NYLAG
New York Legal Assistance Group

Oct. 29, 2020

NYS Department of Health
Division of Finance and Rate Setting
99 Washington Ave.
One Commerce Plaza, Suite 1432,
Albany, NY 12210

by email to spa_inquiries@health.ny.gov

RE: SPA No. 20-0041 (Changes in eligibility criteria and assessment for personal care and consumer-directed personal assistance)

SPA No. 20-0002 (Delay in implementing certain CFCO services and other changes in CFCO)

To Whom It May Concern:

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. NYLAG submits these comments on the above-numbered proposed State Plan Amendment (SPA) that will change eligibility criteria and assessment procedures for personal care services (PCS) and consumer-directed personal assistance program services (CDPAP). These comments primarily address SPA No. 0041, which, despite the subject line of its cover letter to CMS of Sept. 29, 2020, which states "Long Term Care Facility Services," mostly concerns community-based long term care – PCS and CDPAP. We also address the lack of public notice for both SPA's.

Preliminary Concerns:

Inadequate Public Notice of SPA's – These Comments are Timely. Notice that both SPA's would be available for public comment and review was published in the State Register on April 1, 2020, before the budget law was even enacted and before the State agency was authorized to publish the notice. The Notice was amended on June 3, 2020, again stating that the SPA's could be found online for public comment and review. However, SPA No. 20-0041 was only posted on the State DOH website on Oct. 8, 2020, with the cover letter to CMS dated Sept. 29, 2020. After June 3rd, DOH did not post any subsequent notice in the State Register prior to submitting this SPA to CMS on Sept. 29, 2020, depriving the public of meaningful notice of the opportunity to comment prior to submission of the SPA to CMS.

SPA 20-041 implicates the state's compliance with the Community First Choice Act (CFCO), as discussed below, since CFCO is provided through PCS and CDPAP services. Failure to provide meaningful public notice with the opportunity to comment on both SPA's therefore also violates CFCO requirements. 42 CFR § 441.575. With the CFCO SPA No. 20-002, there is no indication that the State consulted with the Development and Implementation Council, as required for not only development but implementtation of

CFCL by the law, regulations and CMS Technical Guide.[1] Finally, no deadline for public comment was included in the State Register, so these comments must be considered as timely.

Implementation of any new assessments 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 medical professional makes home visits, which should be required in normal times, concerns about spreading the virus should preclude such visits now. Nor should these visits be permitted using telehealth, even though telehealth has been appropriately relied on as an alternative means of securing medical treatment or conducting assessments for PCS and CDPAP during the pandemic. However, these new layers of assessments are not necessary for treatment. To be effective, after the pandemic, they should be conducted in person in order to assess all the medical and functional factors, which require the benefits of in-person observation and communication.

Summary

The new criteria requiring two or three Activities of Daily Living (ADLs) for eligibility discriminate based on diagnosis, in violation of federal Medicaid regulations. By denying services to consumers who need an institutional level of care but do not meet the new ADL thresholds, the new criteria jeopardize the state's compliance with the Community First Choice Option (CFCO), which not only prohibits discrimination based on diagnosis or severity of impairment but also requires assistance with both ADLs and Instrumental ADLs (IADLs), including cueing and supervision as well as hands-on assistance. Moreover, the proposed new independent review of high-needs consumers and the revised assessment process generally fail to solicit and consider input from the treating physician. Also, the added levels of assessment are likely to cause delays in authorizations that would violate federal regulations, including those that prescribe time limits for managed care plans to authorize services. Finally, the extra scrutiny of high-need consumers to determine whether they are "safe" at home must be implemented to preclude the use of assumptions that lead to the use of "safety" as a pretext to deny community services, violating the Americans with Disabilities Act.

I. The Minimum Two or Three ADL Threshold Unlawfully Denies Services Based on Diagnosis, Violating Federal Medicaid Regulations, and Violates Requirements of the Community First Choice Option (CFCO) to Provide Supervision -- not only Physical Assistance -- with ADLs

The SPA proposes new restrictions that violate federal regulations banning discrimination based on diagnosis and requirements for the Community First Choice Option (CFCO) that require provision of cueing and supervision -- not only hands-on assistance -- with ADLs and Instrumental ADLs (IADLs). Under the proposed SPA, personal care and CDPAP

[1] See CMS, CFCO State Plan Option Technical Guide, page 2, available at https://www.medicaid.gov/sites/default/files/2019-12/cfc-technical-guide_0.pdf. It is unclear whether the State has reconvened the Development and Implementation Council, many of whose original members from 2012 have died or moved on to other positions so can likely not serve.

services will be available only to individuals assessed as needing at least limited assistance with *physical maneuvering* with three or more Activities of Daily Living (ADLs), or for individuals with a dementia or Alzheimer's diagnosis, assessed as needing at least *supervision* with two or more ADL's. To avoid unlawful discrimination and CFCO violations, the new criteria must be amended so that individuals who need supervision with two ADLs by reason of any medical impairment, not only because of dementia or Alzheimer's disease, qualify for PCS and CDPAP. Moreover, instead of requiring two or three ADLs, eligibility should be based on the need for assistance with two or three ADLs or IADLs, provided that the individual need assistance with at least one ADL.

A. Denial of Services Based on Diagnosis Violates 42 C.F.R. §440.230(c)

People with vision impairments, traumatic brain injury (TBI), developmental disability (DD), and other cognitive, neurological or psychiatric impairments will all be denied PCS or CDPAP under the proposed SPA if they need supervision with two or more ADLs, but they do not need 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").

B. Denial of Services Based on Diagnosis Violates CFCO Requirements

New York is claiming an enhanced federal match for CDPAP and PCS recipients found eligible for CFCO, both in fee for service and managed care, including Managed Long Term Care plans (MLTC). As implemented in New York, the consumer must score a "5" on the Uniform Assessment (UAS) to indicate institutional Level of Care (LOC), and must receive services in a community-based setting. If an applicant needs an institutional level of care, under the CFCO option, she must 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). An individual may need an "institutional level of care" even if determined not to meet the new ADL threshold requirement. This may be especially true for people with developmental disabilities, psychiatric or visual impairments, who may not need hands-on care but without supervisory assistance through PCS or CDPAP services would have to be institutionalized, which is defined to mean an ICF-DD, hospital or psychiatric hospital level of care. We question whether the UAS score of "5" correctly captures eligibility for these other types of institutional levels of care, as opposed to nursing home level of care.

A consumer who needs supervision with two ADLs and two IADLs because of a Traumatic Brain Injury would be denied PCS or CDPAP under the new ADL test, but could still very well require an institutional Level of Care in an ICF-DD or other facility without community-based services. 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). In this example, the consumer would be denied services solely because of lacking a dementia or Alzheimer's diagnosis; a person with dementia with the same need for supervision with two ADLs would qualify for PCS and CDPAP. The state may not deny eligibility of PCS/CDPAP or CFCO services because a consumer lacks a particular diagnosis or the threshold number of ADLs.

An applicant determined not to meet the ADL threshold for PCS or CDPAP should not be denied these services without a determination as to whether they would need an institutional level of care without services. If they meet the LOC threshold, they are eligible for CFCO and they may not be denied PCS/CDPAP.

C. The Need for Assistance with IADLs, not only with ADLs, must be Considered for Consumers who Meet the Level of Care Criteria for CFCO

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 "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."[2] The proposed regulation would violate this requirement by denying PCS or CDPAP services to an individual who needs supervision and cueing with, for example, one ADL and three IADLs, even though the individual meets the level of care criteria for CFCO.

RECOMMENDATION: Instead of requiring specific diagnoses to qualify for services based on needing supervision with two or more ADLs, any person who, because of a medical impairment needs supervision with the threshold number of ADLs (or as discussed below, combination of ADLs and IADLs).

[2] 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.

D. *To Protect Current Enrollees, the Definition of Who is "Grandfathered" under the Former Criteria Must be Clarified*

The SPA would apply the changes in eligibility criteria for CDPAP for "initial authorizations beginning on and after October 1, 2020." The amended state law establishing the new ADL thresholds for CDPAP, however, 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."[3] Unlike the grandfather clause for PCS, which applies to those who were initially authorized for PCS prior to the effective date,[4] the grandfather clause for CDPAP accords grandfathered status to those who *applied* for CDPAP services before the effective date. The grandfather clause for the Managed Long Term Care program under the 1115 waiver is different than either the one for CDPAP and PCS, stating 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." [5] It would be impossibly confusing for both administrators and consumers -- and unfair to consumers – to accord grandfathered status differently for PCS and CDPAP recipients and MLTC enrollees. Therefore, the "grandfather" clause should be defined liberally to protect all consumers who applied to receive PCS or CDPAP prior to Oct. 1, 2020, or such later effective date that the new criteria apply. It would be much simpler to align the grandfathering standard for PCS and MLTC with the one for CDPAP.

Also, individuals whose MLTC enrollment was or will be temporarily interrupted either before or after Oct. 1, 2020 would potentially lose their grand-fathered status and be subject to the new criteria when they have to re-enroll. There are many reasons for a gap in enrollment that could require re-enrollment. Bureaucratic errors or mailing delays in the annual Medicaid renewal process often to lead to discontinuance of Medicaid and then disenrollment from the MLTC plan. Also, consumers who were temporarily in a nursing home for 3 months are disenrolled from the MLTC plan, requiring them to re-enroll in order to return home. Any of these individuals who re-enroll in an MLTC plan should be grandfathered into the former criteria.

II. The Added Layers of Assessment – Including the new Review of High Needs Consumers – Potentially Violate Federal Law and Regulations – and should Not be Implemented During the Public Health Emergency

In addition to the concerns about delays caused by the new assessments and failure to consider the treating physician's opinion, discussed below, implementation of any new assessments should be postponed entirely until after the COVID-19 pandemic is over. With the risk of exposure in additional assessments, and inevitable delays caused by the added assessments, these changes should not be implemented until the pandemic is over.

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[3] Soc. Serv. Law §365-f, subd. 2(c)(eff. Oct. 1, 2020), as amended, L. 2020, Ch. 56 §3.

[4] Soc. Serv. Law §365-a, subd. 2(e)(v)(eff. Oct. 1, 2020), as amended, L. 2020, Ch. 56 §2-a ("The provisions of this subparagraph shall only apply to individuals who receive an initial authorization for such services on or after October 1, 2020").

[5] Public Health Law §4403-f subd. 7 (b)(v)(14), added by L. 2020, Ch. 56 §18.

populations for whom the virus could be particularly dangerous. Nor should telehealth be relied on for these assessments.

A. State Law does Not Authorize the State to Impose a High Need Review Panel for CDPAP Consumers – only for Personal Care consumers

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, L. 2020, Ch. 56 §2. This language is absent from the amendments of the CDPAP statutory language.

B. By Failing to Require an MCO or Medicaid agency -- and any Independent Reviewer - to Consult with the Treating Provider in Assessing the Need for PCS or CDPAP, the Proposed Scheme Violates the Federal Medicaid Managed Care Regulations

The State is seeking to add several levels of assessment for anyone seeking PCS or CDPAP, which fail to adequately solicit and consider the opinion of the consumer's treating physician. First, service authorizations for PCS or CDPAP "that exceed a specified level be forwarded for an additional independent medical review by an independent panel of medical professionals to review the appropriateness or sufficiency of such services."[6] Second, as stated in the SPA Summary, an independent physician or clinical professional will provide orders for PCS and CDPAP services for all consumers, not just those with a higher level of need. This new independent medical assessment replaces the longtime role of the treating physician, whose "order" for these services in accordance with a plan of treatment has long been the required basis for an authorization for PCS services. 42 C.F.R. §440.167.[7] The SPA should provide that the MCO or Medicaid agency, and the new high need review panel where utilized, must review any information provided by the consumer's treating physician and consult with the treating physician. In proposed regulations by which State DOH plans to implement this new procedure, the independent panel would not even be provided with any documents from the treating physician or the consumer's requested plan of care.[8] There is no procedure

[6] §365-a subd.2 (e), as amended, L. 2020, Ch. 56 §2.

[7] Ch. 56, L. 2020, Part MM Sec. 20, annexed to SPA; see proposed regulations at 18 NYCRR §505.14(b)(2)(ii), 505.28(d)(2).

[8] Proposed regulations at 18 NYCRR 505.14(b)(2)(iii)(f); 505.28(d)(3)(vi), available at https://regs.health.ny.gov/sites/default/files/proposed-

for the consumer to submit a statement of need from the treating physician, and no requirement that this be considered by the independent review panel and by the MCO or Medicaid agency in determining need and a plan of care.

Federal managed care regulations 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 MCO's 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).

An MCO that provides LTSS must be required 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, and the "independent assessor" and the MCO or state agency must consult with the treating physician.

C. The Added Assessments will Prevent Services from Being Authorized with Reasonable Promptness, within Federal and State Deadlines for MCO's and for Those in "Immediate Need," and without Undue Delay.

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 SPA should not be approved without specific time limits for each step of the assessment process that are reasonably capable of being performed within time limits established by law and regulations. Mere lip service by the State that authorizations will be completed timely is not sufficient without a specific realistic timeline for each stage, including referring, scheduling, conducting and returning the independent assessment, the physician's assessment, and the clinical review panel review, and for the local district or MCO to develop a plan of care and authorize services.

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regulations/Personal%20Care%20Services%20and%20Consumer%20Directed%20Personal%20Assistance%20Program.pdf (pp. 36, 94 of PDF)("Proposed regulations").

The SPA should not be approved without a realistic plan for how Managed Long Term Care plans and other MCO's, which provide the majority of PCS and CDPAP services, can meet the strict time limits for making service determinations set forth in 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 authorizations, let alone expedited ones.

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. N. Y. 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.

Aside from these specific deadlines, 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."[9]

D. 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.

The SPA proposes that those consumers determined to have high needs (services exceeding a certain level) would go through an enhanced review process to determine whether such a consumer, "with the provision of such services is capable of safely

[9] 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. 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).

remaining in the community in accordance with the standards set forth in Olmstead v. LC by Zimring, 527 US 581 (1999).[10] 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) as amended; §365-f, subd. 2, as amended.

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).

Implementation of the SPA should be conditioned on development of procedures that a 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.[11] 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.

The guidelines for Person-Centered Service Plans, developed for New York's CFCO program (see https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2018-12-19_pcsp_guidelines.htm) incorporate some but not all of the principles described above for an adequate risk assessment. Some variation of these guidelines must be incorporated into the assessment policies and protocols for assessing whether a high-need consumer is "safe."

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[10] Safety is assessed or determined not only in the high-needs review (proposed regulations 505.14(b)(2)(iv)(f), 505.28(d)(4)(vi)(pp. 39, 96), but also the independent medical exam 505.14(b)(2)(ii)(g), 505.28(d)(2)(vii)(pp. 25, 80), and by the LDSS or plan (pp. 27, 42, 89, 98, 100). All assessors must be trained to assess the risk factors that could affect safety, and strategies to mitigate risk.

[11] 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

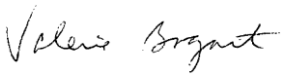
To recommend or determine if an individual is capable of safely living in the community, the assessor must be informed of both the MCO's or Medicaid agency's proposed care plan and the consumer's requested care plan. A consumer who requires suctioning of a tracheostomy might be unsafe if the proposed care plan was only 4 hours/day of formal care with no informal supports, but safe with a care plan covering 24/7 needs with a combination of formal and informal care. For this reason, whoever is asked to make a recommendation or determination about safety must be provided with both (1) the proposed plan of care by the agency or 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.

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.

Thank you for the opportunity to submit these comments on the SPAs.

Very truly yours,



Valerie J. Bogart, Director
Evelyn Frank Legal Resources Program
New York Legal Assistance Group
Evelyn Frank Legal Resources Program
7 Hanover Square, 18th Floor
New York, NY 10004
tel 212.613.5047
vbogart@nylag.org