the proposed two new grounds for reducing personal care or CDPAP services. This regulation setting forth the criteria for reducing personal care services was promulgated as part of a settlement in *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), modified in part, unpublished Orders (May 20 and 21, 1996); Stipulation & Order of Discontinuance (Nov. 1, 1997). The federal court decision held that reductions in personal care services were arbitrary and capricious and violated due process where there was no medical improvement or other change in circumstances, and where the reduction notices did not explain the basis for the reductions. The proposed regulation appropriately leaves intact the grounds for reductions adopted pursuant to *Mayer* – requiring the LDSS to identify in the adverse notice and prove that a specific change occurred, or a mistake was made, as a result of which the consumer needs less services. 505.14(b)(4)(vii)(c)(2)(i)-(ii). The same limitations on reductions of personal care or CDPAP services cited in the regulation above were specifically applied to MLTC plans in DOH MLTC Policy 16.06, which was issued pursuant to a different lawsuit, *Caballero et al. vs. Senior Health Partners and Zucker, Comm'r. NYS Dept of Health* (E.D.N.Y. 16-ci-00326, Final Stipulation and Order of Settlement, DATE). Policy 16.06 further clarifies the criteria for reductions in the context of managed long term care. The new proposed paragraphs essentially nullify the limitations on reductions set forth in 505.14(b)(4)(vii)(c)(2)(i) – (ii), though it remains intact, and MLTC Policy 16.06. The federal court in Mayer found arbitrary reductions essentially the same as those proposed to violate due process.	
45 113	505.14(b)(4)(vii)(c)(2) 505.28(h)(4)(ii)(h)	**NEW GROUNDS FOR REDUCTIONS:** (vii) the client's need(s) can be met either without services or with a reduced level of services by fully utilizing any available informal supports, or other supports and services, that are documented in the plan of care and identified in the notice; and	**(vii) A change in availability of informal supports is** already a basis for a reduction under (c)(2)(i), as a change in social circumstances. The proposed language, would not require the LDSS/MMCO to identify a change in informal support availability unlike the existing language. This burden of proof on the LDSS/MMCO that an actual change occurred in availability is critical. As *Mayer* held, due process requires that the government agency allege and prove that a change occurred from when the services were originally authorized; otherwise a reduction is totally arbitrary and a violation of due process.

46-47 113	505.28(h)(4)(ii)(i)	(viii) an assessment of the client's needs demonstrates that the immediately preceding social services district or MMCO authorized more services than are medically necessary following any applicable continuity of care period required by the Department of Health.	Moreover, state fair hearing regulations have long assigned the burden of proof to the LDSS concerning discontinuance or reduction of all public benefits, including Medicaid. 18 N.Y.C.R.R. § 358-5.9(a). **(viii)** would allow an MMCO to reduce services after the continuity of care or "transition" period ends that followed the consumer's mandatory enrollment in the plan, *without the plan being required to identify and prove any specific change in the consumer's medical condition or social circumstances, or any specific mistake* in the prior authorization. The continuity of care period is a period of time following a consumer's mandatory enrollment in an MLTC/MCO, during which the MLTC/MCO must continue the previously authorized plan of care. The CMS Special Terms & Conditions [ST&C] of the 1115 waiver authorizing mandatory enrollment in MLTC provides: **MMMC or MLTC Enrollment and Transition of Care Period**. For initial transitions into MLTC or MMMC from fee-for-service, each enrollee receiving community-based LTSS must continue to receive services under the enrollee's preexisting service plan for at least 90 days after enrollment or until a care assessment has been completed. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR § 438.404 and applicable appeal rights.[2] The 90-day continuity of care or transition period follows mandatory enrollment into an MLTC plan after a consumer received fee for service personal care or CDPAP services authorized by the LDSS through the "immediate need" procedure or on any other basis. A 90-day period also is required after a consumer transitioned from a mainstream Medicaid MCO to an MLTC plan upon enrolling in Medicare. DOH MLTC Policy 15.02 - Transition of Medicaid Managed Care to MLTC.

[2] CMS Special Terms & Conditions, NYS Medicaid Redesign Team Section 1115(a) Medicaid Demonstration, CMS Approved: December 7, 2016 through March 31, 2021, Last Amended on December 19, 2019 § V. 4.g. p. 31, available at https://www.health.ny.gov/health_care/managed_care/appextension/docs/2020-04-16_ny_stc.pdf.

			A 120-day continuity of care transition period applies if a consumer was required to enroll in a new MLTC plan after their former MLTC plan closed; the new plan must continue the closing plan's plan of care for 120 days (DOH MLTC Policy 17.02, which was issued in response to a lawsuit, NAME, CITE). if the new plan reduces services after the continuity of care/transition period, the ST&C citation above make clear that this action is a reduction of previously authorized services, requiring notice that complies with federal regulations. *Mayer v Wing*, which is binding in New York?), challenged the legality of repeated attempts by NYC HRA to reduce personal care services of the same recipients. The Court stated, > At a minimum, due process requires that government officials refrain from acting in an irrational, arbitrary or capricious manner. *[cite omitted].* This is precisely the manner in which the City Defendant appears to have acted. The testimony of the named Plaintiffs ... indicates that the City Defendant has, without any adequate justification, repeatedly determined to reduce services initially authorized to home care recipients. The capricious nature of these decisions is evidenced by the fact that Plaintiffs received notices of reduction while in the same or worse physical condition they were in when home care was initially authorized, and were given no explanation for why they were assessed differently the second time around. 922 F. Supp. at 911. Here, the proposed regulation would permit Plan B to reduce hours to less than the amount authorized by Plan A simply because Plan B's assessment allegedly determined that fewer hours were medically necessary than the amount Plan A authorized. With no burden to identify and establish a change in the consumer's condition or circumstances since Plan A's authorization, consumers may well be "in the same or worse physical condition they were in when home care was initially authorized" by Plan A, yet be subject to threatened reduction of services, which the *Mayer* court found was unlawful.

47 113	505.14(b)(4)(vii)(c)(3) 505.28(h)(4)(iii)	**Adds new notice requirements for the new grounds for reductions:** **(**3) Social services districts and MMCOs that deny, reduce or discontinue services based on medical necessity must identify and document in the notice and in the client's plan of care the factors that demonstrate such services are no longer medically necessary. Any such denial or reduction in services must clearly indicate a clinical rationale that shows review of the client's specific clinical data and medical condition; the basis on which the client's needs do not meet specific benefit coverage criteria, if applicable; and be sufficient to enable judgment for possible appeal.	The proposed standard -- allowing Plan B to reduce services simply by asserting its own proprietary standard of "medical necessity," with no identification of a change since services were previously authorized in a higher amount, is essentially the same standard that the *Mayer* court rejected outright as inadequate for reducing services. Reviewing the former version of 505.14(b), the Court stated, "For example, services may be reduced or discontinued because a "reassessment indicates that personal care services are inappropriate or that the personal care services hours authorized must be reduced or discontinued." § 504.14(b)(3)(iv)(f)(2)." The Court cited this version of the regulation as giving excessive discretion to the LDSS. "The absence of standards governing the withdrawal or modification of services permits arbitrary decisionmaking." 922 F. Supp. at 27-28. **The proposed notice language in 505.14(b)(4)(vii)(c)(3) does not remedy this deficiency and due process violation**. It requires no meaningful standard for a plan to justify reducing services other than its own characterization of what is medically necessary and that "the client's needs do not meet specific benefit coverage criteria," which again is meaningless. The proposed paragraph 505.14(b)(4)(vii (c)(2)(viii) together with par. (c)(3) allows plans to engage in the same arbitrary decisionmaking that the *Mayer* Court found violated due process. The regulation will no doubt be challenged as a violating the due process rights of consumers established under *Mayer*.
49 **102**	505.14(b)(4)(xi) **505.28(f)(1)**	**REAUTHORIZATIONS** 1. The proposed regulation should make it more clear that the reauthorization process will be conducted annually, rather than every six months, pursuant to the 2020 budget amendments. Public Health Law §4403-f, subd. 7(g)(iv). The regulation as proposed specifically says the Physician's Order is required only annually (absent an unexpected change), but is vague about the Independent Assessment. (b)(4)(xi)(b)-(c). 2. The proposed regular reauthorization process includes the Independent Assessment by the nurse, and the Independent Medical Exam. If those two assessments "indicate that the patient's mental status and medical condition is unchanged and the authorization is unchanged," then the "independent medical review by the clinical review panel" is not required. (b)(4)(xi)(b)-(c). The phrase "and the authorization is unchanged" should be deleted from the sentence quoted immediately	

		above. If these two assessments indicate no change in condition, then the authorization should not be changed. Neither the Independent assessor nor the Medical Examiner authorize services, so this phrase makes no sense. The section should read: (b) Reauthorization of Level II services shall not require an independent medical review by the clinical review panel if the independent assessment and physician order indicate that the consumer's ~~patient~~'s mental status and medical condition is unchanged ~~and the authorization is unchanged~~." [change of "patient" to "consumer" discussed in TERMINOLOGY section above). 3. There may be a typo in the 505.14(b)(4)(xi)(b), that requires a new physician order annually unless a new physician order is clinically indicated by the independent assessor or as provided in subparagraph **(xiii)** of this paragraph. Should the referenced subpar. be (xii), which as renumbered in the proposal describes the procedures for unexpected changes. This would be parallel to the corollary CDPAP paragraph, which cross-references the section on unexpected changes.
50 **104**	505.14(b)(4)(xii) **505.28(f)(2)**	**UNEXPECTED CHANGES** This section essentially maintains the existing process for assessing reported changes in the consumer's social circumstances, mental status or medical condition and making changes in the plan of care. As before, a new Independent Medical Exam is not needed for a change solely in social circumstances, but the medical exam along with a new Independent Assessment by a nurse is required for a change in mental status or medical condition. While not making major changes in the existing scheme, we have several concerns. 1. The proposed regulation does not take into account the deadlines imposed by federal regulations for MMCO's to process requests for services based on unexpected changes, which in many cases will require expedited processing. (See TIMING section above at pp. 21-23 for citations – expedited authorizations must be made within 72 hours of the request). These time limits must be incorporated in the regulation. As stated above, if the Independent Assessment and Medical Assessment are to be required, then tight deadlines are needed for scheduling, conducting and submitting these assessments to the LDSS/MMCO. 2. For a change in **social circumstances**, the proposed regulation requires the MMCO/LDSS to review the Independent Assessment, but not necessarily schedule a new one. We do not believe a new one should necessarily be required ***if*** the Independent Assessment includes all of the necessary specific information about the availability, willingness and ability of informal caregivers that is recommended above, p. 8., detailing exactly what tasks and at what scheduled times each informal caregiver can and will provide care. That information is essential for the LDSS/MMCO to adjust the plan of care to fill in the gap resulting from "loss or withdrawal of support provided by informal caregivers." 505.14(b)(4)(xii)(a). Too often, we have had clients left at risk when a caregiver daughter requires surgery or is unavailable for another reason,

		and the plan fails to authorize additional home care because the assessments failed to document exactly what days and times the daughter is scheduled to provide care. **3.** Time limits must also be specified for assessments by the LDSS, though the federal Part 438 regulations do not apply. 4. The change in **mental circumstances** section adds a new clause requiring the LDSS/MMCO, in addition to obtaining a new independent assessment and physician order, "review the appropriateness and cost-effectiveness of services." We question why this clause is needed. If there is a change that renders the consumer ineligible for services, such as if "the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice," these are already grounds for discontinuing services under the regulations. 505.14(b)(4)(vii)(c)(2)(i)(See p. 25 above). Adding a review of cost-effectiveness solely because a change in mental circumstances potentially constitutes discrimination based on diagnosis. 5. Language should be added requiring any changes to be made with written notice to the consumer that complies with other sections on notice discussed above.	
51-58 115	505.14(b)(6) 505.28(k) 505.14(b)(6)(i)(a)(2)(i)	**IMMEDIATE NEED** The proposed immediate need procedure requires all of the same assessments required for the proposed regular procedure to apply for PCS/CDPAP through the LDSS. The applicant is referred for the Independent Assessment and Medical exam, and then their needs are assessed through paragraphs (2)(i) through (2)(iv) – which is the entire process, including the new high-need medical review. This whole process plus approval of the Medicaid application, if not yet approved, is required by state statute to be completed within 12 days. Even before these new assessments are added, many LDSS do not meet the short 12-day deadline. We commend HRA for making a real effort to do so, and noticeably expediting the time frame, but even with that effort the 12-day deadline is often not met. The Department must omit one or more of these assessments in order to meet the statutory time limits. Since the proposed regulation requires the applicant to submit a new "physician statement of need" on a new state form to be created, we propose that the Independent medical exam be dispensed with for this expedited procedure. Additionally, the extra high-need medical review should be eliminated in this process.	
		CDPAP – sections unique to the CDPAP regulation not in the PCS regulation.	
69	505.28(k)	..a CDPA assistant may include any other adult relative of the consumer <u>provided that the district or MMCO determines that the services provided by such relative are consistent with the</u>	It is unclear what the intent of this provision is. Whether the assistant is an adult relative or other unrelated person, the service plan is based on medical necessity. If this language is intended to deny overtime pay to an adult relative, then it still doesn't make sense.

		consumer's plan of care and that the aggregate cost for such services does not exceed the aggregate costs for equivalent services provided by a non-relative personal assistant	
98	505.28(e)(1)(v)	The social service district or MMCO shall not authorize services provided through more than one fiscal intermediary per consumer.	**????**
	505.28(g)	**Consumer & Designated Rep Responsibilities** (g)(2) the designated representative must make themselves available to ensure that the consumer responsibilities are carried out without delay. In addition, designated representatives for nonself-directing consumers must make themselves available and be present for any scheduled assessment or visit by the independent assessor, examining medical professional, social services district staff or MMCO staff. (g)(3) A consumer, or if applicable the consumer's designated representative, may not work with more than one fiscal intermediary at a time.	(g)(2) We recommend these changes: The designated representative for non-self-directing consumers must have the option of participating in any scheduled assistant by telephone, telehealth, or video call, instead of being physically present. Also all assessments must be scheduled in advance with accommodation of the schedule of the consumer and the designated representative. ???
	505.28(i)	**FI Responsibilities**	**??**