NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

November 1, 2021

TO: Medicaid Managed Care Organizations
Local Departments of Social Services
Plan and Provider Associations
Interested Parties

FROM: Susan Montgomery, Director
Division of Long Term Care, OHIP

SUBJECT: Implementation Dates of PCS/CDPAS Regulatory Changes

The Department of Health (Department) is providing direction on the implementation timeline for recent regulatory changes to 18 NYCRR §§ 505.14 and 505.28. The notice of adoption for these final regulations was published in the New York State Register on September 8, 2021.

The regulations give the Department the ability to delay the effective date of certain provisions both to ensure adherence to federal requirements and ensure an appropriate implementation of the required changes. Accordingly, these regulatory provisions are divided into two categories:

- those that take effect on November 8, 2021, upon publication of the Notice of Adoption, and
- those that are pended to be effective at a later date (after November 8, 2021). The Department will issue additional direction to announce the later effective date(s) and provide the implementation timeline for changes in this category; however, it is anticipated that these later changes will not be effective prior to January 1, 2022 and that the Department will provide at least sixty (60) days prior written notice of these changes taking effect.

This letter is also posted to the Department's MRT II website here under Long Term Care. Please direct any questions on the information provided below to independent.assessor@health.ny.gov.

The Department is developing a pre-recorded webinar with slides to provide further detail for the provisions listed below effective November 8, 2021. The webinar will be posted to the MRT II website's "Proposed and Final Regulations Implementing MRT II Recommendations" page under the Long Term Care section on or about November 12, 2021.

REGULATORY AMENDMENT PROVISIONS EFFECTIVE NOVEMBER 8, 2021

Section 505.14(a)(3)(iii): Amendments reorganize existing prohibition on authorization of services if voluntary assistance, other formal services, and/or adaptive or specialized equipment are available and cost-effective.

Section 505.14(a)(5)(iii): Added to clarify and codify existing Department of Health policy that supervision and cueing may be provided as a means of assisting an individual to perform nutritional and environmental support functions or personal care functions, but are not a standalone personal care service, and may not be authorized, paid for, or reimbursed, except if they are provided to assist with one of the enumerated functions in section 505.14(a)(5)(ii).

Sections 505.14(a)(7) and 505.28(b)(12): Added to define the term "Medicaid Managed Care Organization (MMCO)." The proposed regulations add express references to MMCOs, in addition to existing references to LDSSs. Except where the amendments would implement new requirements and procedures, the addition of MMCOs acts to codify existing policies and practices with respect to MMCOs and the provision of PCS and CDPAS, such as those based on Federal regulations, the Department of Health's model contract requirements, and Department guidance. The term MMCO does not include an entity approved to operate a Program of All-inclusive Care for the Elderly (PACE) organization.

Sections 505.14(a)(8) and 505.28(b)(13): Added to provide a definition for "medical assistance" or "Medicaid" or "MA" to clarify that these terms as used throughout the regulation refer to the same program.

Section 505.28(b)(4): Amended to align the definition of "consumer directed personal assistant" with State law.

Section 505.28(b)(5): Added to provide a definition for "consumer directed personal assistance program" or "consumer directed program" or "the program" to clarify that these terms as used throughout the regulation refer to the same program.

Section 505.28(b)(16): Amends the definition for "self-directing consumer" to include the capability of performing the consumer responsibilities outlined in section 505.28(g).

Sections 505.14(b)(2)(ii)(g) and 505.28(d)(2)(vii) shall be effective November 8, 2021 only to the extent necessary to allow for the expansion of medical professionals that can sign forms DOH-4359 and M11Q.

Sections 505.14(b)(4)(vii) and 505.28(e)(5) shall be effective November 8, 2021 only to the extent that such provisions permit services to be authorized for a period of up to 12 months.

Sections 505.14(b)(4)(viii)(b) and 505.28(i)(4): Amended to provide the Department of Health greater flexibility in determining when the LDSS or MMCO must use Department-developed forms in providing notice of service authorization, reauthorization, increase, decrease, discontinuance or denial.

Sections 505.14(b)(4)(viii)(c)(1) and 505.28(i)(4)(iii): Added to require LDSSs or MMCOs to document in the notice and plan of care the factors and clinical rationale specific to the client that went into the medical necessity determination that PCS or CDPAS should be denied, reduced, or discontinued.

Sections 505.14(b)(4)(viii)(c)(2)(i) and 505.28(i)(4)(ii)(a): Amended to clarify that a denial may be made if the clients health and safety cannot be "reasonably" assured with the provision of personal care services or consumer directed personal assistance.

Sections 505.14(b)(4)(viii)(c)(2)(vi) and (b)(4)(viii)(c)(3)(iv) and 505.28(i)(4)(i)(e) and (i)(4)(ii)(d): Amended to clarify and provide examples of technological developments that may obviate the need for PCS or CDPAS.

Sections 505.14(b)(4)(viii)(c)(2)(vii) and 505.14(b)(4)(viii)(c)(3)(v): Amended to clarify that a denial may be made, or services may be reduced or discontinued, on the basis of residence in a facility if the client is not seeking to transition into a less restrictive setting or whose health and safety cannot be reasonably assured in such setting.

Sections 505.14(b)(4)(viii)(c)(2)(ix) and (b)(4)(viii)(c)(3)(vii) and 505.28(i)(4)(i)(g), (i)(4)(i)(h), (i)(4)(ii)(g), and (i)(4)(ii)(h): Added to provide additional examples for denying, reducing, or discontinuing services.

Sections 505.14(b)(4)(viii)(c)(3)(i) and 505.28(i)(4)(iii)(a): Amended to provide that services may be reduced or discontinued in cases where voluntary informal supports that are acceptable to the client have become available to meet some or all of the client's needs.

Sections 505.14(b)(4)(xiii) and 505.28(f)(3): Added to provide that the LDSS or MMCO shall document any changes in an individual's need for services in the plan of care, and consider and make any necessary authorization changes.

Sections 505.14(b)(8) and 505.28(m): Added to allow the Department of Health to permit the current assessment process to continue until such time as the independent assessment and practitioner services are established at capacity or if the Department has not contracted with or designated an entity to provide independent assessment and practitioner services.

Section 505.14(g)(3)(i): Amended to clarify that case management activities include determining that the patient is financially eligible for Medicaid, including community-based long term care services.

Previous Section 505.28(h)(1): Removed requirement that the LDSS annually notify those receiving other home care services about CDPAS.

Section 505.28(h)(2): Added to require consumer designated representatives to make themselves available to ensure that they can carry out the consumer responsibilities and must be present at scheduled assessments or visits for non-self-directing consumers.

Sections 505.28(e)(1)(v) and 505.28(h)(3): Added to prohibit the authorization of services provided through more than one fiscal intermediary per consumer and prohibit consumers from working with more than one fiscal intermediary at a time.

REGULATORY AMENDMENT PROVISIONS PENDED FOR A LATER EFFECTIVE DATE (AFTER NOVEMBER 8) – DATE(S) TO BE ANNOUNCED

Any provision not specifically cited above is pended until further direction from the Department, including but not necessarily limited to the following:

Sections 505.14(b)(2)(ii) and 505.28(d)(2): Added to describe the independent medical examination and practitioner order. Most of the examination and practitioner order requirements remain the same, such as the licensure, documentation, and practitioner signature requirements. However, the medical professionals who perform the examination and sign the practitioner order must be employed by or contracted with an entity designated by the Department of Health. Consequently, the 30-day deadline for the order to be provided after the examination has been eliminated. Also, as required by statute, the medical professionals who perform the examination and sign the practitioner order must be independent, meaning that they must not have a prior established provider-patient relationship with the individual.

Section 505.14(a)(1): Amended to align the "personal care services" definition with statutory requirements that such services be ordered by a qualified and independent practitioner, and not the individual's attending physician.

Section 505.14(b)(1) and the opening paragraph of section 505.28(d): Added to provide an overview of the assessment process, which include an independent assessment, a medical examination and practitioner order, an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required, an additional independent medical review for high needs cases. The paragraph further provides for how portions of the process may be conducted through telehealth modalities.

Sections 505.14(b)(2)(i) and 505.28(d)(1): Added to describe the independent assessment which is performed by an independent assessor as opposed to the LDSS or MMCO. The independent assessment contains most of the elements of the current social and nursing assessments. Other portions of the current social and nursing assessments have either become unnecessary or remain the responsibility of the LDSS or MMCO to perform. For example, the nursing assessment requirements to review the practitioner order and document the primary diagnosis code have become moot because, under the proposed regulation, the medical examination that leads to a practitioner order will occur after the independent assessment.

Sections 505.14(b)(2)(iii) and 505.28(d)(3): Added to describe the LDSS or MMCO responsibilities related to the assessment process. The LDSS or MMCO remain responsible for significant portions of the current assessment process requirements, including a) the review of other available services and supports to determine cost-effectiveness, b) determining frequency of nursing supervision, c) determining the individual's preferences and social and cultural considerations for the receipt of care; d) heightened documentation requirements for 24-hour cases, and e) the development of the plan of care. In addition, before developing a plan of care or authorizing services, the LDSS or MMCO must review the independent assessment and practitioner order by the independent assessor and independent medical professional. Also, prior to authorizing more than 12 hours of services per day on average, the LDSS or MMCO must refer the case to the independent review panel, for an additional independent medical review of the

individual and plan of care, and must consider the recommendation of the independent review panel when finalizing the plan of care and in its decision to authorize such services.

Sections 505.14(b)(2)(iv) and 505.28(d)(4): Added to require the LDSS or MMCO to coordinate with the entity or entities providing independent assessment and practitioner services. These sections also describe the process for resolving mistakes and clinical disagreements in the assessment process, as well as sanctions for failure to cooperate and abuse of the resolution process.

Sections 505.14(b)(2)(v) and 505.28(d)(5): Added to describe the revised independent medical review process. Under the revised process, an independent medical review must be obtained when the LDSS or MMCO proposes to authorize more than 12 hours of services per day on average. The review is performed by an independent panel of medical professionals and coordinated by a lead physician. The lead physician cannot be the practitioner who was involved in the initial examination or practitioner order. The lead physician, or another member of the panel, may evaluate the individual, consult with other providers and individuals, and obtain other medical records that may be relevant to the panel's recommendation. When the independent medical review is complete, the lead physician shall produce a report to the LDSS or MMCO providing the panel's recommendation on whether the plan of care is reasonable and appropriate to maintain the individual's health and safety in his or her home. The recommendation may not include a specific amount or change in amount of services.

Sections 505.14(b)(3)(i) and 505.28(g)(1): Added to require the independent assessment and practitioner order processes to be completed at least annually and in sufficient time to allow LDSSs and MMCOs to, when needed, comply with all applicable federal and state time frames for notice and determination of services.

Sections 505.14(b)(3)(ii) and 505.28(g)(2): Added to require that all determinations by the LDSS must 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.

Sections 505.14(b)(3)(iii) and 505.28(g)(3): Added to provide that MMCOs must make a determination and provide notice to current enrollees within the timeframes provided in their contract with the Department of Health, or as otherwise required by Federal or state statute or regulation.

Sections 505.14(b)(4)(i) and (b)(4)(ii) and 505.28(e)(1)(i) and (e)(1)(ii): Added to provide that an individual's eligibility for services must be established prior to authorization, and that authorization must occur prior to the provision of services.

Sections 505.14(b)(4)(iii) and 505.28(e)(1)(iii): Added to provide that the authorization and reauthorization of services must be based on and reflect the assessment process and any exceptions to that process applicable to reauthorizations.

Sections 505.14(b)(4)(vi) and 505.28(e)(4): Added to require the LDSS or MMCO to consider the recommendation of the independent review panel prior to authorizing more than 12 hours of services.

Sections 505.14(b)(4)(xi), (b)(4)(xii), and (b)(4)(vii) and 505.28(f)(1)(i), (f)(2), and (e)(5): Amended to clarify and align the required reassessment procedures when reauthorizing services under the new assessment process. In particular, an independent assessment and practitioner order are not needed to reauthorize services provided that they occur annually, rather than every six months, to maintain authorization or for another enumerated reason.

Sections 505.14(b)(6) and (7) and 505.28(l): Amended to align the immediate need process with the new assessment process. An individual must first provide to the LDSS a statement of need for personal care services from a physician with direct knowledge of the applicant's condition and an attestation of immediate need, before the individual is considered to have an immediate need.

Section 505.14(g)(3), (g)(4), and (g)(5): Amended to remove from case management responsibilities related to the coordination and performance of the practitioner order and the social and nursing assessments, and align requirements with the new assessment process.

Sections 505.14(a)(3)(iv), (a)(9) and 505.28(b)(1), (b)(14), (c)(8): Added to update the scope and needs requirements for PCS and CDPAS. Consistent with statutory requirements, recipients would need to demonstrate a minimum need for assistance with activities of daily living (ADL) before such services may be authorized. Specifically, individuals with dementia or Alzheimer's must need at least supervision with more than one ADL, and all others must need at least limited assistance with physical maneuvering with more than two ADLs.

Section 505.14(c): Amended to remove the requirement for LDSSs to maintain contracts for the provision of nursing services.

Section 505.14(f)(3)(vi): Amended to remove references to the nursing assessment and clarify that the LDSS and MMCO are responsible for determining nursing supervision frequency.

Section 505.28(b)(1): Added to provide a definition of "activity of daily living" to align with State law.

Section 505.28(b)(8): Amended definition of "fiscal intermediary" to mean an entity with a contract with the New York State Department of Health.

Section 505.28(j)(1)(vii): Amended fiscal intermediary responsibilities to repeal requirement that fiscal intermediaries enter into contracts with LDSS and replace with requirement that a fiscal intermediary enter into contract with the Department of Health and into administrative agreements with MMCOs