7/20/2020

PCS/CDPAS Proposed Regs:

Initial Questions and Concerns

General Questions and Comments

- Overall, there is significant concern among our members that the process of enrolling in a plan or securing personal care/CDPAS services will become even more bureaucratic and challenging to navigate for older adults and people with disabilities, as they proceed through 2 or three levels of review (or even more) by professionals with whom they have no connection.
- We understand, based on emails from DOH that the CFEEC will be replaced by the Independent Assessment (IA), and that the IA will determine whether applicants and existing recipients meet the new "minimum needs requirements." However, we do not see any provision in the proposed regulations that requires or authorizes the IA to make this determination. Although the regulations define "minimum needs and requires patients to meet them in order to qualify for PCS or CDPAS, the regulations do not assign any entity to make this determination. The minimum need determination is a key element of the process and should be included in the regulations and the process for determining minimum need should be subject to public comment.
- If the IA is charged with making the minimum needs determination, will it be the entity responding to fair hearing requests? If not, what entity will have this responsibility?
- Our members believe that assessments are integral to the development of an effective plan of care and to enabling the individual to maintain his/her safety and health in the community. They are unwilling to rely exclusively on assessments conducted by nurses whom they do not train, supervise, or hold accountable. Moreover, with respect to reassessments and change in condition assessments, these nurses will be generally unfamiliar with the individual, his/her cognitive and physical deficits and strengths, history, social supports, and the variability of his/her condition. Accordingly, plans are likely to continue to conduct assessments, and rates should not be reduced based on the assumption that they no longer need to do so.
- The regulations generally delete or omit timeframes for the completion of assessments. Will the IA, independent medical exam, and independent medical review be subject to timelines that will allow prompt completion of plans of care and addition of services in urgent situations?
- Will the LHCSAs that conduct assessments on behalf of Maximus be subject to conflict of interest provisions? In other words, will they be prohibited from providing services for the patients they assess? In some counties or regions, this type of prohibition may create access problems, due to the limited number of LHCSAs actually serving a geographic area and/or, for some plans, the LHCSA network limits.

Independent Assessment Process

- DOH has indicated that the IA will conduct change in condition assessments. The 'unexpected change' provisions for PCS and CDPAS require the LDSS and the MCO to review the IA, but do not reference a process for obtaining a new IA.
- Is a new IA required, and if so, what is the process and timeframe for obtaining one?

- A typical scenario for a change in service needs is at hospital or nursing home discharge when enhanced services need to be in place quickly notice. How will this be handled by the IA?
- The regs provide that if there is a factual inaccuracy in the IA, the MCO and the LDSS must advise the IA, and the IA must correct it if it agrees. What if the IA does not agree? Is there any recourse? The accuracy of the assessment is critical for care planning, the independent medical review, and the calculation of risk scores and quality measures.
- The proposed regs eliminate the assessment of appropriateness for hospice services. Was this intentional?

Role of Independent Medical Exam and Physician Order

- Is an *in-person* medical examination required? If so, will the applicant/beneficiary have to travel to the physician? Will there be distance/travel time and accessibility requirements for the independent medical practitioners? Will this be waived or modified in light of COVID?
- The regulatory provisions governing the content of the medical exam are not aligned with the elements of the physician order, and neither is aligned with the requirements to qualify for personal care. Was that intended? Specifically:
    - The Independent Medical Exam (IME) must accurately describe patient's medical condition and regimens, including medication and "need for assistance with PCS tasks." The regulations do not use the terminology of ADLs or minimum needs requirements. Nor do they appear to require any assessment or findings related to ability self-direct and to be safe at home, or related to frequency of need for assistance.
    - Even though the medical exam does not include these components, the physician signing the order must indicate whether patient "is self-directing" and can be "safely cared for at home." At a minimum, shouldn't the factors included in the examination be aligned with the findings of the order that is being signed?
- For continuous or live-in services, the MCO or LDSS is supposed to assess and document in the plan of care whether the physician order indicated a medical condition that causes the patient to need frequent assistance with toileting, walking, transferring, turning and positioning, or feeding. However, the regulations governing the IMA and the physician order do not require any evaluation regarding frequency of need. These should be aligned.
- The presentation to the home care associations described the physician "note" needed for the transfer of assets evaluation. In addition, the LHCSA operating regulations (10 NYCRR 766.4) require LHCSAs to obtain medical orders annually for any patient receiving personal care services. Will this physician order satisfy the physician note required for the transfer of assets evaluation and the operating regulation requirement?

Authorization and Reauthorization Standards

- There are various standards for LDSSs and MCOs to authorize services (e.g., medically necessary, actually required to maintain health and safety at home, reasonable and appropriate and cost effective). Was this intended? The inconsistency of the standards in different sections of the regulations will likely lead to confusion for plans, LDSSs, ALJs, and the courts.

Independent Medical Review (IMR) by Clinical Review Panel

- The regulations provide that the lead physician "may evaluate the patient, or review an evaluation performed by another medical professional on the clinical review panel." (p. 39)
- Is this an in-person evaluation? This raises the same questions as above.
- If the plan of care authorizes less than 12 hours on average per day of personal, but also authorizes private duty nursing, home health care, and/or ADHC care, with an aggregate number of hours in excess of 12, would the Independent Medicaid Review (IMR) be required?
- If an ALJ orders more than 12 hours of care daily after a fair hearing, does the plan of care require an IMR?

PACE Regulations Governing Assessment, IDT, and Plan of Care

- The proposed regulations do not align well with the federal PACE regulations and manual. The federal regulations impose rigorous in-person assessment, reassessment, change in condition assessment, IDT, and plan of care procedures within stringent timeframes. The IA cannot substitute for PACE program assessments and reassessments. In addition, in order to qualify for PACE, the individual must require a nursing home level of care.
    - For example, when a participant requests a change in services, the PACE IDT must notify the participant or designated representative of its decision to approve or deny the request from the participant or designated representative as expeditiously as the participant's condition requires, but no later than 72 hours after the date the IDT receives the request for reassessment. Will the IA be able to provide change in condition assessments rapidly enough to allow the IDT to review the assessment, make plan of care changes, and notify the participant within 72 hours of the request?
    - How do the minimum need requirements align with PACE's nursing home eligibility standard?

Data Sharing and Communication

- The IA, IME, physician order, and CRP processes will require seamless communication and data sharing among multiple parties.
- Real-time data is important for care plan development and quality improvement purposes. Many plans use the UAS in combination with an analyzer, such as the Lenavi software, to support quality improvement and plan of care development. The IA process should not disrupt access to the UAS and the use of these types of tools.

Relationship to Other Programs and Services

- How do these regulations affect personal care under waiver programs, if at all, including the NHTD and TBI waivers? How do they affect eligibility for Level 1 personal care and the process for determining such eligibility?

- If a member or fee-for-service beneficiary receives only PDN, ADHC or CHHA services, and no personal care services or CDPAS, would they go through the IA and IME at reauthorization? If not, what entity will conduct the UAS for these services?