March 12, 2020

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New York State Department of Health
Corning Tower
Albany, New York 12210

Via Email

Re: Re-Publication of Amendments to 18 NYCRR §505.14 (personal care services), and 18 NYCRR §505.28 (consumer directed personal assistance program services)

Dear Ms. Ceroalo:

I am writing on behalf of LeadingAge New York's managed long term care (MLTC) plan and provider members to raise a number of concerns and recommendations relating to the re-publication of proposed amendments to the personal care services (PCS) and Consumer Directed Personal Assistance Services (CDPAS) regulations.

We appreciate the careful consideration the Department gave to our earlier comments and the comments of other stakeholders on the initial proposed regulations. The revised amendments address many of the concerns we raised and offer far more clarity than the initial proposals. In particular, we support the decision to exclude PACE programs from the independent assessment and related processes; however, we ask that the Department review beneficiary intake and enrollment processes to ensure that the new independent assessment process does not inadvertently divert prospective PACE enrollees into other plans and that enrollees are made aware of the PACE options. We also commend the effort that went into developing a process for resolving disagreements over independent assessment findings. And, we support the Department's decision to make available telehealth assessments and examinations, while ensuring that beneficiaries would have the ability to receive on-site support in using the technology and the option of selecting an in-person assessment or examination. Finally, we appreciate the Department's decision to give nurse practitioners and physician assistants, as well as physicians, the authority to sign independent practitioner orders for personal care and CDPAS services.

As noted in our earlier comments, we support the goal of the proposed regulations to ensure that Medicaid beneficiaries receive the appropriate PCS and CDPAS to meet their clinical needs. We also share the Department's interest in ensuring program integrity and improving efficiency. However, we remain concerned that exclusive reliance on independent assessors, who do not know the beneficiary, will compromise the accuracy of assessments and the appropriateness of care plans. We further believe that implementing these major changes in procedures for determining eligibility and level of need for PCS and CDPAS on a compressed timeline in the midst of a pandemic, when systems and consumers are under significant strain, will exacerbate concerns related to the validity of the processes and jeopardize access to needed services. Accordingly, we are providing the following recommendations:

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Need for Continued Plan-Based Assessment and Reimbursement

- **Issue:** We have recently been informed that the Department intends to eliminate reimbursement for plan-based assessments from MLTC rates. The standards for effective care planning set forth in the federal regulations and in the MLTC contract are rigorous and demand accurate assessments. The MLTC contract requires the plan to develop a person-centered service plan that reflects, among other issues, the beneficiary's assessed needs (including health and safety risk factors) and personal goals. As part of care management, the contract requires at least one in-person home visit every 6 months. It will be extraordinarily difficult to develop a person-centered service plan that meets these standards without assessing the beneficiary and discussing these issues with him or her. Moreover, it is difficult to understand the reason for the in-person visit, if not to assess the beneficiary.

  Our members believe that plan-based assessments are critically important to support effective person-centered care planning. They believe that a one-time assessment by an individual who has no prior knowledge of the beneficiary, his/her good days and bad days, communication style, habits, informal supports, and physical environment, is not likely to yield an accurate picture of the individual's needs and resources. Although the proposed regulations do not directly address reimbursement for assessments, we wish to point out the need for plan-based assessments and the need for reimbursement of associated expenses.

- **Recommendation:** We urge the Department to recognize the need for continued plan-based assessments and reconsider its decision to eliminate reimbursement for plan assessments. It is also worth noting that the proposed regulations impose extensive requirements on plans and LDSSs related to notification, cooperation, and coordination among the IA/IRP, the beneficiary and his/her representatives, and the plan or LDSS. In addition, new penalties are imposed for failure to fulfill these responsibilities. These new responsibilities must be recognized in plan rates.

Effective Date and Phased Implementation

- **Issue:** The implementation of these regulations and associated procedures entail major changes in the way that older adults and people with disabilities access community-based long-term care. The regulations also require mainstream managed care plans and managed long-term care plans (collectively MCOs), local social services districts, providers, and beneficiaries to coordinate assessments, enrollment, and authorizations. Launching this new process in the context of a pandemic, when all stakeholders are operating under significant stress, heightens the challenges. Communication failures, delays, technical flaws, superficial training, and/or errors in assessments may create barriers to needed care or enable ineligible individuals to access care.

  Moreover, these changes are expected to be implemented concurrent with the implementation of the anticipated substantial dislocation of beneficiaries from their current fiscal intermediaries (FIs) to new FIs selected under the state's RFP process. In many cases, the shift to a new FI will entail a shift to a new MLTC plan that contracts with the new FI. Not only will the transition to new FIs and potentially new MLTC plans create turmoil and administrative stress, there is also a

significant backlog of assessments, due to the suspension of routine reassessments for almost a year, that will need to be addressed.

We appreciate that the timeline for implementation of this initiative has been repeatedly delayed; however, in the absence of finalized regulations and critical workflow documentation and development, it will be infeasible to implement these processes within the 60 days contemplated by the regulations, without negative impacts on beneficiaries.

- **Recommendation**: We recommend a delay in the effective date of the regulations until at least July 1. When the regulations take effect, we recommend a phased implementation beginning with assessments of new applicants only. The savings to be achieved from these measures appear to be related to the change in the eligibility criteria for PCS and CDPAS (i.e., the ADL requirements or "minimum need requirements"). Under the statute, these enhanced eligibility criteria apply only to new enrollees. Thus, any savings associated with the independent assessment process could be achieved by launching the process at the outset for new enrollment assessments only and delaying the implementation for change in condition assessments and reassessments. This would allow existing enrollees to receive change in condition assessments through their plans and avoid delays in accessing additional services for enrollees who are being discharged from hospitals or nursing homes or experiencing a deterioration in their condition.

Mistakes and Clinical Disagreements

- **Issues:** As noted in our earlier comments, our members express significant concerns about the validity of independent assessments conducted by nurses who have little, if any, first-hand knowledge of the individual being assessed. Plans and providers note that beneficiaries often do not have accurate recall of issues or are reluctant to report to an unfamiliar person on issues addressed by assessments (e.g., flu shots, falls within 30 days, ER visits in the last 90 days, incontinence, degree of assistance needed for ADLs and IADLs, willingness and availability of informal caregivers). This lack of familiarity with the individual and his/her social and environmental context raises the possibility of either inflated assessed need that exceeds actual need *or* assessed need that understates actual need. These concerns are heightened by the prospect of these assessments being conducted virtually.

  We appreciate the Department's effort to create a fair and efficient process for resolving both mistakes and clinical disagreements between the IA and the MCO or LDSS. We are concerned that the short turn-around time allowed between the second assessment and the issuance of the care plan, along with the prospect of penalties, will unnecessarily deter plans from raising clinical disagreements. The result may be assessments that too often do not reflect the true needs of the beneficiary.

- **Recommendations:** We recommend that the Department eliminate monetary penalties as a possible consequence of over-use of the correction and clinical disagreement process. At a minimum, plans that frequently identify mistakes or clinical disagreements should not be penalized if their corrections are usually adopted or their clinical findings are validated in the second assessment.

PACE Programs

- **Issues:** As noted above, we support the Department's decision to exempt PACE programs from the IA, independent medical examination and independent review panel processes. However, we noted that the commentary accompanying the proposed regulations indicates that DOH is still considering whether PCS and CDPAS services authorized by PACE programs should be subject to minimum needs criteria and that it will issue subsequent guidance informed by federal rules. PACE programs are subject to an eligibility standard set forth in federal regulations (i.e., nursing home level of care). Although the State's minimum needs criteria will in most cases align with that standard, there are situations in which a beneficiary would be eligible for PACE under federal regulations, but would not qualify under the state's minimum need criteria. For example, a beneficiary with cognitive impairment caused by a condition other than dementia who needs supervision (but not assistance with physical maneuvering) with three ADLs would not qualify for PCS or CDPAS under the state's minimum need criteria, but might quality as nursing home eligible for PACE purposes.

- **Recommendation**: The regulations should be revised to recognize the federally-mandated PACE eligibility standard and clearly state that the minimum needs criteria do not apply to prospective and enrolled PACE members.

Timing of Steps in the Process

- **Issues:**
  - Change-in-Condition Assessments and IRP Review: The timing of change-in-condition assessments is perhaps the most challenging aspect of the new system. It is worth noting that the elimination of semiannual reassessments and the suspension of reassessments during the pandemic may result in greater need for change-in-condition assessments, as there may be fewer opportunities to observe a gradual decline in beneficiaries' condition. While many change-in-condition assessments may be conducted on a non-urgent basis, others demand immediate attention. Under their contract with the State, MLTC plans must meet compressed time frames for expedited prior authorization and concurrent review – generally 3 business days from the request or 1 business day from receipt of the necessary information. Our MLTC members report that they conduct same-day assessments when needed, such as prior to discharge from a hospital.

    It is critical that same-day assessments remain available to address unexpected needs. The time allotted for change-in-condition assessments must also take into account the need for MCOs to review and follow up on the IA's assessment, make the necessary changes in the care plan, and coordinate with the beneficiary, family members, and providers to put in place the needed services, supplies, and equipment, and to accommodate an IRP referral where applicable. Likewise, IRP reviews must be conducted on an expedited basis where applicable. While these timeframes do not necessarily have to appear in the regulations, they should be incorporated into the contract with the IA and in workflows.

- Recertification Assessments: These assessments must be conducted well in advance of the end of the month in which the recertification is due in order to provide the MCO with sufficient time to review the assessment, conduct its own assessment if needed, modify the person-centered service plan (PCSP), and issue authorizations.

- Independent Review Panel Referrals: The proposed regulations provide that an MCO should not refer a case to the IRP unless and until the individual is enrolled or scheduled for enrollment in the MCO, and the MCO has received confirmation that then enrollment will be processed on a date certain by the enrollment broker. The expected timing of referrals and mode of communication is unclear, given existing enrollment systems.

- **Recommendations:** The proposed regulations should be amended to include provisions to:
  - Ensure timely completion of recertification assessments and change in condition assessments, including, for expedited requests, the availability of same-day change-in-condition assessments;
  - Ensure, in response to a change in condition, the availability of same-day IRP recommendations, in response to expedited requests, if the plan authorizes more than 12 hours daily;
  - In advance of the effective date of these regulations, provide plans, LDSSs, and the IA with a clear workflow and guidance for IRP referrals and reviews, taking into account the enrollment workflow and systems.

Nurse Supervision

Issue: The assessment of public comment in response to the prior publication notes that: "Both LDSSs and MMCO must provide nursing supervision, and documentation of nursing supervisory visits must occur regardless of whether the service is provided or arranged by an LDSS or MMCO." We are not aware of any requirement on MLTC plans to provide nursing supervisory visits. Home care agencies are responsible for providing nursing supervision of aides.

Recommendation: Please clarify the Department's intent concerning this statement in the assessment of public comment.

Thank you for your consideration of these concerns and recommendations. We would be happy to schedule a call with you to discuss them in more detail.

Sincerely yours,

Karen Lipson
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cc: Darius Kirstein
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