NYLAG
New York Legal Assistance Group

September 9, 2020

New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
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Attention: Katherine Ceroalo

by email to regsqna@health.ny.gov

RE: Amendment of Sec. 505.14 & 505.28 of Title XVIII to Personal Care and CDPAP regulations, published July 15, 2020 (ID HLT-28-20-00019-P)

Dear Counsel:

NYLAG submits these comments on the proposed regulations implementing the statutory amendment to the Social Services Law provisions for personal care services (PCS) and consumer-directed personal assistance program services (CDPAP) enacted in the State Fiscal Year 2020-21 Enacted Budget.[1]

Regarding the regulatory impact, we are skeptical that these new layers of assessments will result in "minimal costs" to the State and do not impose costs or burden on local government. The Department has failed to disclose or even acknowledge the increased costs in expanding Maximus' contract to perform these multiple assessments, as required by NY SAPA §202-A, subd. 3(c). For the reasons stated below, we strongly doubt that "this proposal will better facilitate access to PCS and CDPAS for people with disabilities" as claimed. NYS Register Vol XLII, Issue 28, July 15, 2020, p. 18. On the contrary, delays are likely with the added bureaucracy, violating consumer rights, and the extra scrutiny of high-need consumers to determine whether they are "safe" at home evokes the kind of assumptions that underlie the use of "safety" as a pretext to deny community services, violating the Americans with Disabilities Act.

The following comments are meant to apply to both the PCS and CDPAP regulations to the extent that the proposed changes are substantially the same for both. Please note that the order in which the issues are listed should not be interpreted as meaning the ones listed at the end are less important. The order roughly tracks the order in the proposed regulation.

[1] The comments herein are sent on behalf of NYLAG as an organization. We note that NYLAG has also joined Cardozo Bet Tzedek Legal Services and JASA/Queens Legal Services for the Elderly on a separate set of comments primarily addressing concerns regarding the impact of the proposed regulations on the constitutional and statutory due process rights established by previous lawsuits brought by the signatories to the letter. These comments address the proposed regulations more broadly.

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The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services and financial counseling, and engages in policy advocacy efforts, including health access advocacy. to help people experiencing poverty.

1. The Minimum Two or Three ADL Limit Unlawfully Denies Services Based on Diagnosis, Violating Medicaid Regulations and the Community First Choice Option (CFCO) That Requires States to Provide Cueing and Supervision as well as Hands-On Assistance.

The recently amended law, Soc. Serv. Law §§ 365-a(2)(e)(v) and 365-f, subd. 2(c), and proposed regulation requiring a minimum of two or three Activities of Daily Living (ADL's) for eligibility for PCS and CDPAP violate federal regulations banning discrimination based on diagnosis and requirements for the Community First Choice Option (CFCO) that New York has implemented in the local districts and is scheduled to implement in the managed care and MLTC plans. The Department of Health has discretion to implement the law – and indeed must implement it-- in a way that avoids such illegalities.

We recommend first that the list of ADLs be amended to include transfer and administration of medication. Second, to minimize discrimination based on diagnosis and to comply with CFCO requirements to provide cueing and supervision -- not only hands-on assistance with ADLs and IADLs --we propose amending the list of who qualifies based on the need for supervision with ADLs or IADLs. Additionally, an individual who fails the ADL test must be evaluated for CFCO services through the level of care determination, and if eligible, must be authorized for PCS or CDPAP notwithstanding failing the ADL test. Third, the proposed language intended to clarify that "supervision" is not a stand-alone task is confusing and weakens longstanding guidance. Fourth, the rule of who is "grandfathered" in and not subject to the ADL thresholds must be clarified.

A. The Definition of ADL Must Include Transfer for purposes other than Toileting and Medication Administration

The proposed definition of "ADL" includes "transfer" only as part of the ADL of toilet use, and omits assistance with medication administration.[2] 505.14(a)(9) and 505.28(b)(1**).** By listing as one ADL "transferring on to and off the toilet and toilet use," the proposed language omits transfer from or to bed or chair as an ADL. Some consumers who require assistance with transfer to and from bed or chair may use a catheter, so do 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. "Transfer" must be listed as a separate ADL to ensure they are not wrongly denied services.

Also, other than transfer on and off the toilet, the ADL of toileting is described solely as "toilet use." It should include all assistance with use of toilet, bedpan, urinal or commode,

[2] The proposed regulation defines "ADL" as a new term. 505.14(a)(9), 505.28(b)(1). We suggest instead updating terminology in the existing regulation by replacing the term "personal care functions" with ADL, and the term "nutritional and environmental support functions" with "IADL." This would align the regulations with federal CFCO and Medicaid regulations, the NYS DOH CFCO ADM, and other guidance. It would also reduce confusion since "personal care functions" are ADLs. This would require amending the list of activities now listed as "personal care functions." See suggested edit in chart p. 1. Whether ADL is defined as a new term or replaces the term "personal care functions," it must include transfer, expand toileting to include incontinence care, and include medication administration.

including adjusting clothes, post-elimination hygiene, and incontinence care, including management of ostomy or catheter.

Finally, medication administration is an essential ADL. Some individuals need cueing and supervision to take medication from a pre-poured medication box. Others need an aide to bring them the pre-poured medication– whether a pill or injection from the refrigerator -- and a glass of water for them to self-administer.

B. The Definition of Who Must Have Two or Three ADLs to Qualify for Services Must be Amended to Prevent Denial of Eligibility based on Diagnosis and to Comply with CFCO Requirements.

i. Improper Denial of Services Based on Diagnosis.

People with vision impairments, traumatic brain injury (TBI), developmental disability (DD), and other cognitive, neurological or psychiatric impairments may need supervision with two or more ADLs, but not physical maneuvering with three or more ADLs. Denying them PCS or CDPAP solely because they are not diagnosed with dementia or Alzheimer's disease denies eligibility solely based on diagnosis in violation of federal Medicaid regulations. See 42 C.F.R. §440.230(c). ("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").

Additionally, the denial of PCS/CDPAP for those who otherwise meet the level of care requirements for CFCO services violates the CFCO regulations, which prohibit discrimination based on diagnosis. "States must provide Community First Choice to individuals …[i]n a manner that provides such services and supports … *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 (emph. added). Since NYS is claiming an enhanced federal match for CDPAP and PCS recipients found eligible for CFCO, and plans to expand this service to managed care and MLTC, the state may not deny eligibility because of lacking a particular diagnosis or the threshold number of ADLs.

RECOMMENDATION: Instead of requiring specific diagnoses to qualify for services based on needing supervision with two or more ADLs, any person who, because of an impairment(s) need supervision with more than one ADLs should qualify. Alternately, the list of diagnoses should be amended to include all of those in the first sentence of the preceding paragraph. 505.14(a)(3)(iv)(a) (pp. 12, 68, 72)[3]

ii. CFCO Requires Count Need for Assistance with IADLs as well as ADLs

In addition to prohibiting discrimination based on the type of disability, CFCO requires states to provide ADL and IADL assistance to a CFCO-eligible individual not only through hands-on assistance but also through supervision and cueing. An individual qualifies for CFCO if, without home care services, she would require an institutional

[3] Page number references after cites to proposed regulation are to proposed regulation posted at https://regs.health.ny.gov/sites/default/files/proposed-regulations/Personal Care Services and Consumer Directed Personal Assistance Program.pdf

"level of care" – whether in a nursing home, psychiatric hospital, or Intermediate Care Facility for Developmental Disabilities (ICF-DD). It is very possible that an individual with a developmental, neurological, or psychiatric disability, TBI or other cognitive impairment, would in the absence of PCS or CDPAP services require an institutional level of care. If an individual meets the CFCO level of care criteria, "…the State must provide …[a]ssistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing." 42 C.F.R. § 441.520(a). In the CFCO Technical Guide, CMS clarified, "CMS reminds states that all three ways of delivering assistance with ADLs, IADLs and health related tasks must be made available. States may not limit the scope of this benefit to offer less than all three." [4] The proposed regulation would violate this requirement by denying PCS or CDPAP to an individual who needs supervision and cueing with, for example, one ADL and three IADLs, even though meeting the level of care criteria for CFCO.

RECOMMENDATION: We also propose allowing one of the two tasks for which supervision is needed to be an IADL rather than an ADL. The inability to independently perform IADLs is a risk factor for falls and other accidents which can lead to unnecessary hospitalization and institutionalization. A suggested edit is:

> a) for ~~patients~~ consumers ~~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 one activity of daily living and with one additional activity of daily living or instrumental activity of daily living, as a result of an impairment(s) diagnosed by a physician.

The proposed edit of 505.14(a)(3)(iv)(b) would allow two of the three minimum tasks for which physical assistance is needed to be an IADL rather than an ADL. "Extensive assistance" of an IADL is defined in the UAS Manual as, "Help required throughout task, but performs 50% or more of task on own." P. 27. If the individual needs help throughout the IADL, they cannot perform it without assistance. The proposed edit is:

> (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~~ one activity ~~activities~~ of daily living and needing assistance with two other activities, which may be any combination of extensive assistance with an instrumental activity of daily living and/or limited assistance with an activity of daily living.

iii. Must Assess for Institutional Level of Care and Authorize Personal Care Services if Meet Level of Care even if Do Not Meet New ADL Threshold

Third, if the State wishes to draw down the enhanced match for CFCO, for any applicant who is determined not to need the new minimum ADL requirements, the LDSS or Maximus must still assess to determine if the individual would, without home care services, need an institutional level of care -- whether in a hospital, nursing home, psychiatric hospital, or ICF-DD. The CFCO requirements require such individuals to

[4] CMS, Community First Choice State Plan Option Technical Guide, available at https://www.medicaid.gov/sites/default/files/2019-12/cfc-technical-guide_0.pdf.

receive "…[a]ssistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing, … and …[a]cquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks." 42 C.F.R. § 441.520(a). This level of care assessment must specifically assess not only for nursing home level of care but for ICF-DD or psychiatric hospital level of care as well. If an individual has that level of care, but does not meet the ADL test, they must nevertheless be authorized for PCS/CDPAP through CFCO – whether accessed through the LDSS or a managed care plan.

C. The Requirement that Supervision or Cueing Assistance be Authorized for Safe Performance of ADLs or IADLs, but not for "Stand-Alone" Safety Monitoring, Should Conform to Longstanding Guidance to Avoid Wrongful Denial of Services.

A proposed new paragraph apparently attempts to codify longstanding State that requires authorization of personal care or CDPAP services for those who, because of cognitive, psychiatric, visual and other impairments, need cueing and supervision for safe performance of ADLs and IADLs. However, the new paragraph is not as clear as the previous guidance and creates more confusion; it can be interpreted to improperly deny authorization for services. The proposed regulation states in part,

> …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 nutritional and environmental support functions or personal care functions.

505.14(a)(5)(iii) (p. 13).

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). In 2003, when that decision was improperly misinterpreted to ban personal care aides from assisting a consumer to safely perform ADLs, 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 .[5]

[5] CMS has reinforced that a cognitively impaired individual "…may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly." CMS State Medicaid Manual §4480, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.

In 2011 and 2016, DOH reiterated that the same policy applies to mainstream managed care plans[6] and to MLTC plans in DOH MLTC Policy 16.07:

> "…When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. …
>
> *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, the 2011 managed care guidelines (n 5) or MLTC Policy 16.07. The second sentence of proposed 505.14(a)(5)(iii) quoted above could be interpreted to improperly deny authorization of personal care or CDPAP services to provide supervision or cueing assistance for safe performance of ADLs or IADLs. We recommend using the clearer language from the longstanding guidance cited above.

Recommended Edit of Proposed Language:

> 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.~~ <u>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, walking, or other ADLs or IADLs to assure the task is being safely completed</u>.

Also see recommendation herein to change "nutritional and environmental support functions" to "Instrumental Activities of Daily Living" and "personal care functions" to "Activities of Daily Living."

D. To Protect Current Enrollees, Definitions of Who is "Grandfathered" under the Former Eligibility Requirements Must be Clarified and Aligned

The State Fiscal Year 2020-21 Enacted Budget adding the new minimum ADL requirements for eligibility for MLTC enrollment and PCS/CDPAP services contains three different grandfather clauses protecting current enrollees. These definitions must be aligned, using the least restrictive definition, which is the one for CDPAP, to minimize confusion and fully protect enrollees. This would grandfather in anyone who initially sought eligibility for (applied for) PCS, CDPAP or MLTC before Oct. 1, 2020.

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[6] NYS DOH, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care, posted at https://www.health.ny.gov/health_care/medicaid/redesign/final_personal_care_guidelines.htm.

The statutory amendments for PCS, CDPAP, and MLTC enrollment use slightly different language to describe to whom the new minimum ADL requirements apply. For personal care, the law states, "The provisions of this subparagraph shall only apply to individuals who receive an initial authorization for such services on or after October 1, 2020."[7] The corollary section applied to CDPAP states, "…the provisions related to activities of daily living in this paragraph shall only apply to persons who initially seek eligibility for the program on or after October 1, 2020."[8] For MLTC enrollment, the new ADL requirements "…shall not apply to a person who has been continuously enrolled in a MLTC program beginning prior to October 1, 2020." [9]

The MLTC grandfathering standard is stricter than the standards for grandfathering PCS and CDPAP consumers, and must align with the PCS/CDPAP standards to avoid violation of federal regulation requiring managed care plans to make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a) (4)(i). For MLTC, the individual must have been continuously enrolled in the MLTC program prior to Oct. 1, 2020. However, an individual may enroll in MLTC on December 1, 2020, after receiving PCS or CDPAP under the "immediate need" program for 120 days or from a mainstream managed care plan. That individual could be denied MLTC enrollment under the new ADL requirements even though they are grandfathered in under the PCS and CDPAP amendments because they either initially applied for CDPAP before Oct. 1, 2020 or were initially authorized for PCS before that date. See n 6-8. If such grandfathered individuals may receive PCS or CDPAP through the LDSS, denial of MLTC enrollment may not be harmful. But this would require cumbersome new procedures to exempt such individuals from mandatory MLTC enrollment. For those new dual eligibles transitioning from mainstream managed care plans, new procedures would be needed for their PCS/CDPAP services to seamlessly transition to LDSS without disruption. It would be much simpler to align the grandfathering standard for MLTC with the one for CDPAP.

Also, as the proposed waiver amendment is written, individuals whose MLTC enrollment was temporarily interrupted prior to Oct. 1, 2020 would potentially lose their grand-fathered status and be subject to the new criteria. NYLAG commonly troubleshoots cases where a bureaucratic error by NYC HRA in processing an annual Medicaid renewal, or other problems in the renewal process such as mailing delays, leads to discontinuance of Medicaid and then disenrollment from the MLTC plan. Some of these cases require the consumer to re-enroll after a gap in enrollment. Also, on August 1, 2020, the State carried out a mass disenrollment from MLTC plans of over 15,000 members who had been in a nursing home for three months or more. NYLAG has at least one client who was mistakenly disenrolled. When any of these individuals try to re-enroll in an MLTC plan in order to be discharged home, or after a gap in enrollment caused by a renewal snafu, they would not be grandfathered into the former criteria because they were not "continuously

[7] Soc. Serv. Law §365-a, subd. 2(e)(v)(eff. Oct. 1, 2020), as amended, L. 2020, Ch. 56 §2-a.
[8] Soc. Serv. Law §365-f, subd. 2(c)(eff. Oct. 1, 2020), as amended, L. 2020, Ch. 56 §3.
[9] Public Health Law §4403-f subd. 7 (b)(v)(14), added by L. 2020, Ch. 56 §18.

enrolled" prior to Oct. 1, 2020. Yet they remain eligible for PCS/CDPAP because they initially applied for or were authorized for PCS or CDPAP services prior to Oct. 1, 2020.

2. By Failing to Require a Managed Care Plan to Consult with the Treating Provider in Assessing a Request for PCS or CDPAP, the Proposed Scheme Violates the Federal Medicaid Managed Care Regulations

Federal regulations require personal care services to be authorized based on a physician's order in accordance with a plan of treatment. 42 C.F.R. §440.167. The amended state law changes the physician that orders the services from the consumer's treating physician to a physician under contract with the State. Even if the state is not barred from enlisting an "independent" physician to examine the consumer and assess her needs, the plan must still consult with the treating physician, and where the treating physician has requested the services, issue a decision within the time limits set by federal managed care regulations. For these reasons, the regulations must provide an opportunity for the consumer's physician to submit information regarding the consumer's medical diagnoses, functional impairments, and service needs. Not only is this required by federal regulations for managed care plans, this information is needed for the Independent Assessment for both FFS and plan decisions. 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 is proposed in the regulations for Immediate Need applications.** 505.14(b)6)(i)(a)(2)(i) (p. 52).

While the proposed 505.14(b)(1) does not bar a treating physician from requesting services for a managed care enrollee, it states that the independent medical professional *may* – not *must* -- review other medical records and consult with the patient's providers and others involved with the patient's care. 505.14(b)(2)(ii)(e), 505.28(d)(2)(v) (pp. 25, 79). Federal managed care regulations, however, require consultation with the "providers caring for the enrollee" in developing the treatment or service plan. 42 C.F.R. 438.208(c)(3)(i). Further, "[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. Id. §§ 438.210(c) and (d) (Emph. added). Additionally, the federal regulation contains specific requirements for plans providing Long Term Services and Supports (LTSS), which include personal care and CDPAP services: "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)(emph. added).

The proposed regulation also fails to require plans to defer to the treating provider's judgment that emergency circumstances warrant an expedited determination, contrary to the federal regulation, which provides: "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).

For all of these reasons, the consumer must be given the opportunity for their treating physician to submit a statement and additional medical records. We recommend 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 regulations propose for Immediate Need applications**,** which must be considered in each assessment. 505.14(b)6)(i)(a)(2)(i) (pp. 52, 57).

3. Clarification is Needed as to How the New Assessments will Change Conflict-Free Assessment and MLTC Enrollment Procedures – without Delaying Enrollment

Though the regulations now incorporate MMCO's, they are silent on how the new assessments and new minimum ADL requirement for eligibility impact MLTC enrollment. NYLAG is concerned about more delays in MLTC enrollment.

In the Medicaid Matters NY call on Sept. 8, 2020, we suggested that if the Independent Assessment functions as the Conflict-Free Assessment ["CFEEC"], with the assessor now using the new minimum 2- or 3-ADL criteria to assess eligibility, the individual should be able to enroll in an MLTC plan as soon as NY Medicaid Choice approves MLTC eligibility based on that assessment, as occurs now. If eligibility is denied, notice with hearing rights would be provided, as now. We expressed concern that since the regulations are silent, it is not clear whether the CFEEC is now a two-part assessment, adding on the new independent medical exam as well. If so, this would cause unacceptable delays in enrollment that may violate reasonable promptness requirements under federal Medicaid law. These delays are compounded by the inherent nature of insurance enrollment which is by the month, for which enrollment forms must be signed and filed by the 18th of the previous month. The Independent Assessment MUST function as the CFEEC with no other assessments required. We appreciate the response on the Sept. 8th call that would consider this approach.

The last clause in proposed 505.14(b)(1) [10] suggests that perhaps a two-part CFEEC is contemplated, which we strongly oppose. It requires an MMCO to refer an applicant for services to the local district to determine Medicaid financial eligibility *after* the MMCO has referred the applicant for an independent assessment and physician order. Since this applicant needs a Medicaid eligibility determination, she apparently has not even applied for Medicaid so cannot be enrolled in the MLTC plan. Why would the MMCO be referring an individual who is not a plan member for an independent assessment and physician order? If the referral for the independent assessment is essentially a referral

[10] This sentence is "… 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." Proposed 505.14(b)(1) (pp. 15, 75).

for a CFEEC, then this could make sense, as a CFEEC can even now be conducted with a Medicaid application pending. However, it says the MMCO must refer it for both an independent assessment and a physician order, suggesting that the CFEEC is now a two-part assessment – the independent nurse assessment and the independent medical exam. If this is the case, it is entirely too burdensome and will cause severe enrollment delays.

In the Sept. 7th Medicaid Matters call, the DOH personnel said that even if an individual could enroll in an MLTC plan based on the Independent nurse assessment alone as the CFEEC, the Independent medical exam and physician's order must still be done. We recommended that this not be required prior to actual MLTC enrollment. Since the signed enrollment form must be submitted by the 18th of the month to secure enrollment for the 1st of the next month, the independent medical exam could be scheduled and conducted during that waiting period. If completed before MLTC enrollment begins, there is no reason why the MLTC plan could not proceed to complete the next steps – developing a plan of care and referring for the high-need review if required – even before the first day of enrollment or soon after. The goal should be to minimize delay.

Also, 505.14(b)(1) should make clear that for Medicaid applicants seeking MLTC enrollment or fee-for-service PCS or CDPAP (if excluded or exempt from MLTC), the LDSS must 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. §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.

4. Services will Not be Provided with Reasonable Promptness, without Undue Delay, and in Compliance with Federal and State deadlines for Managed Care Plans and for Those in "Immediate Need."

The new layers of assessments will unduly delay authorization of services. The State may not set up a system that, by its design, prevents local districts and MCO's from meeting federal and state time limits for authorizing services, including specific time limits for managed care members. The Medicaid Act requires the provision of medical assistance "with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8), 42 C.F.R. § 435.930, § 435.911(e). If there was any doubt that this provision requires prompt provision of services as well as prompt eligibility determinations, the Patient Protection and Affordable Care Act ["ACA"] clarified that medical assistance is defined as payment for "care and services, the care and services themselves, or both." 42 U.S.C. § 1396d(a), added by ACA § 2304. "As one court has already noted, it appears that Congress intended to squarely address the circuit split and 'to clarify that where the Medicaid Act refers to the provision of services, a participating State is required to provide (or ensure the provision of) services, not merely to pay for them[.]"[11]

[11] Leonard v. Mackereth, No. CIV.A. 11-7418, 2014 WL 512456 (E.D. Pa. Feb. 10, 2014), citing John B. v. Emkes, 852 F.Supp.2d 944, 951 (M.D.Tenn.2012); see also Disability Rights N.J., Inc. v. Velez, Civ. No.

Members of managed are plans have additional rights to plan service determinations within the strict timeframes of federal Medicaid regulations and state Insurance Law. See 42 CFR 438.210(d) (requiring standard authorizations in 14 calendar days and expedited authorizations in 72 hours absent a proper 14-day extension). "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 proposed regulations pay lip service to the federal time limits for managed care plans, but fail to specify them, and are silent on state Insurance Law, which requires utilization review determinations in writing within three business days of receipt of the necessary information, and within one business day for home health care services following an inpatient hospital admission. NY Insurance Law §4903(b)(1), 4903(c)(1); proposed 505.14(b)(3)(ii) and 505.28(e)(i)(8) pp. 40, 102. With the new assessment scheme requiring scheduling, conducting, and transmitting results of three separate assessments prior to the final determination, it is unrealistic for the plan to meet the time limits even for standard appeals, let alone expedited appeals.

State law and regulations also set time limits for local districts to authorize PCS/CDPAP services. Those applying to the LDSS for services based on Immediate Need are entitled to a determination of both Medicaid eligibility and an authorization for services within 12 days. Soc. Serv. L. § 366-a(12). Even before these new assessments are added, many LDSS's do not meet the short 12-day deadline, despite efforts by HRA and other districts. For PCS/CDPAP services not based on immediate need, in New York City, the eligibility determination for personal care services must be completed within **30 days** of the request.[12] The proposed regulation says that LDSS must make a determination and provide notice "with reasonable promptness," and within 7 business days after receipt of the independent assessment, physician order, and clinic review panel recommendation if applicable. 505.14(b)(3)(i), 505.28(e)(i)(7). This limit is meaningless because there are no time limits on referring the applicant for the other assessments and for the outside assessors to conduct and transmit the assessments. Moreover, the only way that the entire process could be completed in 30 days was if each of the steps in the list above had at most a 3-calendar day turn around time limit, leaving the 7 business days allotted for the LDSS determination after all assessments are received. However, this timeline is unrealistic and the entire process will more likely run two to three months, leaving consumers without critical care.

The agency's proposed procedures to implement the amended state law cannot possibly ensure that requests for services can be processed with reasonable promptness in compliance with the federal and state requirements above. Of the eight steps that will now be performed before a determination is made by the LDSS or MCO, the regulations specify only one time limit -- at the very last step of the process--and only for local districts, not MCO's**.**

05-4723, 2010 WL 5055820 (D.N.J. Dec. 2, 2010) (reconsidering earlier decision that medical assistance is only payment and reinstating plaintiffs' claim challenging delays in accessing waiver services).

[12] *Miller et al. v. Bernstein*, Supreme Ct. N. Y. County, Stipulation of Settlement of Discontinuance May 11, 1978, paragraph 7(a), available at http://www.wnylc.com/health/download/1/. This stipulation contains no sunset clause and is still in effect.

The regulation must specify a TIME LIMIT for each of these steps:

1. For the LDSS or MCO to refer the applicant for the independent assessment after receiving the request for services;
2. For the Independent assessment to be scheduled once the referral is made;
3. For the independent assessment to be completed and filed with the LDSS or MCO, or to be referred internally within Maximus to refer for the physician assessment;
4. For the LDSS, MCO, or Maximus to refer the individual for a physician assessment; 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 schedule the assessment;
6. For the physician to complete and file the physician orders with the LDSS or MCO.
7. In cases where the LDSS or MCO determines that more than 12 hours are needed, for the LDSS or MCO to refer the individual for the clinical review panel, and
8. For the clinical review panel to complete and return its recommendation.
9. LDSS or MCO must make a determination, develop a plan of care, and provide notice to consumer, and for plans, the requesting provider. The proposed regulation sets a time limit for the LDSS to make the determination -- within 7 business days after receipt of the assessments -- but no specific time limit is stated for the MCO. Proposed 505.14(b)(3)(i), 505.28(e)(i)(7) (pp. 40, 102).

Presumably, the time limits for all of the steps 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 state contracts with Maximus or other assessor organization(s). 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.

Recommendation for Immediate Need Cases: Since the proposed regulation requires the applicant to submit a new "physician statement of need" on a new state form, we propose that the independent medical review and the high-need medical review be eliminated in this expedited process. Otherwise, no local district could comply with the statutory deadline of 12 days to authorize Medicaid and services.

5. The Regulations Fail to Require Standards and Procedures to Ensure that the Determination Whether the Consumer may be Safely Cared for at Home Complies with the ADA and Person-Centered Service Plan requirements.

Various assessors and the LDSS/MMCO are asked to make a determination about whether the consumer can be safely cared for at home.[13] 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).

Both the ADA and Medicaid regulations require that any determination of safety be based on identifying actual risks, with their probability of occurrence, and consider whether reasonable modifications of policies, practices or procedures will mitigate or eliminate the risk. 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 ("PCSP") 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).

The regulation should specify a more nuanced determination 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.[14] This more nuanced process must be specified in the regulations, and will require training of the various assessors, in order to change an outdated black and white matter – the consumer is or is not safe at home.

To recommend or determine if an individual is capable of safely living in the community, the assessor must be informed of both the plan's or LDSS' proposed care plan and the consumer's requested care plan. A consumer who requires suctioning of a tracheostomy

[13] Safety is assessed or determined in the independent medical exam, 505.14(b)(2)(ii)(g), 505.28(d)(2)(vii)(pp. 25, 80), the high-needs review (505.14(b)(2)(iv)(f), 505.28(d)(4)(vi)(pp. 39, 96), and by the LDSS or plan (pp. 27, 42, 89, 98, 100). The independent nurse assessor should be trained to assess the risk factors that could affect safety, and strategies to mitigate risk.

[14] 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

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 recommendation or 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 of care, including informal supports. 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 circumstances.

In order to ensure that recommendations or determinations on whether the consumer can be safely cared for in the community comply with the ADA and PCSP requirements, the assessment tool must be updated to guide the assessor or decision-maker to identify specific risk factors, evaluate the probability of their occurrence, and identify ways by which the risk can be minimized or eliminated.

We suggest DOH compose a workgroup of stakeholders to improve the assessment forms and process to assist assessors in conducting these evaluations methodically and to eliminate individual bias, use of stereotypes and assumptions.

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.

6. The Independent Assessment and Physician's Exam Must More Specifically Assess Night-time Needs, Consumer Preferences, Availability and Acceptability of Informal Caregiver Involvement, and whether to Use Alternate Services

The regulations require the MMCO and LDSS to review many factors in determining the plan of care, but the independent assessments by the nurse and physician do not adequately review certain factors. These factors include night-time needs, the consumer's preferences, the availability and acceptability of informal caregivers, and consumer preferences about and availability of alternative services.

A. Night-time Needs Must be Specifically Assessed in the Independent Assessment and Medical Exam – including Sleeping Accommodations for an aide

The MMCO/LDSS must review "whether the physician order indicated" night-time needs,[15] but the regulation does not specifically require the physician order to address night-time needs. 505.14(b)(2)(iii)(e), 505.28(d)(3)(v) (pp. 25, 79). If the physician order and the medical exam it is based on do not specifically elicit information about night-time needs, then the MMCO/LDSS will invariably find that the needs are not substantiated, simply because the physician was not asked.

For cases involving 24-hour care, the MMCO or LDSS is directed to evaluate several factors that are notably not included – and must be added to -- the independent assessment and physician's assessment. "The social services district or MMCO shall assess and document in the plan of care the following:

[15] 505.14(b)(2)(iii)(e), 505.28(d)(3)(v) (pp. 34, 92)

(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;

(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.

505.14(b)(2)(iii)(e), 505.28(d)(3)(v) (pp. 34, 92) (emphasis added). Not one of these critical factors for determining 24/7 needs is a required part of the physician's order, nor of the Independent Assessment upon which the independent medical professional relies for information. Neither the DOH-4359 Physician's Order form nor the NYC M11q form elicit any of the above information about night-time needs and frequency. The regulation should specifically require these factors to be part of both the Independent assessment and Independent medical exam, and for the forms to be revised to specifically elicit each and every one of these factors. An inference that the consumer does not have needs at night is arbitrary and invalid if the form does not ask about such needs.

The UAS CHA assessment tool – which will presumably be used for the new "independent assessment" -- fails to specifically elicit information about night-time needs. Some nurses fill the information in as comments on the tool, but this defeats the stated purpose of the MRT amendments which is to promote consistency and standardization. The same questions listed in the regulation above must be added to the UAS CHA tool. Since the independent physician is required to 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, which the MMCO/LDSS in turn relies on to make its decision.

Similarly, the regulation requires the MMCO or LDSS to evaluate whether there are sleeping accommodations for an aide (505.14(b)(2)(iii)(d), 505.28(d)(3)(iv) p. 33, 91) but the Independent assessor is not directed to assess for these accommodations. The Independent nurse assessor who examines the consumer in her home is in the best position to evaluate sleeping accommodations.

B. Acceptability of Informal Caregivers to the Consumer Must be Assessed

The LDSS or MMCO must determine 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. 505.14(b)(2)(iii)(b)(11), 505.28(d)(3)(ii)(h) (pp. 30, 91). The regulation correctly incorporates federal Person-Centered Service Plan requirements that require that "natural supports" (the term used in the federal regulations) must be voluntary. § 441.301(c)(2), cross-referenced from § 438.208(c)(3)(ii).

The independent assessment would assess the potential contribution of informal caregivers that was previously done in the social assessment, including the number and kind of informal caregivers, their ability and motivation to assist in care, the extent of their potential involvement, future availability, and acceptability to the consumer. 505.14(b)(2)(i)(b)(3), 505.28(d)(1)(ii)(c) (pp. 20-21, 77). We make these recommendations:

- The UAS tool or other form used for the independent assessment must be revised or supplemented to **collect specific information as to the availability of each potential informal caregiver**, specifying the times of day and days of the week they are available. Now the UAS only asks generally if the family is supportive, in which a "yes" is often misinterpreted as meaning that they are available at all times. 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 **assessor should contact the informal caregivers** identified in but who are not present for the assessment to ascertain their availability and willingness to provide voluntary informal care, and document the times and nature of contact.
- Though **acceptability to the consumer** of the informal caregiver's help is properly listed as a factor to be assessed in the independent assessment, this factor must also be listed in the section requiring the MMCO/LDSS to determine whether the patient's needs can be met through voluntary assistance.[16] The acceptability to the consumer must be considered by plans under Patient-Centered Service Plan requirements. For example, the consumer may prefer her adult son does not assist with incontinence care or bathing, and cannot be required to rely on his assistance.

C. Person-Centered Planning Requires MMCOs to Consider Consumer Preferences in Developing Plan of Care and use of Alternate Services

The proposed 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, including informal care. This requirement has long been in the regulation, but pre-dates the 2016 amendments to federal Medicaid managed care regulations, which require both MLTC and mainstream plans to do **person-centered care planning** regarding long-term services and supports [LTSS]. The federal regulations cross-reference to HCBS regulations to define person-centered planning requirements in managed care, which 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."

[16] Compare 505.14(b)(2)(i)(b)(3)(v) with 505.14(b)(2)(iii)(b)(11)(pp. 20-21, 30); 505.28(d)(1)(ii)(c)(5) with 505.28(d)(3)(ii)(h)(pp. 77, 92).

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)(pp. 31, 91) stating the patient MUST use alternate services rather than PCS/CDPAP conflicts with the PCSP mandates and must be deleted for MMCO cases**.**

The proposed regulations do not adequately elicit and consider **consumer preferences.** The independent assessment must include "a discussion with the patient to determine perception of his/her circumstances and preferences." 505.14(b)(2)(i)(b)(2); 505.28(d)(3)(ii)(b) (pp, 20, 76). Yet the list of factors the LDSS and MMCO must consider in determining the plan of care notably does not include the consumer's preferences and perception of her circumstances. 505.14(b)(2)(iii)(b)(11)(pp. 30, 91). The assessment should specifically elicit the consumer's requested plan of care, including number of hours of personal care or CDPAP services, their preferred daily schedule, their preferences about other services in the MMCO benefit package (adult day care, nursing, etc), and, as discussed above, the acceptability of informal care. These preferences should be recorded in a modified UAS or other form.

The MMCO or LLDS cannot properly develop a plan of care without considering the consumer's specific preference as to the amount and schedule of services. This preference must be included in the independent 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 amount of care sought by the consumer, it is impossible for subsequent reviewers, and appeals reviewers, to review the adequacy of a care plan or a determination that the consumer cannot be safely cared for at home.

The regulation lists a series of alternate services that the LDSS or MMCO must consider if "appropriate" and "cost-effective," and states the consumer "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." 505.14(b)(2)(iii)(c), 505.28(d)(3)(iii) (pp. 31, 91). As stated above, for managed care members, PCSP requirements preclude requiring a consumer to accept any of the listed alternate services if they are eligible for PCS or CDPAP. For all consumers, whether applying through LDSS or MMCO, some particular concerns about the services listed in 505.14(b)(2)(iii)(b)(3) 505.28(d)(3) follow:

> (b)(3) **CDPAP services are optional**. SSL 365-f states CDPAP is for "eligible individuals who **elect** to participate in the program…." (emphasis added). Given the responsibility that the consumer must accept in order to participate in CDPAP, this program must be optional whether 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**.
>
> (b)(4) **PERS -**Given the new minimum ADL requirements for PCS and CDPAP, no one will ever receive PCS or CDPAP "solely for monitoring the medical condition and well-being." This paragraph should be amended to ensure that

PERS is authorized to supplement home care at those times that the consumer needs monitoring, but is not a substitute for assistance with ADLs and IADLs.

(b)(7) **Assisted living or enriched housing** -- Requiring a managed care enrollee to move out of their home into assisted living or enriched housing because it is more cost-effective would violate person-centered planning principles. For all enrollees, it potentially violates *Olmstead* since the consumer's home is the "most integrated setting." Also, even where the individual agrees to the change, theoretical availability of such options should not be a basis for reducing or denying home care. Historically, the LDSS would sometimes deny or discontinue PCS/CDPAP because CHHA, nursing home, or some other service was theoretically available, leaving the consumer with no services.

(b)(8) **Use of equipment and supplies such as commodes, urinals, walkers, wheelchairs and insulin pens**; While use of such equipment has always been considered, whether to use equipment or supplies must be the managed care enrollee's option, with their preferences elicited in the person-centered planning process. Now, plans often 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, or the consumer's inability to safely transfer to a commode alone, if the consumer prefers to go to the bathroom at night, thereby maintaining continence and autonomy, this preference must be considered in person-centered care planning.

(b)(9) **Adult day health or social adult day care** - 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. An LDSS may not deny or reduce PCS or CDPAP services on the theoretical availability of adult day care services.

(b)(10) "**Formal" services provided outside of Medicaid** - It is unclear what this paragraph refers to. 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.

(11) Availability of **voluntary care** by informal caregivers--see discussion above requiring consideration of consumer preference and actual availability of the informal caregivers at specific times.

7. Independent Assessment – Other Issues and Concerns

A. Independent Assessment Should Assess Consumer's Ability to Self-Direct and, if not, Identify a Person or Entity who is Willing and Able to Direct Care

We recommend above that the Independent Assessment go into more detail about the availability of informal caregivers. As part of that evaluation, this assessor should assess the consumer's ability to "self-direct" and if not, identify any informal caregiver or other person or entity who is willing able to direct care. The MMCO and LLDS are charged with determining if the consumer is self-directing, but should have the benefit of the independent nurse's assessment of this factor. 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.

B. Whether Other Services in Service Package Can Meet those Needs

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.

C. Logistical and Scheduling Concerns of Independent Assessment

a. 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."

b. As discussed above, the regulation must give time limits for the LLDS or MMCO to refer for the assessment, for the contractor to schedule and conduct the assessment, taking into account availability of the consumer and their designated representative, and to submit the assessment to the MMCO or LLDS.

c. 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 specify that assessment must be conducted there.

d. 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. Also the CFEEC must be able to determine eligibility to enroll in MLTC with the 2- or 3-ADL criteria, and not require the additional medical exam – which would delay enrollment.

e. 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. 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 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). All of the prescribed assessments are part of the person-centered planning process.

D. Improper Authority Given to MMCO or LDSS to Require Correction of So-called "Factual Inaccuracies" in Independent Nurse Assessment

We adamantly oppose two proposed paragraphs that direct the LDSS or MMCO to advise the independent assessor if they identify a "factual inaccuracy" in the independent assessment, and direct the independent assessor to "issue a correction to the assessment." Proposed 505.14(b)(2)(iii)(a)(1)–(2), 505.28(d)(3)(i)-(ii)(pp.77, 88-89).

First, these sections undermine the entire concept of independence in the 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). =. 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 specter 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. The MMCO clearly has a conflict of interest with its financial interest in minimizing its costs.

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.

8. Concerns About Independent Medical Exam and Physician's Order

A. Postpone Until After Pandemic – Implementation of this new exam should be postponed entirely until after the COVID-19 pandemic is over. Anyone seeking or receiving PCS or CDPAP falls into one of the more vulnerable populations for whom the virus could be particularly dangerous. To require them to travel outside of their home for a medical exam that is not for medically necessary treatment is simply unacceptable. If the physician or medical professional makes home visits, perhaps this is acceptable, with full precautions taken.

B. Qualifications – The proposed regulation's authorization of a physician assistant, specialist assistant, or nurse practitioner – rather than a physician -- to conduct the medical exam conflicts with the statute. The 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 2(e); 505.14(b)(2)(ii)(b); 505.28(d)(2)(ii)(pp. 24, 78). If non-physicians are permitted to do the examination, both the medical examiner and the prescribing 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)(p. 20), should have specialization in or two years of satisfactory recent experience in geriatrics, rehabilitation medicine, or a related field.

C. Examining medical professional must sign the physician's order form, even if it is also signed by a physician. The proposed regulation states that the form ***may*** be signed and certified to by the examining professional. 505.14(b)(2)(ii)(f)-(g); 505.28(d)(2)(vi)(pp, 25, 79-80). The examining professional **must** be required to sign and certify the accuracy of the information in the form, even if the examiner is a nurse practitioner or physician assistant, and indicate their name, affiliation, and license number. This is necessary even if a physician *also* signs the form for accountability and for the appeal record.

D. Examiner must consult with treating physician and review their records - The regulation states that the examiner *may* review other medical records and consult with the patient's providers and others involved with the patient's care. 505.14(b)(2)(ii)(e); 505.28(d)(2)(v) (pp. 25, 79). As discussed above, Point 2, this consultation must be mandatory.

E. Scheduling and Accessability - The regulation states the local district or MMCO shall provide assistance to the individual in making contact with the independent assessor, but is silent on assisting the consumer with scheduling the independent medical exam, and on the location of the exam. 505.14(b)(1); 505.28(d)(1) (p. 15, 75-77) The LDSS or MMCO "must coordinate" with the entity conducting the independent assessment and medical exam "to minimize patient disruption and in-home visits." Sec. 505.14(b)(2)(iii)(a); 505.28(d) (3)(i)(pp. 26, 88). 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, which could makes sense, but a time limit is still needed, and scheduling must take into account availability of the consumer and their designated representative.

Putting aside the ongoing pandemic, many applicants and recipients of PCS and CDPAP have difficulty traveling to medical appointments, or are unable to leave their home at all. These exams must be accessible – in the consumer's home if necessary. If the consumer is able to travel to a medical appointment, the plan or LDSS must arrange transportation if needed. Now that non-emergency medical transportation is being carved out of the MLTC benefit package, this poses yet another hurdle of coordination. A consumer should not be burdened with using Access-a-ride or other paratransit, even if it is feasible, because of all of the notorious delays and other problems with this service.

F. The consumer's representative – whether family member, social worker or other person – must be given the opportunity to be present for this examination. 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).

G. Examining medical professional must sign the physician's order form, even if it is also signed by a physician..Assessment of whether the patient can be safely cared for at home should not be part of the examination. It is premature for the medical examiner to make this safety determination before the LDSS/MMCO has developed a proposed plan of care, including the role of voluntary supports. 505.14(b)(2)(ii)(g); 505.28(d)(2)(vii) (pp. 25, 79-80). 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 in Point 4 above about "safety."

H. 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, identify the person or entity that will direct care and describe their availability and the tasks to be performed. Without this information, the physician could not make this determination.

I. 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.

9. Referral for High Need Review Panel is Not Authorized for CDPAP Consumers – and Other Concerns About High Need Review

A. ***CDPAP Statute, unlike Personal Care Statute, does not authorize New High Need Review***. The amended law governing PCS specifically authorizes a high need review, but no such language is included in the CDPAP statute. The amended statute defining Personal Care Services states, in part:

"[T]he commissioner is authorized to adopt standards, pursuant to emergency regulation, for the provision [and], management and assessment of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner, and who with the provision of such

services is capable of safely remaining in the community in accordance with 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. L. §365-a subd.2 (e), as amended,), as amended, L. 2020, Ch. 56 §2.

While DOH may require LDSS and plans to assess whether a CDPAP applicant, "…with the provision of such services is capable of safely remaining in the community in accordance with the standards set forth in Olmstead…" (§365-f, subd. 2, as amended, L. 2020, Ch. 56 §2-b), there is no authorization for DOH to require a separate high-needs review. Since the legislature specifically authorized the commissioner to adopt such standards for PCS, the lack of such legislative authorization in the CDPAP statute means that this extra level of review cannot be required for CDPAP applicants – either by local districts or plans.

B. Proposed Regulation says High-Need review Required to Authorize More than 12 Hours/week but DOH PowerPoint says "12+ Hours"

The proposed regulation appropriately requires the high need "independent medical panel" review "…before a social services district or MMCO may authorize more than 12 hours of personal care services per day on average, including continuous personal care services or live-in 24-hour personal care services ('high needs cases')." Proposed 505.14(b)(2)(iv). Yet DOH documents such as the PowerPoint for MMNY July 29, 2020 meeting titled "Advocate Plan Meeting: MRT Outreach" uses in some places "12+" hours which would mean 12 or more hours (at slides 28, 29). Prior communications suggest it is not DOH's intent to subject anyone needing 12 hours to this extra review. We hope that is the case. If it is not the proposed regulation this would be a substantial change requiring republication for notice and comment. In future communications we suggest using the symbol "<12 hours" to indicate who is subject to high-needs review.

C. ***Treating Physician Documents and Consumer's Requested Plan of Care must be provided to Review panel***. 505.14(b)(2)(iii)(f); 505.28(d)(3)(vi) (pp. 36, 94)
The regulation omits from the documents to be provided to the panel any documents from the treating physician and the consumer's requested plan of care. The panel is give only the Independent assessment, Physician's Order, and the MMCO's or LDSS' plan of care. As stated above in Section 2, federal regulations require consulting with the treating physician. Above, we recommend that the treating physician use the same Statement of Need form that the regulations propose for Immediate Need. The panel should determine whether the care plan recommended by the MLTC/LDSS is sufficient to maintain safety at home, and if not, the panel must assess whether the consumer's requested plan of care would maintain safety at home. The consumer's preferences regarding their requested plan of care, informal caregiver support, and alternative services should be provided. We recommend above that the Independent Assessment be expanded to obtain this information from the consumer.

D. ***Where Consumer Has Requested 24/7 Care, the MMCO or LDSS Must Refer it for High Need Review even if LDSS/MMCO does not Determine More than 12 Hours/day are Medically Necessary***.

If the LDSS/MMCO determines that the consumer needs 12 or less hours, a consumer is entitled to notice of Initial Adverse Determination authorizing 12 or fewer hours/day and denying the requested hours exceeding 12 hours/day. Will an ALJ be precluded from reversing the plan or LDSS decision and ordering the provision of 24/7 care if they did not have the Independent Medical Review of High Needs Cases because the plan never referred it? If so, we recommend as follows:

Recommendation: Where the consumer or their physician has requested more than 12 hours/day, the LDSS/MMCO *must ref*er 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 or MMCO in its final authorization. Otherwise, the consumer's right to appeal the denial of > 12 hours/day services and win full relief on appeal is obstructed and unnecessarily delayed.

E. The MMCO or LDSS must develop the plan of care 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, and because the Panel must review whether safety can be maintained with the proposed plan of care or, if not, with the consumer's requested plan of care. Therefore, paragraph 505.14(b)(2)(iii)(g) or 505.28(d)(3)(vii) should be moved up in this section, either switched with (f) or moved up earlier (pp. 37, 94).

F. We are glad to see the CDPAP regulation 505.28(d)(3)(vii) 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 parallel PCS regulation, to require MMCO's to comply with the federal person-centered-planning requirements. 505.14(b)(2)(iii)(g) (pp. 37, 94).

G. **Conduct of the High Need Review** - 505.14(b)(2)(iv), 505.28(d)(4)(pp. 37, 94)

a. <u>The case should be referred to this panel with *both* (1) the LDSS/MMCO's plan of care AND the (2) consumer's requested plan of care</u>. 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. If one cannot maintain the consumer's health and safety, then the other must be considered. The reviewer should specify which, if any, plan can maintain consumer's heath and safety. The proposed regulation, however, would allow referral for this review with no plan of care. That the lead physician must review "any plan of care created" implies that the LDSS/MMCO may not have created one yet. 505.14(b)(2)(iv)(d).

b. <u>We are concerned about more delay</u> with another evaluation by the lead physician, who, as proposed, "…may evaluate the individual, or review an evaluation performed by another medical professional on the clinical review panel." 505.14(b)(2)(iv)(e). If they do an evaluation, whether in person or by telehealth/phone, it must be scheduled quickly and any results must be recorded and available to the consumer in any record for appeal.

c. <u>That the lead physician "may" – not must -- consult with the patient's treating or primary care physician, under 505.14(b)(2)(iv)(f), does not satisfy federal</u>

requirements for managed care plans particularly pertaining to LTSS. "The treatment or service plan must be: (i) Developed … with enrollee participation, and in consultation with any providers caring for the enrollee…" 42 C.F.R. 438.208c)(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.

d. **We strongly oppose the proposal that independent medical reviewer "…must not recommend specific hours of services or an alternative plan of care."** 505.14(b)(2)(iv)(g); 505.28(d)(4)(vii) (pp. 40, 96). The entire purpose of this review is to determine whether the consumer needs more than 12 hours/day, and if so, whether the proposed care plan reasonably maintains their health and safety. The high needs reviewer must be able to recommend that 24-hour live-in or 24-hour split-shift care is necessary to maintain the consumer's health and safety. This prohibition on recommending hours presumably has its origins in the long-ago adopted amendment of section 505.14(b)(3) (i)(a)(3) 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 the consumer's requested plan of care or a different care plan is 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.

e. The regulation is not clear on what is meant by a "panel of medical professionals or other clinicians" -- how many medical professionals would participate, or what other professionals would be included on the panel beside physicians. The larger the panel the more difficult scheduling will be which may further delay services.

f. Upon appeal, the consumer must be provided with the complete record, which must identify and include copies of all documents provided to the panel and that the panel requested, who participated in the panel, whether any exam was conducted by any member of the panel with a copy of the exam report, and must include records of any internal communications between members of the panel and with the consumer, their physician(s) or other persons.

10. The Definition of Medical Necessity is Unduly Restrictive and Must be Expanded to Comply with State Law and Federal Medicaid Regulations

The proposed regulation defines a standard of medical necessity as "…only the hours or frequency of services that the patient actually requires to maintain his or her health and safety in the home." 505.14(b)(4)(iv), 505.28(e)(2) (pp. 42, 100). The proposed language is more limited than the broader definition of medical necessity in New York law as well as in federal managed care regulations.

New York Medicaid law defines Medicaid as including 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).

Also, 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 define "medical necessity" in a manner that addresses 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 [and] (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."

42 C.F.R. § 438.10(a)(5)(C)-(D). 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.

RECOMMENDED EDIT: The social services district or MMCO ~~may~~ must authorize ~~only~~ the hours or frequency of services 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 impairments from interfering with their capacity for normal activity, and that are necessary 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.

11. The Two New Proposed Grounds for Reductions Allow Plans to Arbitrarily Reduce Services, without Alleging any Change in Circumstances, Nullifying Longstanding Regulations Based on Due Process as Held in *Mayer v. Wing.*

We strongly oppose the proposed two new grounds for reducing personal care or CDPAP services. These new grounds essentially nullify due process protections as held in *Mayer v. Wing*,[17] codified in the longstanding regulation requiring that any reduction be justified by a medical improvement, change in circumstances, or a mistake in the previous authorization. 505.14(b)(4)(vii)(c)(2); 505.28(h)(4)(ii)(h)(pp. 45, 113). We also have concerns about reductions based on telehealth.[18]

The longstanding regulation specifying limited grounds for reductions was promulgated as part of a settlement in *Mayer v. Wing*, in which the federal court held that reductions in personal care services were arbitrary and violated due process where there was no change in the consumer's circumstances. Twenty years after *Mayer*, DOH specified that MLTC plans are bound by the same rules limiting the grounds for reductions (DOH MLTC Policy 16.06) as DOH had required for mainstream managed care plans in 2011. See n 5. While the proposed regulation nominally leaves intact the grounds for reductions stated in existing regulations and Policy 16.06, the two new grounds for reductions essentially invalidate them, opening the door for the same arbitrary reductions that the *Mayer* court found violated due process. 505.14(b)(4)(vii)(c)(2)(i)-(ii); 505.28(h)(4)(ii)(h)-(i)(pp. 46-47, 113).

<u>The first proposed new ground allows reductions if informal supports are fully utilized</u>. Services may be reduced if:

> …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.

505.14(b)(4)(vii)(c)(2)(vii); 505.28(h)(4)(ii)(h) (pp. 46-47, 113).

Since a change in availability of informal supports is already a basis for a reduction as a change in social circumstances, this new regulation is redundant, but also eliminates important consumer rights. The proposed language would not require the LDSS/MMCO to specify a change in informal support availability or state why the services should be reduced as a result of the change, 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

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[17] *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).

[18] The regulation would permit a reduction if telehealth or assistive devices render "certain services unnecessary or less time-consuming," and "it can be demonstrated and documented to reduce the amount of services that are medically necessary." 505.14(b)(4)(iv)(c)(2)(iv), 505.28(h)(4)(ii)(d) (pp. 45, 112). Notice must be required specifically identifying how these technologies reduce the need for personal care or CDPAP services. We recommend that the regulation require the notice to identify the specific ADLs or IADLs for which telehealth services or specifically identified assistive devices reduce the amount of services that are medically necessary and how and when they reduce the need for assistance.

from when the services were originally authorized; otherwise a reduction is totally arbitrary and a violation of due process. 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).

The second proposed new ground 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 proposal would allow reductions if:

> 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.

505.14(b)(4)(vii)(c)(2)(viii); 505.28(h)(4)(ii)(i) (pp. 46-47, 113).

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.[19]

The continuity of care period may be 90 days or 120 days depending on the circumstances. A 90-day transition period follows mandatory enrollment into an MLTC plan after a consumer received PCS or CDPAP services through the LDSS, such as through the "immediate need" procedure. 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*. A 120-day continuity of care period applies when a consumer's MLTC plan closed; after the consumer enrolls in a new MLTC plan, the new plan must continue the closing plan's plan of care for 120 days. DOH MLTC Policy 17.02.

If a plan reduces services after the continuity of care/transition period, the ST& C makes clear that this action is a reduction of previously authorized services. Though the *Mayer* holding requires that any reduction of services be based on a specific change in condition or circumstances, the proposed regulation would allow a plan to reduce services simply by

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[19] CMS Special Terms & Conditions ("ST&C"), 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.

claiming that the previous plan or LDSS "authorized more services than are medically necessary." With no burden on the plan to identify and establish a change in the consumer's condition or circumstances since the earlier authorization, consumers may well be "in the same or worse physical condition they were in when home care was initially authorized" by the previous plan or LDSS, yet be subject to threatened reduction of services. The *Mayer* 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.

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 that occurred since services were previously authorized, 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 found this version of the regulation gave 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 new notice language, applying to the new grounds for reductions, does not remedy this deficiency and will result in due process violations:

> (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.

505.14(b)(4)(vii)(c)(3),505.28(h)(4)(iii)(pp. 47, 113). This language may look like it requires the plan or LDSS to identify reasons for the reduction in the notice, but upon closer examination it lacks any requirement to specify a change in the consumer's condition or circumstances from when the services were previously authorized. It requires no meaningful standard to justify reducing services other than the plan's own characterization of what is medically necessary. It allows a plan to allege that "the client's needs do not meet specific benefit coverage criteria," which is meaningless because each

plan defines its own coverage criteria. The proposed provisions allow plans to engage in the same arbitrary decision making 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*.

A third concern is the addition of telehealth and assistive devices as a technological development that may justify a reduction if they render "certain services unnecessary or less time-consuming," and "it can be demonstrated and documented to reduce the amount of services that are medically necessary." Proposed §§ 505.14(b)(4)(iv)(c)(2)(iv), 505.28(h)(4)(ii)(d) (pp. 45, 112). Notice must be required specifically identifying how these technologies reduce the need for personal care or CDPAP services. **We recommend this edit:**

> 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 assistive devices, which must be specifically identified and available, reduce the amount of services that are medically necessary, specify the times in which telehealth services are available, and describe how these technologies or devices reduce the need for assistance.

12. Grounds for Denial - 505.14(b)(4)(vii); 505.28(h)(4)(i) (pp. 43-45, 110)

A. Paragraph 505.14(b)(4)(vii)(a) should be deleted. This longstanding paragraph, allowing denial or reduction of services based on medical necessity, pre-dated the federal court decision in *Mayer v. Wing*, which held that consumers are due additional protections when personal care services are reduced compared to when they are denied. Pursuant to this lawsuit, DOH later amended the section of this regulation requiring more justification for reduction of personal care services than mere assertion of medical necessity, discussed below. This paragraph confusingly discusses denial and discontinuance of services together, even though the distinct standards and procedures for each type of action are discussed separately later in the regulation.

B. We are skeptical of the addition of **telehealth** services as a reason for denial when "…demonstrated and documented to reduce the amount of services that are medically necessary." 505.14(b)(4)(vii)(c)(1)(vi). 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.

C. This ground for denying services because **the consumer resides in a facility** must be repealed, 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. Additionally, an MMCO may not deny services on this ground if the consumer's preference is to return to the community, under person-centered care planning principles.

D. The ground for denying services by fully utilizing available informal supports should be amended to specify that the **informal care must be voluntary and acceptable to the consumer**. 505.14(b)(4)(vii)(c)(1)(ix). As discussed above, 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(c)(3)(ii).

13. REAUTHORIZATIONS - 505.14(b)(4)(xi), 505.28(f)(1) (pp. 49, 102)

A. The 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. 505.14(b)(4)(xi)(b)-(c), 505.28(f)(1)(pp. 49-50, 102)

B. 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), 505.28(f)(1)(ii) (pp. 49-50, 103). 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 there is no basis to change the authorization. Neither the Independent assessor nor the Medical Examiner authorize services, so this phrase makes no sense.

RECOMMENDED EDIT:

(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 below).

C. There may be one or more typo errors in the 505.14(b)(4)(xi)(c), 505.28(f)(1)(ii) (p. 50, 103):

> (c) Reauthorization of Level II services shall **only** require 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.

Is "only" meant to be "not" – meaning that a new physician order is not required annually unless a new physician order is clinically indicated by the independent assessor?

Should the referenced subpar. (xiii) 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.

14. UNEXPECTED CHANGES - 505.14(b)(4)(xii), 505.28(f)(2) (pp. 50, 104)

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.

A. 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 are true **emergencies** that require expedited processing. (See section No. 4 on DELAYS above at pp. 12-13 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.

B. 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. 505.14(b)(4)(xii)(a); 505.28(f)(2)(i)(pp. 50, 104) 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, pp. 15-16, 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); 505.28(f)(2)(i)(pp. 50, 104). 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.

C. **Time limits** must also be specified for assessments by the LDSS, though the federal Part 438 regulations do not apply.

D. 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); 505.28(h)(4)(ii)(h)(pp. 45-47, 113)(See above). Adding a review of cost-effectiveness solely because a change in mental circumstances potentially constitutes discrimination based on diagnosis.

E. 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.

15. Terminology and Other Miscellaneous Recommendations

A. Change "Patient" to "Consumer." The Regulatory impact statement says the proposal modernizes language but it still 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.

B. Update Terms to IADLs and ADLs from "personal care functions" and "nutritional and environmental support 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, ADM, and other guidance all use these terms.

a. For IADLS, to align the regulation with the UAS, add to 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

b. Rename "personal care functions" as "Activities of Daily Living" and and update that list at 505.14(a)(5)(ii)(a) as suggested below.

(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, 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)

c. If instead of renaming "personal care functions" as ADLs, a separate definition of ADLs is used as proposed (pp. 14, 68) then we recommend this edit:

505.14(a)(9) Activities of daily living means bathing, personal hygiene, dressing, walking, locomotion, transfer, ~~transferring on to and off the toilet and~~ toilet use and incontinence care, including transferring on to and off the toilet , bed mobility, medication administration, and eating. (also 505.28(b)(1)

The last clause in proposed 505.14(b)(1); 505.28(d) (pp. 15, 75) 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.

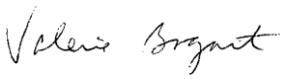
16. Provision Unique to CDPAP – Physical Presence of Designated Representative Should Not Be Required at All Assessments

We object to Par. 505.28(g)(2)(p. 108) to the extent it requires the designated representative for non-self-directing consumers be physically present for any scheduled assessment or visit by the independent assessor, examining medical professional, social services district staff or MMCO staff. Insisting on the physical presence of the designated representative is burdensome and unnecessary in light of the many other available means of communication. The designated representative for non-self-directing consumers must have the option of participating in any scheduled assessment 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. If the designated representative works, attending so many assessments would not likely be possible. Nearly thirty years ago, the State Medicaid agency made clear that the person directing care for a non-self-directing person did not need to reside with the consumer or but need only have "substantial daily contact," which was not necessarily in person. NYS 92 ADM-49. That directive applies to personal care generally, not specifically CDPAP but the same principle applies. If anything, 28 years later, technology makes virtual or remote communication be more feasible. \

* * *

Thank you for the opportunity to submit these comments. As always, we would welcome the opportunity to participate in a stakeholder workgroup to express consumers' concerns as policy and procedures are developed to implement these major changes.

Very truly yours,



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