GT GreenbergTraurig

Alert | Health Care & FDA Practice

February 2021

New York Proposes Revised Changes to Personal Care and Consumer-Directed Personal Assistance Services Regulations

On Jan. 27, 2021, the New York State Department of Health (DOH) published revised proposed amendments (referred to herein as the *revised proposed amendments*) to the regulations governing personal care services (PCS) and consumer-directed personal assistance services (CDPAS). The revised proposed amendments would implement requirements of the State Fiscal Year 2020-2021 Budget and certain Medicaid Redesign Team II long-term care reform proposals.

DOH's initial draft of proposed amendments to the regulations (referred to herein as the *proposed amendments* and discussed in a previous GT Alert) was published July 15, 2020. In response to more than 200 comments from stakeholders, DOH has made substantive changes to the *proposed amendments*. The *proposed amendments*, including the *revised proposed amendments*, include the following:

Eligibility for PCS and CDPAS. The *proposed amendments* would require an individual's eligibility for PCS or CDPAS to be established prior to authorization or provision of such services. Under the *proposed amendments*, eligibility would be based on an individual meeting minimum-need criteria. Specifically, individuals with dementia or Alzheimer's disease would require supervision with at least one activity of daily living (ADL), and all others would require at least limited assistance with physical maneuvering with more than two ADLs, as determined by the independent assessor. The *revised*

proposed amendments clarify that supervision and cueing would only be authorized if such activities were necessary to assist with nutritional and environmental support functions or personal care functions, not as standalone services.

Denial or Reduction of PCS and CDPAS. The *revised proposed amendments* clarify that Local Departments of Social Services (LDSS) and Medicaid Managed Care Organizations (MMCO) would be required to document specific factors and clinical rationale that went into the medical necessity determination that PCS or CDPAS should be denied, reduced, or discontinued. Services could be denied if an individual living in a facility is not seeking to transition into a less-restrictive setting (or if the individual's health and safety cannot be maintained in a less-restrictive setting). Under the *revised proposed amendments*, services could be reduced or discontinued in cases if voluntary informal supports became available to meet some or all of the client's needs. Finally, under the *revised proposed amendments*, telehealth or assistive devices and other technological developments could obviate the need for or amount of PCS or CDPAS if readily available and reliably accessible.

Assessment Process. The *proposed amendments* would require an independent assessment, a medical examination and practitioner order, an evaluation of the need and cost-effectiveness of services, and an independent review panel for high-needs cases. The *revised proposed amendments* would permit the medical examination to be conducted by an MD, PA, or NP, and would require such professional not to have had a prior provider-patient relationship with the individual. The *revised proposed amendments* also clarify that the independent assessment must consider the individual's home when evaluating the proposed plan of care. The *revised proposed amendments* eliminate the 30-day deadline for the practitioner order to be provided and would allow telehealth modalities to be used for all aspects of the assessment process.

Immediate Need. The *revised proposed amendments* align the immediate need process with the new assessment process. Thus, the *revised proposed amendments* clarify that the statement of need required to be submitted to the LDSS by an individual seeking to establish Medicaid and PCS eligibility must be from a physician with direct knowledge of the individual's condition.

MMCO Assessment Process Responsibilities. Under the *proposed amendments*, an MMCO would be responsible for the review of available services and supports to determine cost-effectiveness of services, determining the frequency of nursing supervision, heightened documentation requirements for cases involving 24-hour care, and the development of a plan of care. The *revised proposed amendments* would also require an MMCO: to determine and to consider an individual's preferences and social and cultural considerations when developing the plan of care; to review the independent assessment and practitioner order prior to developing the plan of care or authorizing services; to refer a case involving more than 12 hours of services per day to the independent review panel; to consider available informal supports in developing the plan of care; and to confirm the caregiver's willingness to meet the identified plan of care requirements.

Material Errors and Clinical Disagreements. The *revised proposed amendments* would establish a process to resolve mistakes (i.e., material errors of fact or observation not subject to clinical judgement) and clinical disagreements (i.e., a finding or determination that is subject to the independent assessor's clinical judgement). Material errors of fact that do not contradict the assessor's observation could be corrected with supporting evidence. A second independent assessment would be utilized to resolve any perceived clinical inconsistency or inaccuracy. In addition, the *revised proposed amendments* would hold an MMCO accountable by requiring that the second assessment be included in the time the MMCO has to develop a plan of care and make service authorizations. Sanctions would be imposed on MMCOs for failing to cooperate and abusing this resolution process.

Independent Medical Review Process. The *proposed amendments* create an independent medical review process for cases in which the LDSS or MMCO intends to authorize services in excess of an average of 12 hours per day, the high-needs threshold. The review would be performed by an independent panel of medical professionals and coordinated by a lead physician not involved in the initial examination. The *revised proposed amendments* clarify that the high-needs threshold would be calculated based on the authorizations of both PCS and CDPAS hours. The *revised proposed amendments* would also require the independent review panel to produce a report of its recommendation on whether the plan of care is reasonable and appropriate to maintain the individual's health safely at home. Further, the *revised proposed amendments* would permit the panel to suggest modifications to the plan of care, including level, frequency, and duration of services (although the panel would not be permitted to recommend specific amount of services).

Determination Timing. The *revised proposed amendments* would establish timeframes for assessments and authorizations. Specifically, all determinations by an LDSS for PCS and CDPAS would be required to be made with reasonable promptness, not to exceed seven business days after receipt of both the independent assessment and practitioner order (or the independent review panel recommendation if applicable), except as provided under the immediate need process. An MMCO would be required to make a determination and provide notice to current enrollees within the timeframes provided in its contract with DOH (or as otherwise required by Federal or state statute or regulation).

Reassessments and Reauthorizations. The *proposed amendments* are intended to align reassessment requirements when there is an unexpected change to an individual's social circumstances or medical condition. The *revised proposed amendments* clarify the specific instances in which an independent assessment and medical order are needed to reauthorize or maintain an authorization of services (i.e., upon discharge from an inpatient setting, certain unexpected changes in condition, and upon request from a consumer). Under the *revised proposed amendments*, a change of social circumstances alone will not trigger the need for a new independent assessment or practitioner order. The *revised proposed amendments* clarify that independent assessments and practitioner orders would not be required to reauthorize services, provided such assessments and orders occur annually. In addition, the *revised proposed amendments* clarify that if an independent medical review panel previously reviewed a high-needs case, another panel review is not necessary to reauthorize services if the case remains high-needs. However, if services are reduced below the high-needs level and then increased to a high-needs level, another review by the independent review panel would be required.

Fiscal Intermediaries. The *revised proposed amendments* clarify that where more than one fiscal intermediary is serving the same consumer, the consumer will be required to select a single fiscal intermediary in accordance with DOH guidance. Consumers will have up to 90 days to transition to a single fiscal intermediary.

Implementation. The *revised proposed amendments* include provisions that would allow the current PCS and CDPAS assessment process to continue until the independent assessment and practitioner services are established or if DOH has not contracted with or designated an entity to provide independent assessment and practitioner services. The *revised proposed amendments* also clarify that current recipients of Level I or Level II PCS or CDPAS will not be subject to the new minimum needs criteria described above, provided they have been assessed and authorized for services prior to the effective date of the amended regulations.

Fair Hearings. The *revised proposed amendments* clarify that the independent assessor and independent medical review recommendations are not binding on the MMCO or LDSS with respect to an individual's plan of care or for authorizing services. The *revised proposed amendments* require the LDSS

or MMCO to review such recommendations but to make their own determination of whether to amend the prepared plan of care. The recommendations by the independent assessor and independent medical review could be relevant clinical documentation for use by either the individual or LDSS or MMCO, in considering the plan of care as part of the fair hearing record. In cases where the individual is not eligible for MMCO enrollment, the independent assessor will provide notice and appear at any resulting fair hearing, if necessary.

View the draft regulations and comments here.

Comments on the *revised proposed amendments* can be submitted through March 13, 2021.

Authors

This GT Alert was prepared by:

- Tricia A. Asaro | +1 518.689.1416 | asarot@gtlaw.com
- Whitney Magee Phelps | +1 518.689.1427 | phelpsw@gtlaw.com
- Binny Seth | +1 518.689.1432 | sethb@gtlaw.com