

## **SUMMARY OF EXPRESS TERMS**

The proposed rulemaking would amend 18 NYCRR § 505.14, related to personal care services (PCS), and 18 NYCRR § 505.28, related to consumer directed personal assistance program services (CDPAS), to implement recent statutory changes resulting from recommendations of the Medicaid Redesign Team II as adopted in the State Fiscal Year 2020-21 Enacted Budget and to make other conforming changes.

Section 505.14(a)(1) is amended to align the “personal care services” definition with statutory requirements that such services be ordered by a qualified and independent physician, and not the individual’s attending physician.

Section 505.14(a)(3)(iii) is amended to fully align the scope of services with local social services departments (LDSSs) and Medicaid Managed Care Organizations (MMCOs) evaluation responsibilities. Both LDSSs and MMCOs must evaluate the cost effectiveness of the provision of services relative to other services and supports available to the individual. Services may not be provided if they are not cost-effective in comparison to other appropriate alternatives.

Sections 505.14(a)(3)(iv), (a)(9) and 505.28(b)(1), (b)(13), (c)(8) are added to update the scope and eligibility 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.

Subparagraph 505.14(a)(5)(iii) is 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 independent from one of the enumerated functions in section 505.14(a)(5)(ii).

Sections 505.14(a)(7) and 505.28(b)(11) are 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.

Section 505.14(a)(8) is 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) is amended to align the definition of “consumer directed personal assistant” with State law.

Section 505.28(b)(5) is 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)(15) 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)(1) through (4) and 505.28(d) are repealed and sections 505.14(b)(1) to (3) and 505.28(d) are added to implement a revised assessment process required for the authorization of PCS and CDPAS.

Section 505.14(b)(1) and the opening paragraph of section 505.28(d) provide the main elements of the assessment process, which include an independent assessment, a medical exam and physician 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. New provisions are also added to require the LDSS or MMCO to refer applicants as needed to complete the elements of the assessment and eligibility process.

Sections 505.14(b)(2)(i) and 505.28(d)(1) describe the independent assessment which is performed by an independent assessor as opposed to the LDSS or MMCO. The independent assessment contains the following elements from the current social and nursing assessments: the functional needs, the individual’s perception of circumstances and preferences, and potential contributions of informal caregivers in meeting the individual’s needs. The minimum qualifications currently in place for a nurse conducting the nursing assessment have been maintained for the independent assessor. 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 physician order and document the primary diagnosis code have become moot because, under the proposed regulation, the medical exam that leads to a physician order is not required to occur prior to the independent assessment.

Sections 505.14(b)(2)(ii) and 505.28(d)(2) describe the independent medical exam and physician order. Most of the exam and physician order requirements remain the same, such as the licensure, documentation, and physician signature requirements. However, the medical professionals who perform the exam and sign the physician 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 exam has been eliminated. Also, as required by statute, the medical professionals who perform the exam and sign the physician order must be independent, meaning that they must not have a prior established provider-patient relationship with the individual.

Sections 505.14(b)(2)(iii) and 505.28(d)(3) 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) heightened documentation requirements for 24-hour cases, and d) the development of the plan of care. In addition, the LDSS or MMCO must now specifically review the results of the independent assessment and medical exam performed 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 clinical review panel, for an additional independent medical review of the individual and plan of care, and must consider the recommendation of the clinical review panel in its decision to authorize such services.

Sections 505.14(b)(2)(iv) and 505.28(d)(4) describe the revised independent medical review process. Under the revised process, an independent medical review is required only 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 physician who was involved in the initial examination or physician 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 provide to the LDSS or MMCO the panel's recommendation of whether the plan of care is reasonable and appropriate to maintain the individual's health and safety in his or her home, identify any other Medicaid services that may be appropriate, and include the clinical rationale for such recommendation. The recommendation may not include specific hours of services or an alternative plan of care.

Sections 505.14(b)(3)(i) and 505.28(e)(7) 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 physician order, or the clinical review

panel recommendation if applicable, except as provided under the immediate need process.

Sections 505.14(b)(3)(ii) and 505.28(e)(8) 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), (ii) and 505.28(e)(1)(i), (ii) are 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) are 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.

Section 505.28(e)(1)(v) is added to prohibit the authorization of services provided through more than one fiscal intermediary per consumer.

Sections 505.14(b)(4)(vi) and 505.28(e)(4) are amended to extend the maximum default authorization periods from 6 to 12 months.

Sections 505.14(b)(4)(vii)(b) and 505.28(h)(4) are 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)(vii)(c)(1)(vi) and (2)(iv) and 505.28(h)(4)(i)(e) and (ii)(d) are amended to clarify and provide examples of technological developments that may obviate the need for or cost-effectiveness of providing PCS or CDPAS.

Sections 505.14(b)(4)(vii)(c)(1)(ix), (b)(4)(vii)(c)(2)(vii), and (b)(4)(vii)(c)(2)(viii) and 505.28(h)(4)(i)(h), (h)(4)(i)(i), (h)(4)(ii)(g), (h)(4)(ii)(h), and (h)(4)(ii)(i) are added to provide additional examples for denying, reducing, or discontinuing services. Section 505.28(h) is also amended to remove the requirement to notify those receiving other home care services about CDPAS in alignment with State law.

Sections 505.14(b)(4)(vii)(c)(3) and 505.28(h)(4)(iii) are added requiring 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)(xi) and 505.28(f)(1) are amended to better align the required reassessment procedures when reauthorizing services with the new assessment process. In particular, a new physician order is not needed unless the order on file is more than 12 months old, or if a physician order is otherwise clinically indicated.

Sections 505.14(b)(4)(xii) and 505.28(f)(2) are amended to better align reassessment requirements when there is an unexpected change to the individual's social circumstances, mental status or medical condition with the new assessment process.

Sections 505.14(b)(4)(xiii) and 505.28(f)(3) are 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)(6) and (7) and 505.28(k) align the immediate need process with the new assessment process. An individual must first provide to the LDSS a physician's statement of need for personal care services and an attestation of immediate need, before the individual is considered to have an immediate need.

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

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

Section 505.14(g) is amended to remove from case management responsibilities related to the coordination and performance of the physician order and the social and nursing assessments, and align requirements with the new assessment process.

Section 505.28(g)(2) requires 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 nonself-directing consumers.

Section 505.28(g)(3) prohibits consumers from working with more than one fiscal intermediary at a time.



Pursuant to the authority vested in the Commissioner of Health by Social Services Law sections 363-a, 365-a(2)(e), and 365-f(5)(b) and Public Health Law section 201(1)(v), sections 505.14 and 505.28 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) are amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Paragraph (1) of subdivision (a) of section 505.14 is amended to read as follows:

(1) *Personal care services* means assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be [essential to the maintenance of] medically necessary for maintaining the patient's health and safety in his or her own home, as determined by the social services district or Medicaid managed care organization in accordance with this section; ordered by [the attending] a qualified independent physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph [(b)(3)(iv)] (b)(2)(iii) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

The opening paragraph of paragraph (3) of subdivision (a) of section 505.14 is amended to read as follows:

(3) Personal care services, as defined in this section, can be provided only if the [services are medically necessary] patient meets applicable minimum needs requirements described in subparagraph (iv) of this paragraph, and the social services district or Medicaid managed care organization reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

Subparagraph (iii) of paragraph (3) of subdivision (a) of section 505.14 is amended and new subparagraph (iv) is added to read as follows:

(iii)

[(a)] Personal care services, including continuous personal care services and live-in 24-hour personal care services [as defined in paragraphs (2) and (4), respectively, of this subdivision],<sup>2</sup> shall not be authorized to the extent that the social services district or Medicaid managed care organization determines that any of the services or supports identified in paragraph (2)(iii)(b) of subdivision (b) of this section are available and appropriate to meet the patient's [need for assistance can be met by the following:] needs and are cost-effective if provided instead of personal care services.

[(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

(b) The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.]

(iv) Patients must meet minimum needs requirements in accordance with state statute to be eligible for personal care services. For purposes of this section, *minimum needs requirements* means:

(a) for patients with a diagnosis by a physician of dementia or Alzheimer's, being assessed in accordance with subdivision (b) of this section as needing at least supervision with more than one activity of daily living.

(b) for all other patients, being assessed in accordance with subdivision (b) of this section as needing at least limited assistance with physical maneuvering with more than two activities of daily living.

Clause (b) of subparagraph (ii) of paragraph (5) of subdivision (a) of section 505.14 is amended to read as follows:

(b) Before more than 12 hours of personal care services per day on average, including continuous personal care services or live-in 24-hour personal care services, may be authorized, additional requirements for the authorization of such services, as specified in [clause (b)(4)(i)(c)] subdivision (b)(2)(iv) of this section, must be [met] satisfied.

A new subparagraph (iii) is added to paragraph (5) of subdivision (a) of section 505.14 is amended to read as follows:

(iii) The personal care aide may perform nutritional and environmental support functions and personal care functions for the recipient and may also assist the recipient to perform such tasks themselves. Assistance may include supervision and cueing to help the recipient perform a nutritional and environmental support function or personal care function if the recipient could not perform the task without such assistance. Supervision and cueing are not standalone personal care services and may not be authorized, paid for or reimbursed separately from or in addition to the performance of nutritional and environmental support functions or personal care functions.

New paragraphs (7), (8) and (9) are added to subdivision (a) of section 505.14 to read as follows:

(7) *Medicaid managed care organization* or *MMCO* means an entity that is approved to provide medical assistance services, pursuant to a contract between the entity and the Department of Health, and that is: (i) certified under article forty-four of the Public Health Law, or (ii) licensed under article forty-three of the Insurance Law.

(8) *Medical assistance* or *Medicaid* or *MA* means the program to provide services and benefits under title 11 or article 5 of Social Services Law.

(9) *Activities of daily living* means bathing, personal hygiene, dressing, walking, locomotion, transferring on to and off the toilet and toilet use, bed mobility, and eating.

The opening paragraph and paragraphs (1) through (4) of subdivision (b) of section 505.14 are amended to read as follows:

(b) Criteria for the assessment and authorization [for provision] of services.

[(1) When the local social services department receives a request for services, that department shall determine the applicant's eligibility for medical assistance.

(2) The initial authorization for personal care services must be based on the following:

(i) a physician's order that meets the requirements of subparagraph

(3)(i) of this subdivision;

(ii) a social assessment that meets the requirements of subparagraph (3)(ii) of this subdivision;

(iii) a nursing assessment that meets the requirements of subparagraph (3)(iii) of this subdivision;

(iv) an assessment of the patient's appropriateness for hospice services and assessment of the appropriateness and cost-effectiveness of the services specified in subparagraph (3)(iv) of this subdivision; and

(v) such other factors as may be required by paragraph (4) of this subdivision.]

(1) The assessment process includes an independent assessment, a medical exam and physician order, an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required under paragraph (2) of this subdivision, a referral to a clinical review panel. When the social services district or MMCO receives a request for services, that social services district or MMCO shall refer the applicant for an independent assessment and physician order, provide assistance to the individual in making contact with the independent assessor designated by the Department of Health to begin the assessment process and, if needed,

the MMCO shall refer the applicant to the social services district and the social services district shall begin to determine the applicant's financial eligibility for medical assistance services, including community based long term care services.

~~(3)~~ (2) The initial [authorization] assessment process shall include the following procedures in all cases:

(i) A physician's order must be completed on the form required by the department.

(a) The physician's order form must be completed by a physician licensed in accordance with article 131 of the Education Law, a physician's assistant or a specialist's assistant registered in accordance with article 131-B of the Education Law, or a nurse practitioner certified in accordance with article 139 of the Education Law.

(1) Such medical professional must complete the physician's order form within 30 calendar days after he or she conducts a medical examination of the patient, and the physician's order form must be forwarded to a social services district or another



entity in accordance with clause (c) of this subparagraph.

(2) Such medical professional must complete the physician's order form by accurately describing the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks and by providing only such other information as the physician's order form requires.

(3) Such medical professional must not recommend the number of hours of personal care services that the patient should be authorized to receive.

(b) A physician must sign the physician's order form and certify that the patient can be cared for at home and that the information provided in the physician's order form accurately describes the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks, at the time of the medical examination.

(c) Within 30 calendar days after the medical examination of the patient, the physician, other medical professional, the patient or the patient's representative must forward a completed and signed copy of the physician's order form to the social services district for completion of the social assessment; however, when the social services district has delegated, pursuant to subdivision (g) of this section, the responsibility for completing the social assessment to another agency, the physician, other medical professional, the patient or the patient's representative must forward a completed and signed copy of the physician's order form to such other agency rather than to the social services district.

(d) When the social services district, or the district's designee pursuant to subdivision (g) of this section, is responsible for completing the social assessment but is not also responsible for completing the nursing assessment, the district or its designee must forward a completed and signed copy of the physician's order form to the person or agency responsible for completing the nursing assessment.

(e) The physician's order is subject to the provisions of Parts 515, 516, 517 and 518 of this Title. These Parts

permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services, or supplies when medical care, services, or supplies that are unnecessary, improper or exceed patients' documented medical needs are provided or ordered.]

[(ii)] (i) Independent assessment. [The social] An assessment shall be completed by [professional staff of the social services district] an independent assessor employed or contracted by an entity designated by the Department of Health to provide independent assessment services on forms approved by the [department .] Department of Health in accordance with the following:

(a) The independent assessment must be performed by a nurse employed with the following minimum qualifications:

(1) a license and current registration to practice as a registered professional nurse in New York State;  
and

(2) at least two years of satisfactory recent  
experience in home health care.

(b) The independent assessment shall include the  
following:

(1) an assessment of the functions and tasks  
required by the patient;

[(a)] (2) [The social assessment shall include] a  
discussion with the patient to determine perception  
of his/her circumstances and preferences[.]; and

[(b)] (3) [The social] an assessment [shall include  
an evaluation] of the potential contribution of  
informal caregivers, such as family and friends, to  
the patient's care, and shall consider all of the  
following:

[(1)] (i) number and kind of informal  
caregivers available to the patient;

[(2)] (ii) ability and motivation of informal caregivers to assist in care;

[(3)] (iii) extent of informal caregivers' potential involvement;

[(4)] (iv) availability of informal caregivers for future assistance; and

[(5)] (v) acceptability to the patient of the informal caregivers' involvement in his/her care.

[(c) When live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide.

[(d) The social assessment shall be completed on a timely basis and shall be current.

(iii) The nursing assessment shall be completed by a nurse from the certified home health agency, a nurse employed by, or under

contract with, the local social services department, or a nurse employed by a voluntary or proprietary agency under contract with the local social services department.

(a) A nurse employed by, or under contract with, the local social services department or by a voluntary or proprietary agency under contract with the local social services department shall have the following minimum qualifications:

(1) a license and current registration to practice as a registered professional nurse in New York State;  
and

(2) at least two years of satisfactory recent experience in home health care.

(b) The nursing assessment shall be completed within five working days of the request and shall include the following:

(1) a review and interpretation of the physician's order;

(2) the primary diagnosis code from the ICD-9-CM;

(3) an evaluation of the functions and tasks required by the patient;

(4) an evaluation whether adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, can meet the patient's need for assistance with personal care functions and whether such equipment or supplies can be provided safely and cost-effectively;

(5) development of a plan of care in collaboration with the patient or his/her representative; and

(6) recommendations for authorization of services.]

(ii) Independent medical exam and physician order.

(a) Each patient seeking personal care services must have an examination by a medical professional employed or

contracted by an entity designated by the Department of Health to provide independent physician order services.

(b) The medical professional who examines the patient must be a physician licensed in accordance with article 131 of the Education Law, a physician assistant or a specialist assistant registered in accordance with article 131-B of the Education Law, or a nurse practitioner certified in accordance with article 139 of the Education Law.

(c) The medical professional must be independent with respect to the patient, meaning that they must not have established a provider-patient relationship prior to the clinical encounter from which the physician order is completed.

(d) The medical professional must examine the patient and accurately describe the patient's medical condition and regimens, including any medication regimens and the patient's need for assistance with personal care services tasks.



(e) The medical professional must review the independent assessment and may review other medical records and consult with the patient's providers and others involved with the patient's care if available to and determined necessary by the medical professional.

(f) The medical professional must complete a form required or approved by the Department of Health (the "physician order form").

(g) A physician employed or contracted by an entity designated by the Department of Health, who may be the examining medical professional, must sign the physician order form, certify that the information provided in the form accurately describes the patient's medical condition and regimens at the time of the medical examination, and indicate whether the patient is self-directing and whether the patient can be safely cared for at home.

(h) The physician order form must be completed and made available by the signing physician to the social services district or any MMCOs as appropriate after the medical examination and independent assessment.

(i) The physician order is subject to the provisions of Parts 515, 516, 517 and 518 of this title. These Parts permit the Department of Health or other agencies or organizations duly authorized or delegated by the Department of Health, including but not limited to MMCOs or the Office of the Medicaid Inspector General, to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services, or supplies when medical care, services, or supplies that are unnecessary, improper or exceed patients' documented medical needs are provided or ordered.

[(iv)] (iii) [Assessment of other services] Social services district or MMCO responsibilities.

(a) The social services district or MMCO must review the independent assessment and physician order and must coordinate with the entity or entities designated by the Department of Health to provide independent assessment and physician order services, as appropriate, to minimize patient disruption and in-home visits.

(1) If the social services district or MMCO identifies a factual inaccuracy recorded in the independent assessment, the social services district or MMCO shall advise the independent assessor.

(2) If the independent assessor, in consultation with the social services district or MMCO determines that the information is incorrect, the independent assessor shall promptly issue a correction to the assessment.

[(a)] (b) Before authorizing or reauthorizing personal care services, a social [service] services district [must assess each patient] or MMCO shall review the patient's independent assessment, and may directly evaluate the patient, to determine the following:

(1) whether personal care services can be provided according to the patient's plan of care, whether such services are medically necessary and whether the social services district or MMCO reasonably expects that such services can maintain the patient's health and safety in his or her home, as determined

in accordance with the regulations of the  
Department of Health;

(2) the frequency with which nursing supervision  
would be required to support services if authorized;

[(2)] (3) whether the patient can be served  
appropriately and more cost-effectively by personal  
care services provided under a consumer directed  
personal assistance program authorized in  
accordance with section 365-f of the Social Services  
Law;

[(3)] (4) whether the functional needs, living  
arrangements and working arrangements of a  
patient who receives personal care services solely  
for monitoring the patient's medical condition and  
well-being can be monitored appropriately and  
more cost- effectively by personal emergency  
response services provided in accordance with  
section 505.33 of this Part;

[(4)] (5) whether the functional needs, living arrangements and working arrangements of the patient can be maintained appropriately and more cost-effectively by personal care services provided by shared aides in accordance with subdivision (k) of this section;

[(5)] (6) whether a patient who requires, as a part of a routine plan of care, part-time or intermittent nursing or other therapeutic services or nursing services provided to a medically stable patient, can be served appropriately and more cost-effectively through the provision of home health services in accordance with section 505.23 of this Part;

[(6)] (7) whether the patient can be served appropriately and more cost-effectively by other long-term care services and supports, including, but not limited to, [services provided under the long-term home health care program (LTHHCP),] the assisted living program or the enriched housing program;

[(7)] (8) whether the patient can be served appropriately and more cost-effectively by using adaptive or specialized medical equipment or supplies covered by the MA program including, but not limited to, bedside commodes, urinals, walkers, wheelchairs and insulin pens; [and]

[(8)] (9) whether personal care services can be provided appropriately and more cost-effectively by the personal care services provider in cooperation with an adult day health or social adult day care program[.];

(10) whether the patient's needs can be met through the provision of formal services provided or funded by an entity, agency or program other than the medical assistance program; and

(11) whether the patient's needs can be met through the voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult, and whether such assistance is available.

[(b)] (c) If a social services district or MMCO determines that a patient can be served appropriately and more cost-effectively through the provision of services described in subclauses [(a)(2)] (b)(3) through [(8)] (b)(11) of this subparagraph, and the social services district or MMCO determines that such services are available in the district, the social services district or MMCO must first consider the use of such services in developing the patient's plan of care. The patient must use such services rather than personal care services to achieve the maximum reduction in his or her need for home health services or other long-term care services.

[(c)] A social services district may determine that the assessments required by subclauses (a)(1) through (6) and (8) of this subparagraph may be included in the social assessment or the nursing assessment.

(d) A social services district must have an agreement with each hospice that is available in the district. The agreement must specify the procedures for notifying patients who the social services district reasonably expects would be

appropriate for hospice services of the availability of hospice services and for referring patients to hospice services. A social services district must not refer a patient to hospice services if the patient's physician has determined that hospice services are medically contra-indicated for the patient or the patient does not choose to receive hospice services.

(v) An authorization for services shall be prepared by staff of the local social services department.

(4) The initial authorization process shall include additional requirements for authorization of services in certain case situations:

(i) An independent medical review shall be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the local social services department to review personal care services cases when:

(a) there is disagreement between the physician's order and the social, nursing and other required assessments; or



(b) there is question about the level and amount of services to be provided; or

(c) the case involves the provision of continuous personal care services as defined in paragraphs (a)(2) and (4), respectively, of this section. Documentation for such cases is subject to the following requirements:]

[(1)] (d) [The social assessment shall demonstrate that all alternative arrangements for meeting the patient's medical needs have been explored and are infeasible including, but not limited to, the provision of personal care services in combination with other formal services or in combination with voluntary contributions of informal caregivers. In cases involving live-in 24-hour personal care services, the social assessment shall also] For cases involving live-in 24-hour personal care services the social services district or MMCO shall evaluate whether the patient's home has sleeping accommodations for a personal care aide. When the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient's circumstances change and sleeping accommodations for a

personal care aide become available in the patient's home, the district or MMCO must promptly review the case. If a reduction of the patient's continuous personal care services to live-in 24-hour personal care services is appropriate, the district or MMCO must send the patient a timely and adequate notice of the proposed reduction.

[(2)] (e) [The nursing assessment] For cases involving continuous personal care services or live-in 24-hour personal care services, the social services district or MMCO shall assess and document in the plan of care the following:

[(i)] (1) whether the [physician's] physician order [has documented] indicated a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;

[(ii)] (2) the specific personal care functions with which the patient needs frequent assistance during a calendar day;

[(iii)] (3) the frequency at which the patient needs assistance with these personal care functions during a calendar day;

[(iv)] (4) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and

[(v)] (5) whether, were live-in 24-hour personal care services to be authorized, the personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

[(ii)] The local professional director, or designee, must review the physician's order and the social and nursing assessments in accordance with the standards for services set forth in subdivision (a) of this section, and is responsible for the final determination of the amount and duration of services to be authorized.

(iii) When determining whether continuous personal care services or live-in 24-hour personal care services should be authorized, the

local professional director, or designee, must consider the information in the social and nursing assessments.

(iv) The local professional director or designee may consult with the patient's treating physician and may conduct an additional assessment of the patient in the home. The final determination must be made with reasonable promptness, generally not to exceed seven business days after receipt of the physician's order and the completed social and nursing assessments, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized.]

(f) The social services district or MMCO shall refer high needs cases, as described in subparagraph (iv) of this paragraph, to the clinical review panel for an independent medical review before authorizing services. When a case is referred to the clinical review panel:

(1) the social services district or MMCO shall provide the patient's plan of care and any documentation of the review or evaluation

performed pursuant to this paragraph to the clinical review panel;

(2) the social services district or MMCO shall cooperate with the panel as appropriate to ensure an expedient review of each high needs case; and

(3) the social services district or MMCO shall consider the recommendation from the clinical review panel when determining whether to authorize more than 12 hours of personal care services per day.

(g) The social services district or MMCO is responsible for developing a plan of care that reflects the assessments and physician order described in this paragraph, identifies the personal care service functions with which the patient needs assistance, and includes at least any descriptions and documentation provided for in this section.

(iv) Independent medical review of high needs cases.

(a) An independent medical review shall be required before a social services district or MMCO may authorize more than 12 hours of personal care services per day on average, including continuous personal care services or live-in 24-hour personal care services (“high needs cases”).

(b) The independent medical review must be performed by an independent panel of medical professionals, or other clinicians, employed by or under contract with an entity designated by the Department of Health (the “clinical review panel”).

(c) The case review shall be coordinated by a physician (the “lead physician”) who shall be selected from the clinical review panel. The lead physician may not be the same person who performed the initial medical examination or signed the patient’s physician order.

(d) The lead physician must review the independent assessment, the physician order, any other assessment or review conducted by the social services district or MMCO, including any plan of care created.

(e) The lead physician may evaluate the patient, or review an evaluation performed by another medical professional on the clinical review panel. The medical professional may not have performed the initial medical examination or signed the patient's physician order.

(f) The lead physician may consult with or interview other members of the clinical review panel, the ordering physician, the patient's treating or primary care physician, and other individuals that the lead physician deems necessary and who are available, and may request such additional information or documentation as the lead physician deems necessary to perform the review, including medical records of the patient that may be relevant to the clinical determination of whether the plan of care is reasonable and appropriate to maintain the patient's health and safety in his or her own home.

(g) The results of the independent medical review shall be signed by the lead physician and shall provide a recommendation on the reasonableness and appropriateness of the plan of care to maintain the patient's health and safety in his or her own home, in accordance with the

standards and scope of services set forth in subdivision (a) of this section, whether other Medicaid services may be appropriate, and the clinical rationale for such recommendation. The recommendation must not recommend specific hours of services or an alternative plan of care.

(3) Timeframe for determination of services

(i) A social services district must make a determination and provide notice with reasonable promptness, not to exceed seven business days after receipt of both the independent assessment and physician order, or the clinical review panel recommendation if applicable, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized, or as provided in paragraphs (6) and (7) of this subdivision.

(ii) Notwithstanding subparagraph (x) of this paragraph, an MMCO must provide notice to current enrollees within the timeframes provided in the contract between the Department of Health and the MMCO, or as otherwise required by Federal or state statute or regulation.



Paragraphs (5) and (6) of subdivision (b) of section 505.14 are renumbered paragraphs (4) and (5), and renumbered paragraph (4) is amended to read as follows:

[(5)] (4) [The authorization for personal care services shall be completed prior to the initiation of services] Authorization and reauthorization criteria.

(i) An individual's eligibility for medical assistance and services, including the individual's financial eligibility and eligibility for personal care services provided for in this section, shall be established prior to the authorization for services.

(ii) The authorization for personal care services shall be completed by the social services district or MMCO prior to the initiation of services. In the case of the social services district, the authorization of services shall be prepared by staff of the social services district and such responsibility may not be delegated to another person or entity.

(iii) The authorization and reauthorization of personal care services, including the level, amount, frequency and duration of services, by the social services district or MMCO must be based on and reflect the outcome of the assessment process outlined in paragraph (2) of this

subdivision except as otherwise provided for in subparagraphs (xi) and (xii) of this paragraph.

[(i)] (iv) The social services district [shall] or MMCO may authorize only the hours or frequency of services [actually required by] that the patient actually requires to maintain his or her health and safety in the home.

[(ii)] (v) The duration of the authorization period shall be based on the patient's needs as reflected in the required assessments and documented in the plan of care. In determining the duration of the authorization period, the following shall be considered:

- (a) the patient's prognosis and/or potential for recovery; and
- (b) the expected length of any informal caregivers' participation in caregiving; and
- (c) the projected length of time alternative services will be available to meet a part of the patient's needs.

[(iii)] (vi) No authorization for personal care services shall exceed [six] 12 months, nor may services be authorized for any period greater than 12 months after the most recent physician order. [The local social services

department may request approval for an exception to allow for authorization periods up to 12 months. The request must be accompanied by the following:

(a) a description of the patients who will be considered for an expanded authorization period; and

(b) a description of the local social services department's process to assure that the delivery of services is responsive to changes in the patient's condition and allows immediate access to services by the patient, patient's physician, assessing nurse and provider agency if the need for services changes during the expanded authorization period.]

[(iv)] (vii)

(a) The social services district or MMCO must deny or discontinue personal care services when such services are not medically necessary or are no longer medically necessary or when the social services district or MMCO reasonably expects that such services cannot maintain or continue to maintain the client's health and safety in his or her home.

(b) The social services district or MMCO must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services [on forms required by the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements of this Title]. The Department of Health may require the use of forms it develops or approves when providing such notice.

(c) The social services district's or MMCO's determination to deny, reduce or discontinue personal care services must be stated in the client notice.

(1) Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

\* \* \*

(vi) the client's needs may be met, in whole or part, by a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming, including the use of

telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary;

(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services;

[and]

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify[.]; and

(ix) the client's need(s) can be met either without services or with the current level of services by fully utilizing any available informal supports, or other supports and services, that are documented in the plan of care and identified in the notice.

(2) Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

\* \* \* \*

(iv) the client's needs may be met, in whole or part, by a technological development, which the notice must identify, that renders certain services unnecessary or less time-consuming including the use of telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary;

(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services;  
[and]

(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify[.];

(vii) the client's need(s) can be met either without services or with a reduced level of services by fully

utilizing any available informal supports, or other supports and services, that are documented in the plan of care and identified in the notice; and

(viii) an assessment of the client's needs demonstrates that the immediately preceding social services district or MMCO authorized more services than are medically necessary following any applicable continuity of care period required by the Department of Health.

(3) Social services districts and MMCOs that deny, reduce or discontinue services based on medical necessity must identify and document in the notice and in the client's plan of care the factors that demonstrate such services are no longer medically necessary. Any such denial or reduction in services must clearly indicate a clinical rationale that shows review of the client's specific clinical data and medical condition; the basis on which the client's needs do not meet specific benefit coverage criteria, if applicable; and be sufficient to enable judgment for possible appeal.

(d) The social services district or MMCO may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district [or] the State or MMCO to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

[(v)] (viii) When services are authorized, the local social services department or MMCO shall provide the agency or person providing services, the patient receiving the services, and the agency or individual supervising the services, with written information about the services authorized, including the functions and tasks required and the frequency and duration of the services.

[(vi)] (ix) All services provided shall be in accordance with the authorization. No change in functions or tasks or hours of services delivered shall be made without notification to, and approval of, the social services district or MMCO.

[(vii)] (x) The local social services department or MMCO shall notify the patient in writing when a change in the amount of services authorized is



being considered. Notification shall be provided in accordance with the requirements specified in subparagraph [(b)(5)(v)] (b)(4)(viii) of this section.

[(viii)] (xi) Reauthorization for personal care services shall follow the procedures outlined in [paragraphs (2) through (4)] paragraph 2 of this subdivision, with the following exceptions:

(a) [Reauthorization of Level I services shall not require a nursing assessment if the physician's order indicates that the patient's medical condition is unchanged.

(b)] Reauthorization of Level II services shall include an evaluation of the services provided during the previous authorization period. The evaluation shall include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

(b) Reauthorization of Level II services shall not require an independent medical review by the clinical review panel if the independent assessment and physician order indicate that the patient's mental status and medical condition is unchanged and the authorization is unchanged.

(c) Reauthorization of Level II services shall only require a new physician order annually unless a new physician order is clinically indicated by the independent assessor or as provided in subparagraph (xiii) of this paragraph.

[(ix)] (xii) [When] Upon becoming aware of an unexpected change in the patient's social circumstances, mental status or medical condition occurs which would affect the type, amount or frequency of personal care services being provided during the authorization period, the social services district [is responsible for making] or MMCO shall make necessary changes in the authorization on a timely basis in accordance with the following procedures:

(a) When the change in the patient's services needs results solely from a change in his/her social circumstances including, but not limited to, loss or withdrawal of support provided by informal caregivers, the local social services department or MMCO shall review the [social] independent assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new [physician's] physician order and [nursing] independent assessment shall not be required.

(b) When the change in the patient's services needs results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the local social services department or MMCO shall [review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated] obtain a new independent assessment and physician order, and shall review the appropriateness and cost-effectiveness of services.

(c) When the change in the patient's services needs results from a change in his/her medical condition, the local social services department and MMCO shall obtain a new [physician's] physician order and a new [nursing assessment and shall complete a new social] independent assessment.

(xiii) When there is any change in the patient's service needs, a social services district or MMCO shall consider such changes and document them in the plan of care, and shall consider and make any necessary changes to the authorization.

Paragraph (7) of subdivision (b) of section 505.14 is renumbered paragraph (6) and amended to read as follows:

(6) This paragraph sets forth expedited procedures for social services districts' determinations of medical assistance (Medicaid) eligibility and personal care services eligibility for Medicaid applicants with an immediate need for personal care services.

(i) The following definitions apply to this paragraph:

(a) *A Medicaid applicant with an immediate need for personal care services* means an individual seeking Medicaid coverage who:

\* \* \*

(2) provides to the social services district:

(i) a physician's [order] statement of need for personal care services on a form required by the Department of Health; and

(ii) a signed attestation on a form required by the [department] Department of Health that the applicant has an immediate need for personal care services (attestation of immediate need) and that:

\* \* \*

(b) A *complete Medicaid application* means a signed Medicaid application and all documentation necessary for the social services district to determine the applicant's Medicaid eligibility for Medicaid coverage of community-based long term care services.

For purposes of this paragraph, an applicant who would otherwise be required to document accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts. After the determination of Medicaid eligibility, if the commissioner or the district has information indicating an inconsistency between the value or dollar amount of such resources and the value or dollar amount to which the applicant had attested prior to being determined eligible for Medicaid, and the inconsistency is material to the individual's Medicaid eligibility, the district must request documentation adequate to verify such resources.

(ii) The social services district must determine whether the applicant has submitted a complete Medicaid application. If [the] an applicant has not submitted a complete Medicaid application, the district must notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide such documentation.

(a) When [the] an applicant submits [the] an incomplete Medicaid application together with the physician's [order] statement and the signed attestation of immediate need, the district must provide such notice as soon as possible and no later than four calendar days after receipt of these documents.

(b) When [the] an applicant submits [the] an incomplete Medicaid application and subsequently submits the physician's [order] statement, the signed attestation of immediate need, or both such documents, the district must provide such notice as soon as possible and no later than four calendar days after receipt of both the physician's [order] statement and the signed attestation of immediate need.

(iii) \* \* \*

(iv) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for personal care services, but no later than 12 calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must:

(a) [obtain or complete a social assessment, nursing assessment, and an assessment of other services] refer the applicant for an independent assessment and medical exam and evaluate his or her need for other services pursuant to [subparagraphs (3)(ii) through (3)(iv)] paragraphs (2)(i) through (2)(iv) of this subdivision; and

(b) determine whether the applicant, if determined eligible for Medicaid, would be eligible for personal care services and, if so, the amount and duration of the personal care services that would be authorized should the applicant be determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services; provided, however, that personal care services shall be authorized only for applicants who are determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services. In no event shall personal care services be authorized for a Medicaid applicant unless the applicant has been determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

(v) \* \* \*

Paragraph (8) of subdivision (b) of section 505.14 is renumbered paragraph (7) and subparagraph (i) of renumbered paragraph (7) of subdivision (b) is amended to read as follows:

(i) *A Medicaid recipient with an immediate need for personal care services* means an individual seeking personal care services who:

(a) \* \* \*

(b)

(1) was a Medicaid applicant with an immediate need for personal care services pursuant to paragraph (7) of this subdivision who was determined, pursuant to such paragraph, to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who was also determined pursuant to such paragraph to be eligible for personal care services; or

(2) is a Medicaid recipient who has been determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who provides to the social services district:



(i) a physician's [order] statement of need for personal care services on a form required by the Department of Health; and

(ii) a signed attestation on a form required by the [department] Department of Health that the recipient has an immediate need for personal care services (attestation of immediate need) and that:

\* \* \*

Clause (a) of subparagraph (iii) of renumbered paragraph (7) of subdivision (b) of section 505.14 is amended to read as follows:

(a) With regard to a Medicaid recipient with an immediate need for personal care services who is described in subclause (i)(b)(2) of this paragraph, the social services district, as soon as possible after receipt of the physician's [order] statement and signed attestation of immediate need, but no later than 12 calendar days after receipt of such documentation, must:

(1) [obtain or complete a social assessment, nursing assessment, and an assessment of other services] refer the applicant for an independent assessment and medical exam and evaluate his or her need for other

services pursuant to [subparagraphs (3)(ii) through (3)(iv)] paragraphs  
(2)(i) through (2)(iv) of this subdivision; and

(2) determine whether the recipient is eligible for personal care services and, if so, the amount and duration of the personal care services to be authorized.

Paragraph (1) of subdivision (c) of section 505.14 is amended to read as follows:

(1) Each social services district must have contracts or other written agreements with all agencies or persons providing personal care services or any support functions for the delivery of personal care services. As used in this subdivision, support functions for the delivery of personal care services include, but are not necessarily limited to, [nursing assessments,] nursing supervision and case management, when provided according to subdivisions (b), (f) and (g) of this section, respectively.

Subparagraphs (i) and (ii) of paragraph (5) of subdivision (c) of section 505.14 is amended to read as follows:

(i) The social services district must use a contract or other written agreement for support functions for the delivery of personal care services, including case

management[, nursing assessments] and nursing supervision, that the department approves to be used.

(ii) The social services district must not implement any contract or agreement for case management, [nursing assessments,] nursing supervision, or any other support function until the department approves such contract or agreement.

Subparagraph (vi) of paragraph (3) of subdivision (f) of section 505.14 is amended to read as follows:

(vi) The [nurse who completes the nursing] social services district or MMCO assessment of other services, as specified in subparagraph [(b)(3)(iii)] (b)(2)(iii) of this section, must [recommend] determine the frequency of nursing supervisory visits for a personal care services patient and the social services district or MMCO must [specify] document the [recommended] frequency in the patient's plan of care.

\* \* \*

(b) The nursing supervisor must make nursing supervisory visits at least every 90 days for a personal care services patient except that[:

(1)] nursing supervisory visits must be made more frequently than every 90 days when:

[ (i)] (1) the patient's medical condition requires more frequent visits; or

[ (ii)] (2) the person providing personal care services needs additional or more frequent on-the-job training to perform assigned functions and tasks competently and safely[; and

(2) supervisory and nursing assessment visits may be combined and conducted every six months when:

(i) the patient is self-directing, as defined in subparagraph (a)(3)(ii) of this section; and

(ii) the patient's medical condition is not expected to require any change in the level, amount or frequency of personal care services authorized during this time period].

Paragraphs (3) and (4) of subdivision (g) of section 505.14 are amended to read as follows:

(3) Case management includes the following activities:

(i) receiving referrals for personal care services, providing information about such services and determining, when appropriate, that the patient is financially eligible for [medical assistance] Medicaid, including community-based long term care services;

(ii) informing the patient or the patient's representative that a [physician's] physician order is needed, and making copies of the [physician's] physician order form available to hospital discharge planners, physicians, and other appropriate persons or entities[, and assisting the patient to obtain a physician's order when the patient or the patient's representative is unable to obtain the order];

(iii) [completing the social assessment according to subdivision (b) of this section, including an evaluation of:

(a) the potential contribution of informal caregivers to the patient's plan of care, as specified in subparagraph (b)(3)(ii) of this section;

(b) the patient's physical environment, as determined by a visit to the patient's home; and

(c) the patient's mental status;

(iv) obtaining or completing the nursing assessment according to subparagraph (b)(3)(iii) of this section;

(v) assessing the patient's eligibility for hospice services and] assessing the appropriateness and cost-effectiveness of the services specified in subparagraph [(b)(3)(iv)] (b)(2)(iii) of this section;

[(vi)] (iv) forwarding [the physician's order; the social and nursing assessments;] the assessments required by subparagraph [(b)(3)(iv)] (b)(2)(iii) of this section[;] and any other information as may be required by the Department of Health for an independent medical review according to subparagraph [(b)(4)(i)] (b)(2)(iv) of this section;

[(vii)] (v) negotiating with informal caregivers to encourage or maintain their involvement in the patient's care;

[(viii)] (vi) determining the level, amount, frequency and duration of personal care services to be authorized or reauthorized according to subdivisions (a) and (b) of this section, or, if the case involves an independent medical review, obtaining the clinical review [determination] panel recommendation;

[(ix)] (vii) obtaining or completing the authorization for personal care services, according to subdivision (b) of this section;

[(x)] (viii) assuring that the patient is provided written notification of personal care services initially authorized, reauthorized, denied, increased, reduced, discontinued, or suspended and his or her right to a fair hearing, as specified in Part 358 of this Title [and subparagraph (b)(5)(iv) of this section];

[(xi)] (ix) arranging for the delivery of personal care services according to subdivision (c) of this section;

[(xii)] (x) forwarding, prior to the initiation of personal care services, a copy of the patient's plan of care [developed by the nurse responsible for completion of the nursing assessment], as specified in subdivision (a) of this section, to the following persons or agencies:

\* \* \*

[(xiii)] (xi) monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met;

[(xiv)] (xii) obtaining or completing a copy of the orientation visit report and the nursing supervisory visit report and forwarding a copy of these reports in accordance with subparagraphs (f)(3)(vi) and (vii) of this section;

[(xv)] (xiii) allowing access by the patient to his or her written records, including physicians' orders and [nursing] assessments and, pursuant to 10 NYCRR 766.2(e), by the State Department of Health and licensed provider agencies;

[(xvi)] (xiv) receiving and promptly reviewing recommendations from the agency providing nursing supervision for changes in the level, amount, frequency or duration of personal care services being provided;

[(xvii)] (xv) promptly initiating and complying with the procedures specified in subparagraph [(b)(5)(ix)] (b)(4)(xii) of this section when the patient's social circumstances, mental status or medical condition unexpectedly change during the authorization period;

[(xviii)] (xvi) assuring that capability exists 24 hours per day, seven days per week for the following activities:



\* \* \*

[(xix)] (xvii) informing the patient or the patient's representative of the procedure for addressing the situations specified in subparagraph [(xv)] (xiii) of this paragraph;

[(xx)] (xviii) establishing linkages to services provided by other community agencies including:

\* \* \*

[(xxi)] (xix) establishing linkages to other services provided by the social services district including, but not limited to, adult protective services as specified in paragraph (5) of this subdivision;

[(xxii)] (xx) arranging for the termination of personal care services when indicated and, when necessary, making referrals to other types of services or levels of care that the patient may require; and

[(xxiii)] (xxi) complying with the requirements for advance directives that are set forth in the regulations at 10 NYCRR 700.5 or any successor regulation when personal care services are provided by social services district employees. For purposes of this subparagraph, the

term *facility/agency* as used in such regulations is deemed to mean the case management agency.

(4) The case management agency must maintain current case records on each patient receiving personal care services. Such records must include, at a minimum, a copy of the following documents:

(i) the [physician's] physician orders;

(ii) the [nursing and social assessments] independent assessment in subparagraph (b)(2)(i) of this section;

(iii) [the assessment of the patient's eligibility for hospice services and] the assessments of the appropriateness and cost-effectiveness of the services specified in subparagraph [(b)(3)(iv)] (b)(2)(iii) of this section;

(iv) for a patient whose case must be referred to the [local professional director or designee] clinical review panel in accordance with subparagraph [(b)(4)(i)] (b)(2)(iv) of this section, a record that the [physician's] physician order, the [social and nursing assessments] independent assessment, and the assessments required by subparagraph [(b)(3)(iv)] (b)(2)(iii) of this section were forwarded to the [local professional director or designee] clinical review panel;

(v) for a patient whose case must be referred to the [local professional director or designee] clinical review panel in accordance with subparagraph [(b)(4)(i)] (b)(2)(iv) of this section, a copy of the [local professional director's or designee's determination] panel's recommendation;

\* \* \*

Clause (ii) of paragraph (5) subdivision (g) of section 505.14 is amended to read as follows:

(ii) Professional staff responsible for adult protective services have primary responsibility for case management for a patient who:

\* \* \*

(b) receives or requires personal care services as part of an adult protective services plan; and

\* \* \*

(2) is self-directing, as defined in subparagraph (a)(3)(ii) of this section, but refuses to accept personal care services in accordance with the plan of care developed by the [nurse who completed the nursing assessment] social services district or MMCO.

Subdivision (b) of section 505.28 is amended to read as follows:

(b) Definitions. The following definitions apply to this section:

(1) Activity of daily living means bathing, personal hygiene, dressing, walking, locomotion, transferring on to and off the toilet and toilet use, bed mobility, and eating.

[(1)] (2) consumer means a medical assistance recipient who a social services district or MMCO has determined eligible to participate in the consumer directed personal assistance program.

[(2)] (3) consumer directed personal assistance means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

[(3)] (4) *consumer directed personal assistant* means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative. A person legally responsible for the consumer's care and support, a consumer's spouse, [parent] or the consumer's designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer [who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary] provided that the district or MMCO determines that the services provided by such relative are consistent with the consumer's plan of care and that the aggregate cost for such services does not exceed the aggregate costs for equivalent services provided by a non-relative personal assistant.

(5) *consumer directed personal assistance program or consumer directed program or the program* means the program provided for under section 356-f of title 11 of article 5 of the Social Services Law.

[(4)] (6) *continuous consumer directed personal assistance* means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the

consumer's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

[(5)] (7) *designated representative* means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities specified in subdivision (g) of this section and who is willing and able to perform these responsibilities. With respect to a non self-directing consumer, a *designated representative* means the consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

[(6)] (8) *fiscal intermediary* means an entity that has a contract with [a social services district] the New York State Department of Health to provide wage and benefit processing for consumer directed personal assistants and other fiscal intermediary responsibilities specified in subdivision (i) of this section.

[(7)] (9) home health aide services means services within the scope of practice of a home health aide pursuant to article 36 of the Public Health Law including simple health care tasks, personal hygiene services, housekeeping tasks essential to the consumer's health and other related supportive services. Such services may include, but are not necessarily limited to, the following: preparation of meals in accordance with modified diets or complex modified diets; administration of medications; provision of special skin care; use of medical equipment, supplies and devices; change of dressing to stable surface wounds; performance of simple measurements and tests to routinely monitor the consumer's medical condition; performance of a maintenance exercise program; and care of an ostomy after the ostomy has achieved its normal function.

(10) live-in 24-hour consumer directed personal assistance means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(11) Medicaid Managed Care Organization or MMCO means an entity that is approved to provide medical assistance services, pursuant to a contract between

the entity and the Department of Health, and that is: (i) certified under article forty-four of the Public Health Law, or (ii) licensed under article forty-three of the Insurance Law.

(12) *Medical assistance or Medicaid* means the program to provide services and benefits under title 11 or article 5 of Social Services Law.

(13) *minimum needs requirements* means, for individuals with a diagnosis by a physician of dementia or Alzheimer's, being assessed in accordance with subdivision (d) of this section as needing at least supervision with more than one activity of daily living, and for all other individuals, being assessed in accordance with subdivision (d) of this section as needing at least limited assistance with physical maneuvering with more than two activities of daily living.

[(8)] (14) *personal care services* means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in section 505.14(a)(5) of this Part except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week.

[(9)] (15) a *self-directing consumer* means a consumer who is capable of making choices regarding the consumer's activities of daily living and the type, quality and management of his or her consumer directed personal assistance; understands



the impact of these choices; [and] assumes responsibility for the results of these choices; and is capable of instructing, supervising, managing and directing consumer directed personal assistants and performing all other consumer responsibilities identified in this section.

[(10)] (16) *skilled nursing tasks* means those skilled nursing tasks that are within the scope of practice of a registered professional nurse or a licensed practical nurse and that a consumer directed personal assistant may perform pursuant to section 6908 of the Education Law.

[(11)] (17) *stable medical condition* means a condition that is not expected to exhibit sudden deterioration or improvement and does not require frequent medical or nursing evaluation or judgment to determine changes in the consumer's plan of care.

[(12)] *live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.]

Subdivision (c) of section 505.28 is amended to read as follows:

(c) Eligibility requirements.

To participate in the consumer directed personal assistance program, an individual must meet the following eligibility requirements:

\* \* \*

(2) be eligible for long term care and services provided by a certified home health agency, [long term home health care program] or an AIDS home care program authorized pursuant to article 36 of the Public Health Law; or for personal care services or private duty nursing services;

\* \* \*

(6) be willing and able to fulfill the consumer's responsibilities specified in subdivision (g) of this section or have a designated representative who is willing and able to fulfill such responsibilities; [and]

(7) participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes specified in subdivisions (d) and (f) of this section[.]; and

(8) meet minimum needs requirements in accordance with state statute.

Subdivision (d) of section 505.28 is amended to read as follows:

(d) Assessment process. The assessment process includes an independent assessment, a medical exam and physician order, an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required under paragraph (4) of this subdivision, a referral to a clinical review panel. When the social services district or MMCO receives a request to participate in the consumer directed personal assistance program, the social service district [must assess whether the individual is eligible for the program. The assessment process includes physician's order, a social assessment and a nursing assessment and, when required under paragraph (5) of this subdivision, a referral to the local professional director or designee.] or MMCO shall refer the applicant for an independent assessment and physician order, provide assistance to the individual in making contact with the independent assessor to begin the assessment process and, if needed, the social services district shall begin to determine the individual's financial eligibility for medical assistance services, including community-based long term care services. The initial assessment process shall include the following procedures:

(1) Independent assessment. An assessment shall be completed by an independent assessor employed or contracted by an entity designated by the Department of Health to provide independent assessment services on forms approved by the Department of Health in accordance with the following:

(i) The independent assessment must be performed by a nurse with the following minimum qualifications:

(a) a license and current registration to practice as a registered professional nurse in New York State; and

(b) at least two years of satisfactory recent experience in home health care.

(ii) The independent assessment shall include the following:

(a) an assessment of the functions and tasks required by the individual;

(b) a discussion with the individual or, if applicable, the individual's designated representative to determine the

individual's perception of his or her circumstances and preferences; and

(c) an assessment of the potential contribution of informal supports, such as family members or friends, to the individual's care, which must consider:

(1) the number and kind of informal supports available to the individual;

(2) the ability and motivation of informal supports to assist in care;

(3) the extent of informal supports' potential involvement;

(4) the availability of informal supports for future assistance; and

(5) the acceptability to the individual of the informal supports' involvement in his or her care;

[(1)] (2) [Physician's] Independent medical exam and physician order.

(i) Each individual seeking to participate in the consumer directed program must have an examination by a medical professional employed or contracted by an entity designated by the Department of Health to provide independent physician order services.

[(i) A] (ii) The medical professional who examines the individual must be a physician licensed in accordance with article 131 of the Education Law, a physician assistant or a specialist assistant registered in accordance with article 131-B of the Education Law or a nurse practitioner certified in accordance with article 139 of the Education Law [must conduct a medical examination of the individual and complete the physician's order within 30 calendar days after conducting the medical examination].

(iii) The medical professional must be independent with respect to the individual, meaning that they must not have established a provider-patient relationship prior to the clinical encounter from which the physician order is completed.

[(ii)] (iv) [The physician's order must be completed on a form that the department requires or approves. The physician or other medical professional who conducted the examination must

complete the order form by] The medical professional must examine the individual and accurately [describing] describe the individual's medical condition and regimens, including any medication regimens[;], and the individual's need for assistance with personal care services, home health aide services and skilled nursing tasks[; and provide only such other information as the physician's order form requires. The physician or other medical professional who completes the order form must not recommend the number of hours of services that the individual should be authorized to receive].

(v) The medical professional must review the independent assessment and may review other medical records and consult with the individual's providers and others involved with the patient's care if available to and determined necessary by the medical professional.

(vi) The medical professional must complete a form required or approved by the Department of Health (the "physician order form").

[(iii)] (vii) A physician employed or contracted by an entity designated by the Department of Health, who may be the

examining medical professional, must sign the [physician's] physician order form, [and] certify that [the individual can be safely cared for at home and that] the information provided in the [physician's order] form accurately describes the individual's medical condition and regimens[, including any medication regimens, and the individual's need for assistance at the time of the medical examination] at the time of the medical examination, and indicate whether the individual is self-directing, consistent with the definition of self-directing in this section, and whether the individual can be safely cared for at home.

[(iv)] (viii) The physician's order form must be [submitted] completed and made available by the signing physician to the social services district [within 30 calendar days] or any MMCOs as appropriate after the medical examination and independent assessment. [The form may be submitted by the physician, other medical professional or by the individual or the individual's representative.]

[(v)] (ix) The [physician's] physician order [form] is subject to the provisions of Parts 515, 516, 517 and 518 of this Title[, which]. These Parts permit the [department] Department of Health or other agencies or organizations duly authorized or delegated by the



Department of Health, including but not limited to MMCOs or the Office of the Medicaid Inspector General, to impose monetary penalties on, or sanction and recover overpayments from, providers [and] or prescribers of medical care, services or supplies when medical care, services or supplies that are unnecessary, improper or exceed [recipients'] individuals' documented needs are provided or ordered.

[(2) Social assessment. Upon receipt of a completed and signed physician's order, social services district professional staff must conduct a social assessment. The social assessment must include the following:

- (i) a discussion with the individual or, if applicable, the individual's designated representative to determine the individual's perception of his or her circumstances and preferences;
- (ii) an evaluation of the individual's ability and willingness to fulfill the consumer's responsibilities specified in subdivision (g) of this section and, if applicable, the ability and willingness of the individual's designated representative to assume these responsibilities;
- (iii) an evaluation of the potential contribution of informal supports, such as family members or friends, to the individual's care, which must

consider the number and kind of informal supports available to the individual; the ability and motivation of informal supports to assist in care; the extent of informal supports' potential involvement; the availability of informal supports for future assistance; and the acceptability to the individual of the informal supports' involvement in his or her care;

(iv) for cases involving continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance, the social assessment shall demonstrate that all alternative arrangements for meeting the individual's medical needs have been explored and are infeasible including, but not limited to, the provision of consumer directed personal assistance in combination with other formal services or in combination with voluntary contributions of informal caregivers; and

(v) for cases involving live-in 24-hour consumer directed personal assistance, an evaluation whether the consumer's home has sleeping accommodations for a consumer directed personal assistant. When the consumer's home has no sleeping accommodations for a consumer directed personal assistant, continuous consumer directed personal assistance must be authorized for the consumer; however, should the consumer's circumstances change and sleeping accommodations for a consumer directed personal assistant become available in the consumer's home, the district must promptly review the case. If a reduction of the

consumer's continuous consumer directed personal assistance to live-in 24-hour consumer directed personal assistance is appropriate, the district must send the consumer a timely and adequate notice of the proposed reduction.

(3) Nursing assessment. Upon receipt of a completed and signed physician's order, the social services district must conduct or obtain a nursing assessment.

(i) The nursing assessment must be completed by a registered professional nurse who is employed by, or under contract with, the social services district or by a licensed or certified home care services agency or voluntary or proprietary agency under contract with the district.

(ii) The nursing assessment must include the following:

(a) a review and interpretation of the physician's order;

(b) the primary diagnosis code from the ICD-9-CM;

(c) an evaluation whether the individual's medical condition, as described in the physician's order, would require frequent nursing evaluation or judgment;

(d) an evaluation of the personal care services, home health aide services and skilled nursing tasks that the individual requires;

(e) an evaluation, made in conjunction with the social assessment and physician's order, whether the individual or, if applicable, the individual's designated representative, is self-directing and willing and able to instruct, supervise and direct the consumer directed personal assistant in performing any needed skilled nursing tasks, home health aide services and personal care services;

(f) an evaluation whether the individual's need for assistance can be totally or partially met through the use of adaptive or specialized medical equipment or supplies including, but not limited to, commodes, urinals, adult diapers, walkers or wheelchairs and whether the individual would be appropriate for personal emergency response services provided in accordance with section 505.33 of this Part;

(g) for continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases, documentation of the following:

(1) whether the physician's order has documented a medical condition that causes the consumer to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks;

(2) the specific functions or tasks with which the consumer requires frequent assistance during a calendar day;

(3) the frequency at which the consumer requires assistance with these functions or tasks during a calendar day;

(4) whether the consumer requires similar assistance with these functions or tasks during the consumer's waking and sleeping hours and, if not, why not; and

(5) whether, were live-in 24-hour consumer directed personal assistance to be authorized, the consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(h) development of a plan of care in collaboration with the individual or, if applicable, the individual's designated representative, that identifies the personal care services, home health aide services and skilled nursing tasks with which the individual needs assistance in the home and a recommendation for the number of hours or frequency of such assistance; and

(i) recommendations for authorization of services.

(4) Guidelines for completion of social and nursing assessment. The social services district must conduct the social assessment and conduct or obtain a nursing assessment with reasonable promptness, generally not to exceed 30 calendar days after receiving a completed and signed physician's order, except in unusual circumstances including, but not limited to, when the individual or, if applicable, the individual's designated representative has failed to participate as needed in the assessment process.

(5) Local professional director review.

(i) If there is a disagreement among the physician's order, the nursing assessment and the social assessment, or a question regarding the amount or duration of services to be authorized, or if the case involves continuous consumer directed personal assistance

or live-in 24-hour consumer directed personal assistance, an independent medical review of the case must be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the social services district.

(ii) The local professional director or designee must review the physician's order and the nursing and social assessments. When determining whether continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance should be authorized, the local professional director or designee must consider the information in the social and nursing assessments. The local professional director or designee may consult with the consumer's treating physician and may conduct an additional assessment of the consumer in the home.

(iii) The local professional director or designee is responsible for the final determination regarding the amount and duration of services to be authorized. The final determination must be made with reasonable promptness, generally not to exceed seven business days after receipt of the physician's order and the completed social and nursing assessments, except in unusual circumstances including, but not limited to, the need to resolve any

outstanding questions regarding the amount or duration of services to be authorized.]

(3) Social services district or MMCO responsibilities.

(i) The social services district or MMCO must review the independent assessment and physician order and must coordinate with the entity or entities designated by the Department of Health to provide independent assessment and physician order services, as appropriate, to minimize the individual's disruption and in-home visits.

(a) If the social services district or MMCO identifies a factual inaccuracy recorded in the independent assessment, the social services district or MMCO shall advise the independent assessor.

(b) If the independent assessor, in consultation with the social services district or MMCO determines that the information is incorrect, the independent assessor shall promptly issue a correction to the assessment.



(ii) Before authorizing or reauthorizing services, a social services district or MMCO shall review the individual's independent assessment, and may directly evaluate the individual, to determine the following:

(a) whether services can be provided according to the individual's plan of care, whether such services are medically necessary and whether the social services district or MMCO reasonably expects that such services can maintain the individual's health and safety in his or her home, as determined in accordance with the regulations of the Department of Health;

(b) the individual's ability and willingness to fulfill the consumer's responsibilities specified in subdivision (g) of this section and, if applicable, the ability and willingness of the individual's designated representative to assume these responsibilities;

(c) whether the functional needs, living and working arrangements of an individual who receives services solely for monitoring the individual's medical condition and well-being can be monitored appropriately and more cost-

effectively by personal emergency response services  
provided in accordance with section 505.33 of this Part;

(d) whether the individual can be served appropriately and  
more cost-effectively by other long-term care services and  
supports, including, but not limited to the assisted living  
program or the enriched housing program;

(e) whether the individual can be served appropriately and  
more cost-effectively by using adaptive or specialized  
medical equipment or supplies covered by the medical  
assistance program including, but not limited to, bedside  
commodes, urinals, walkers, wheelchairs and insulin pens;

(f) whether services can be provided appropriately and  
more cost-effectively in cooperation with an adult day  
health or social adult day care program;

(g) whether the consumer's needs can be met through the  
provision of formal services provided or funded by an  
entity, agency or program other than the medical assistance  
program; and

(h) whether the consumer's needs can be met through the voluntary assistance available from informal caregivers including, but not limited to, the consumer's family, friends or other responsible adult, and whether such assistance is available.

(iii) If a social services district or MMCO determines that a patient can be served appropriately and more cost-effectively through the provision of services described in subparagraphs (ii)(c) through (ii)(h) of this paragraph, and the social services district or MMCO determines that such services are available in the district to the individual, the social services district or MMCO must first consider the use of such services in developing the patient's plan of care. The patient must use such services rather than personal care services to achieve the maximum reduction in his or her need for home health services or other long-term care services.

(iv) For cases involving live-in 24-hour consumer directed personal assistance, the social services district or MMCO shall evaluate whether the consumer's home has sleeping accommodations for a consumer directed personal assistant. When the consumer's home has no sleeping accommodations for a consumer directed personal assistant, continuous consumer

directed personal assistance must be authorized for the consumer; however, should the consumer's circumstances change and sleeping accommodations for a consumer directed personal assistant become available in the consumer's home, the district or MMCO must promptly review the case. If a reduction of the consumer's continuous consumer directed personal assistance to live-in 24-hour consumer directed personal assistance is appropriate, the district must send the consumer a timely and adequate notice of the proposed reduction.

(v) For cases involving continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases, the social services district or MMCO shall assess and document in the plan of care the following:

(a) whether the physician order indicated a medical condition that causes the consumer to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks;

(b) the specific functions or tasks with which the consumer requires frequent assistance during a calendar day;

(c) the frequency at which the consumer requires assistance with these functions or tasks during a calendar day;

(d) whether the consumer requires similar assistance with these functions or tasks during the consumer's waking and sleeping hours and, if not, why not; and

(e) whether, were live-in 24-hour consumer directed personal assistance to be authorized, the consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(vi) The social services district or MMCO shall refer high needs cases, as described in paragraph (4) of this subdivision, to the clinical review panel for an independent medical review before authorizing services. When a case is referred to the clinical review panel:

(a) the social services district or MMCO shall provide the individual's plan of care and any documentation of the

review or evaluation performed pursuant to this paragraph to the clinical review panel;

(b) the social services district or MMCO shall cooperate with the panel as appropriate to ensure an expedient review of each high needs case; and

(c) the social services district or MMCO shall consider the recommendation from the clinical review panel when determining whether to authorize more than 12 hours of personal care services per day.

(vii) The social services district or MMCO is responsible for developing a plan of care in collaboration with the individual or, if applicable, the individual's designated representative, that reflects the assessments and physician order described in this subdivision, identifies the personal care services, home health aide services and skilled nursing tasks with which the individual needs assistance in the home, and includes at least any descriptions and documentation provided for in this section.

(4) Independent medical review of high needs cases.

(i) An independent medical review shall be required before a social services district or MMCO may authorize more than 12 hours of services provided through the program per day on average, including continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance (“high needs cases”).

(ii) The independent medical review must be performed by an independent panel of medical professionals, or other clinicians, employed by or under contract with an entity designated by the Department of Health (the “clinical review panel”).

(iii) The case review shall be coordinated by a physician (the “lead physician”) who shall be selected from the clinical review panel. The lead physician may not be the same person who performed the initial medical examination or signed the patient’s physician order.

(iv) The lead physician must review the independent assessment, physician order, any other assessment or review conducted by the social services district or MMCO, including any plan of care created.

(v) The lead physician may evaluate the individual, or review an evaluation performed by another medical professional on the clinical review panel. The medical professional may not have performed the initial medical examination or signed the patient's physician order.

(vi) The lead physician may consult with or interview other members of the clinical review panel, the ordering physician, the individual's treating or primary care physician, and other individuals that the lead physician deems necessary and who are available, and may request such additional information or documentation as the lead physician deems necessary to perform the review, including medical records of the individual that may be relevant to the clinical determination of whether the plan of care is reasonable and appropriate to maintain the individual's health and safety in his or her own home.

(vii) The results of the independent medical review shall be signed by the lead physician and shall provide a recommendation on the reasonableness and appropriateness of the plan of care to maintain the individual's health and safety in his or her own home, in accordance with the standards and scope of services set forth in this section, whether other Medicaid services may be appropriate,



and the clinical rational for such recommendation. The recommendation must not recommend specific hours of services or an alternative plan of care.

Subdivision (e) of section 505.28 is amended to read as follows:

(e) Authorization process.

(1)

(i) An individual's eligibility for medical assistance and services, including the individual's financial eligibility and eligibility for the consumer directed program and services thereunder as provided for in this section, shall be established prior to authorization for services.

(ii) The authorization must be completed by the social services district or MMCO prior to the initiation of services. In the case of the social services district, the authorization of services shall be prepared by staff of the social services district and such responsibility may not be delegated to another person or entity.

(iii) The authorization and reauthorization of services, including the level, amount, frequency and duration of services, by the social

services district or MMCO must be based on and reflect the outcome of the assessment process outlined in subdivision (d) of this section except as otherwise provided in subdivision (f) of this section.

[(i)] (iv) When the social services district or MMCO determines pursuant to the assessment process that the individual is eligible to participate in the consumer directed personal assistance program, the district or MMCO must authorize consumer directed personal assistance according to the consumer's plan of care. The district or MMCO must not authorize consumer directed personal assistance unless it reasonably expects that such assistance can maintain the individual's health and safety in the home or other setting in which consumer directed personal assistance may be provided.

(v) The social service district or MMCO shall not authorize services provided through more than one fiscal intermediary per consumer.

[(ii)] (vi) Consumer directed personal assistance, including continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance, shall not be authorized to the extent that the [consumer's need for assistance can be met by

the following:] social services district or MMCO determines that any of the services or supports identified in paragraph (3) of subdivision (d) of this section are available and appropriate to meet the consumer's needs and are cost-effective if provided instead of consumer directed personal assistance.

(a) voluntary assistance available from informal caregivers including, but not limited to, the consumer's family, friends or other responsible adult;

(b) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(c) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

(iii) The social services district must first determine whether the consumer, because of the consumer's medical condition, would be otherwise eligible for consumer directed personal assistance, including continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance. For

consumers who would be otherwise eligible for consumer directed personal assistance, the district must then determine whether, and the extent to which, the consumer's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in clauses (ii)(a) through (c) of this paragraph.]

(2) The district or MMCO may authorize only the hours or frequency of services that the consumer actually requires to maintain his or her health and safety in the home. [The authorization must be completed prior to the initiation of services.]

(3) The duration of the authorization period must be based upon the consumer's needs as reflected in the required assessments and plan of care. In determining the authorization period, the social services district must consider the consumer's prognosis and potential for recovery and the expected duration and availability of any informal supports or alternative services identified in the plan of care.

(4) No authorization may exceed [six] 12 months, nor may services be authorized for any period greater than 12 months after the most recent physician order. [unless the social services district has requested, and the department has approved, authorization periods of up to 12 months. The

department may approve district requests for authorization periods of up to 12 months provided that professional staff of the social services district or its designee conduct a home visit with the consumer and, if applicable, the consumer's designated representative every six months and evaluate whether:

(i) the plan of care continues to meet the consumer's needs;

(ii) the consumer or, if applicable, the consumer's designated representative continues to be willing and able to perform the consumer's responsibilities specified in subdivision (g) of this section; and

(iii) the fiscal intermediary is fulfilling its responsibilities specified in subdivision (i) of this section.]

(5) The social services district or MMCO must provide the consumer with a copy of the plan of care that specifies the consumer directed personal assistance that the district or MMCO has authorized the consumer to receive and the number of hours per day or week of such assistance.

\* \* \*

(7) A social services district must make a determination and provide notice with reasonable promptness, not to exceed seven business days after receipt of both the independent assessment and physician order, or the clinical review panel recommendation if applicable, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized, or as provided in subdivision (k) of this section.

(8) An MMCO must make a determination and provide notice to current enrollees within the timeframes provided in the contract between the Department of Health and the MMCO, or as otherwise required by Federal or state statute or regulation.

Subdivision (f) of section 505.28 is amended to read as follows:

(f) Reassessment and reauthorization processes.

(1) Prior to the end of the authorization period, the social services district or MMCO must [reassess] determine the consumer's continued eligibility for the consumer directed personal assistance program in accordance with the assessment process set forth in subdivision (d) of this section, except as otherwise provided for in this subdivision.

(i) The [reassessment] social services district or MMCO must evaluate whether the consumer or, if applicable, the consumer's designated representative satisfactorily fulfilled the consumer's responsibilities under the consumer directed personal assistance program. The social services district or MMCO must consider whether the consumer or, if applicable, the consumer's designated representative has failed to satisfactorily fulfill the consumer's responsibilities when determining whether the consumer should be reauthorized for the consumer directed personal assistance program.

(ii) the reauthorization of consumer directed personal assistance shall only require a new physician order annually unless a new physician order is clinically indicated by the independent assessor or as provided in paragraph (2) of this subdivision.

[(ii)] (iii) When the social services district or MMCO determines, pursuant to the reassessment process, that the consumer is eligible to continue to participate in the consumer directed personal assistance program, the district or MMCO must reauthorize consumer directed personal assistance in accordance with the authorization process specified in subdivision (e) of this section. When the district or MMCO determines that the consumer is no

longer eligible to continue to participate in the consumer directed personal assistance program, the district or MMCO must send the consumer, and such consumer's designated representative, if any, a timely and adequate notice under Part 358 and Subpart 360-10 of this Title of the district's or MMCO's intent to discontinue consumer directed personal assistance on forms required by the department.

(2) The social services district must reassess the consumer when an unexpected change in the consumer's social circumstances, mental status or medical condition occurs during the authorization [or reauthorization] period that would affect the type, amount or frequency of consumer directed personal assistance provided during such period. The district or MMCO is responsible for making necessary changes in the authorization or reauthorization on a timely basis in accordance with the following procedures:

(i) when the change in the consumer's service needs results solely from an unexpected change in the consumer's social circumstances including, but not limited to, loss or withdrawal of informal supports or a designated representative, the social services district or MMCO must review the [social] independent assessment, document the consumer's changed social circumstances and make



changes in the authorization or reauthorization as needed. A new [physician's] physician order and [nursing] independent assessment are not required; or

(ii) when the change in the consumer's service needs results from a change in the consumer's mental status or medical condition, including loss of the consumer's ability to make judgments or to instruct, supervise or direct the consumer directed personal assistant, the social services district or MMCO must obtain a new [physician's] independent assessment and physician order, [social assessment and nursing assessment] and must review the appropriateness and cost-effectiveness of services.

(3) When there is any change in the patient's service needs, a social services district or MMCO shall consider such changes and document them in the plan of care, and shall consider and make any necessary changes to the authorization.

Subdivision (g) of section 505.28 is amended to read as follows:

(g) Consumer and designated representative responsibilities.

(1) A consumer or, if applicable, the consumer's designated representative has the following responsibilities under the consumer directed personal assistance program:

[(1)] (i) managing the plan of care including recruiting and hiring a sufficient number of individuals who meet the definition of consumer directed personal assistant, as set forth in subdivision (b) of this section, to provide authorized services that are included on the consumer's plan of care; training, supervising and scheduling each assistant; terminating the assistant's employment; and assuring that each consumer directed personal assistant competently and safely performs the personal care services, home health aide services and skilled nursing tasks that are included on the consumer's plan of care;

[(2)] (ii) timely notifying the social services district or MMCO of any changes in the consumer's medical condition or social circumstances including, but not limited to, any hospitalization of the consumer or change in the consumer's address, telephone number or employment;

[(3)] (iii) timely notifying the fiscal intermediary of any changes in the employment status of each consumer directed personal assistant;

[(4)] (iv) attesting to the accuracy of each consumer directed personal assistant's time sheets;

[(5)] (v) transmitting the consumer directed personal assistant's time sheets to the fiscal intermediary according to its procedures;

[(6)] (vi) timely distributing each consumer directed personal assistant's paycheck, if needed;

[(7)] (vii) arranging and scheduling substitute coverage when a consumer directed personal assistant is temporarily unavailable for any reason; and

[(8)] (viii) entering into a department approved memorandum of understanding with the fiscal intermediary and with the social services district or MMCO that describes the parties' responsibilities under the consumer directed personal assistance program.

(2) the designated representative must make themselves available to ensure that the consumer responsibilities are carried out without delay. In addition, designated representatives for nonself-directing consumers must make themselves available and be present for any scheduled assessment or visit by the independent assessor, examining medical professional, social services district staff or MMCO staff.

(3) A consumer, or if applicable the consumer's designated representative, may not work with more than one fiscal intermediary at a time.

Subdivision (h) of section 505.28 is amended to read as follows:

(h) Social services district and MMCO responsibilities. Social services districts or MMCOs have the following responsibilities with respect to the consumer directed personal assistance program:

[ (1) annually notifying recipients of personal care services, long term home health care program services, AIDS home care program services or private duty nursing services of the availability of the consumer directed personal assistance program and affording them the opportunity to apply for the program; ]

[(2)] (1) complying with the assessment, authorization, reassessment and reauthorization procedures specified in subdivisions (d) through (f) of this section;

[(3)] (2) receiving and promptly reviewing, the fiscal intermediary's notification to the district pursuant to subparagraph (i)(1)(v) of this section of any circumstances that may affect the consumer's or, if applicable, the consumer's designated representative's ability to fulfill the consumer's responsibilities under the program and making changes in the consumer's authorization or reauthorization as needed;

[(4)] (3) discontinuing, after timely and adequate notice in accordance with Part 358 and Subpart 360-10 of this Title, the consumer's participation in the consumer directed personal assistance program and making referrals to other services that the consumer may require when the district or MMCO determines that the consumer or, if applicable, the consumer's designated representative is no longer able to fulfill the consumer's responsibilities under the program or no longer desires to continue in the program;

[(5)] (4) notifying consumers[, on forms required by the department,] of the district's or MMCO's decision to authorize, reauthorize, increase, reduce, discontinue or deny services under the consumer directed personal

assistance program[, and of the consumer's right to request a fair hearing pursuant to Part 358 of this Title the social services district's decision to deny, reduce or discontinue consumer directed personal assistance must be stated in the notice]. The Department of Health may require the use of forms it develops or approves when providing such notice;

(i) Appropriate reasons and notice language to be used when denying consumer directed personal assistance include but are not limited to the following:

\* \* \*

(e) the consumer's needs may be met, in whole or part, by a technological development, which the notice must identify, that renders certain services unnecessary or less time-consuming, including the use of telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary;

(f) the consumer resides in a facility or participates in another program or receives other services, which the

notice must identify, which are responsible for the provision of needed assistance; [and]

(g) the consumer or, if applicable, the consumer's designated representative is unable or unwilling to fulfill the consumer's responsibilities under the program[.];

(h) the consumer can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify; and

(i) the consumer's need(s) can be met either without services or with the current level of services by fully utilizing any available informal supports, or other supports and services, that are documented in the plan of care and identified in the notice.

(ii) Appropriate reasons and notice language to be used when reducing or discontinuing consumer directed personal assistance include but are not limited to the following:

\* \* \*

(d) the consumer's needs may be met, in whole or part, by a technological development, which the notice must identify, that renders certain assistance unnecessary or less time-consuming, including the use of telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary;

(e) the consumer resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed assistance; [and]

(f) the consumer or, if applicable, the consumer's designated representative is no longer able or willing to fulfill the consumer's responsibilities under the program or the consumer no longer desires to continue in the program[.];

(g) the consumer can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify;



(h) the consumer's need(s) can be met either without services or with a reduced level of services by fully utilizing any available informal supports, or other supports and services, that are documented in the plan of care and identified in the notice; and

(i) an assessment of the consumer's needs demonstrates that the immediately preceding social services district or MMCO authorized more services than are medically necessary following any applicable continuity of care period required by the Department of Health.

(iii) Social services districts or MMCOs that deny, reduce or discontinue services based on medical necessity must identify and document in the notice and in the consumer's plan of care the factors that demonstrate such services are no longer medically necessary. Any such denial or reduction in services must clearly indicate a clinical rationale that shows review of the consumer's specific clinical data and medical condition; the basis on which the consumer's needs do not meet specific benefit coverage criteria, if applicable; and be sufficient to enable judgment for possible appeal.

[(6)] (5) maintaining current case records on each consumer and making such records available, upon request, to the department or the department's designee;

[(7)] entering into contracts with each fiscal intermediary for the provision of fiscal intermediary responsibilities specified in subdivision (i) of this section and monitoring the fiscal intermediary's performance under the contract, including reviewing the fiscal intermediary's administrative and personnel policies and recordkeeping relating to the provision of consumer directed personal assistance program services and evaluating the quality of services that the fiscal intermediary provides; and]

[(8)] (6) entering into a [department] Department of Health approved memorandum of understanding with the consumer that describes the parties' responsibilities under the consumer directed personal assistance program.

Subdivision (i) of section 505.28 is amended to read as follows:

(1) Fiscal intermediaries have the following responsibilities with respect to the consumer directed personal assistance program:

\* \* \*

(iv) maintaining records for each consumer including copies of the social services district's or MMCOs authorization or reauthorization;

(v) monitoring the consumer's or, if applicable, the consumer's designated representative's continuing ability to fulfill the consumer's responsibilities under the program and promptly notifying the social services district or MMCOs of any circumstance that may affect the consumer's or, if applicable, the consumer's designated representative's ability to fulfill such responsibilities;

\* \* \*

(vii) entering into a contract with the [social services district] Department of Health and entering into administrative agreements with MMCOs for the provision of fiscal intermediary services; and

\* \* \*

Subdivisions (k) and (l) of section 505.28 are REPEALED and a new subdivision (k) is added to read as follows:

(k) Immediate need.

The process for determining whether an individual may obtain consumer directed personal assistance on an immediate need basis shall be the same as such process used for the determination of whether an individual may obtain personal care services on an immediate need basis, as described in subdivision (b)(6) and (7) of section 505.14 of this part, provided that in determining eligibility for services the social services district and MMCO shall consider the eligibility and authorization requirements in this section.

## **REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

Social Services Law (“SSL”) § 363-a and Public Health Law (“PHL”) § 201(1)(v) provide that the Department of Health (“Department”) is the single state agency responsible for supervising the administration of the State’s medical assistance (“Medicaid”) program and for adopting such regulations, not inconsistent with law, as may be necessary to implement the Medicaid program. SSL § 365-a(2) authorizes Medicaid coverage for specified medical care, services and supplies, together with such medical care, services and supplies as authorized in the regulations of the Department. Under SSL § 365-a(2)(e) and § 365-f, respectively, the Medicaid program includes personal care services (“PCS”) and consumer directed personal assistance services (“CDPAS”). Finally, under SSL § 364-j and PHL Article 44, the Department may contract with Medicaid Managed Care Organizations (“MMCOs”) to provide Medicaid services to enrollees, which the Department has done for PCS and CDPAS.

### **Legislative Objectives:**

SSL § 365-a(2) authorizes Medicaid coverage for specified medical care, services and supplies, together with such medical care, services and supplies as authorized in the regulations of the Department. Under SSL § 365-a(2)(e) and § 365-f, respectively, the Medicaid program includes PCS and CDPAS. Based upon recommendations of the Medicaid Redesign Team II (“MRT II”), the 2020-21 budget (Chapter 56 of the Laws of 2020, Part MM) amended SSL § 365-a, § 365-f and PHL Article 44 to improve the provision of Medicaid funded PCS and CDPAS. As amended, these provisions link the

eligibility criteria for CDPAP and PCS to the performance of activities of daily living (“ADLs”) so services are authorized for those that need them the most, require the establishment of an independent assessor to take over the performance of assessments and reassessments required for determining individuals’ needs for such services, require an independent physician’s order to access PCS, ensure that such services are furnished to the extent medically necessary to maintain a member’s health and safety in his or her home, require that the standards established for the provision, management or assessment of such services meet that standards set forth in *Olmstead v. LC by Zimring*, 527 US 581 (1999), and provide relief for members who need access to such services by modifying the frequency in which assessments and authorizations for services are conducted.

**Needs and Benefits:**

The Department has promulgated regulations governing PCS at 18 NYCRR § 505.14 and CDPAS at 18 NYCRR § 505.28. Amendments to these regulations are essential to implementing requirements of the State Fiscal Year 2020-21 Enacted Budget (Chapter 56 of the Laws of 2020, Part MM) and MRT II long term care reform proposals, which include instituting new eligibility requirements, establishing an independent assessor, reducing the frequency of assessment from semi-annual to annual, centralizing physician orders and establishing a clinical review for high need cases to ensure that recipients receive the care they need to remain safely in the community. These amendments will help ensure Medicaid beneficiaries receive PCS and CDPAS that are required to appropriately meet their clinical needs as determined by the updated assessment and authorization process and documented in the plan of care.

By centralizing many of the functions of the assessment process and making them independent of the LDSS or MMCO responsible for authorizing services, the changes will bring efficiencies and consistency to the approval of PCS and CDPAS, and promote clinically appropriate outcomes. In particular, the review of high needs cases by an independent panel of medical professionals will help ensure that plans of care are reasonable and appropriate to safely service individuals in the community. Accordingly, this proposal will better facilitate access to PCS and CDPAS for people with disabilities who with the provision of such services are capable of safely remaining in the community in accordance with the standards set forth in *Olmstead v. L.C.*, 527 U.S. 581 (1999).

The proposed regulations will further align the PCS and CDPAS regulations, which share many of the same or similar requirements, but historically have diverged in their drafting. This alignment will help to clarify the requirements for these benefits, which should lead to greater consistency in the assessment, authorization, and provision of services.

Proposed amendments to modernize the language are also included. Over the last decade, with the transition to mandatory enrollment into MMCOs, the majority of medical assistance recipients now receive most of their benefits through MMCOs, including community based long term care services. Although regulations in 18 NYCRR Part 505 are currently cast as requirements on LDSSs, contracts between the Department and MMCOs provide that services covered by MMCOs must comply with the terms of the New York State Medicaid Plan, established pursuant to SSL § 363-a, the Department's regulations, and other applicable requirements. This contractual integration has meant that medical assistance service requirements, as outlined in 18 NYCRR Part

505 and throughout the Department's regulations, generally apply to MMCOs even when MMCOs are not specifically referenced in the regulation.

By introducing references to MMCOs directly in 18 NYCRR §§ 505.14 and 505.28, the Department is dictating more directly how these regulatory provisions apply to MMCOs, and where there may be differences in application of the rules between LDSSs and MMCOs. However, nothing in these amendments necessitates a change in the nature of MMCOs' contractual obligations under the model contracts. Requirements for the provision of covered services in 18 NYCRR Part 505 and throughout the Department's regulations still apply to MMCOs through the model contracts, even when they are not specifically referenced.

The Department is also proposing to clarify and reinforce documentation requirements, to ensure that authorizations, and any proposed changes to such authorizations, are well documented and can be supported in the care plan and medical record. The Department also proposes to clarify and add appropriate reasons and notice language to be used when a LDSS or MMCO denies, reduces or discontinues PCS or CDPAS. Together, these proposed regulations should assist LDSSs and MMCOs, as well as Administrative Law Judges, evaluate the appropriateness of PCS and CDPAS authorizations and changes thereto. This proposal should increase consistency of authorizations as well as the outcomes of an appeal or fair hearing process.



## **COSTS**

### **Costs to Private Regulated Parties:**

These regulatory amendments governing PCS at 18 NYCRR § 505.14 and CDPAS at 18 NYCRR § 505.28 do not impose any additional costs to regulated parties. In fact, in centralizing the assessment and physicians' order process of authorizing PCS/CDPAS and reducing the assessment period to once a year absent any change in condition, the costs to private regulated parties is reduced. Furthermore, LDSS and MMCOs are already required to maintain and update plans of care and MMCOs are required to have an internal appeals process.

### **Costs to Local Government:**

The proposed regulations require that social services districts refer Medicaid eligible individuals who may be eligible for long term care services and supports, including PCS and CDPAS, to the State's contracted independent assessor to complete the long term care assessment tool and, if necessary, obtain a physician's order for PCS or CDPAS. This relieves the LDSS from having to conduct initial and periodic reassessments and obtain a physicians' order from the potential recipients' treating physician or other clinician. The proposed regulations do not impose any costs on local government.

### **Costs to the Department of Health:**

The proposed regulations may result in minimal additional costs to the Department, which will be managed within existing resources.

**Costs to Other State Agencies:**

The proposed regulations will not result in any costs to other state agencies.

**Local Government Mandates:**

The proposed regulations do not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

**Paperwork:**

The proposed regulatory amendments include clarifying changes to existing forms, but regulated parties are familiar with and already use such forms. The amendments do not impose any new forms, paperwork or reporting requirements.

**Duplication:**

These regulatory amendments do not duplicate existing State or Federal requirements.

**Alternatives:**

There are no alternatives to the proposed regulations. Chapter 56 of the Laws of 2020, Part MM establishes new eligibility criteria, which must be assessed by an independent assessor. SSL § 363-a and PHL § 201(1)(v) further requires the Department issue regulations to implement the Medicaid program.

**Federal Standards:**

The proposed regulations do not duplicate or conflict with any Federal regulations.

**Compliance Schedule:**

The regulations will be effective upon publication of a Notice of Adoption in the New York State Register.

**Contact Person:** Katherine Ceroalo  
New York State Department of Health  
Bureau of Program Counsel, Regulatory Affairs Unit  
Corning Tower Building, Room 2438  
Empire State Plaza  
Albany, New York 12237  
(518) 473-7488  
(518) 473-2019 (FAX)  
[REGSQNA@health.ny.gov](mailto:REGSQNA@health.ny.gov)

**REGULATORY FLEXIBILITY ANALYSIS**  
**FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS**

**Effect of Rule:**

The proposed regulations change the assessment and authorization process for personal care services and consumer directed personal assistance services through the State's medical assistance plan. Specifically, the frequency of assessments will change from semi-annually to annually; all assessments to determine individuals' needs for assistance with personal care and environmental and nutritional support functions will be conducted by an independent assessor; orders for services will now be obtained based on a medical exam performed by a qualified independent medical professional; and high needs cases will be subject to an additional independent medical review to assure that proposed plans of care are reasonable and appropriate to maintain the individual safely in his or her home.

These changes move many of the responsibilities from the Local Departments of Social Services (LDSS) or Medicaid Managed Care Organizations (MMCOs) and to an independent entity or entities. While these changes provide administrative relief to LDSS and MMCOs, they may impact Certified Home Health Agencies (CHHAs) and Licensed Home Care Services Agencies (LHCSAs) under contract with LDSSs and MMCOs to perform assessments that will no longer be a LDSS or MMCO responsibility. There are approximately 115 CHHAs and 1,400 LHCSAs certified or licensed to operate in New York State, a subset of which are contracted with MMCOs and LDSSs to perform these assessments.

Any changes that occur to the overall scope and number of contracts between LDSSs or MMCOs and CHHAs or LHCSAs are primarily attributable to the State Fiscal Year 2020-21 Enacted Budget, requiring the establishment of an independent assessor to determine individuals functional needs for PCS and CDPAS. The proposed regulations do not propose any further restrictions on the ability of CHHAs or LHCSAs to perform any of these functions, and include no restriction on the ability of the independent assessor to subcontract with CHHAs or LHCSAs.

**Compliance Requirements:**

These proposed regulations do not impose any new compliance requirements on LHCSA, CHHA, MMCO or LDSS.

**Cure Period:**

Chapter 524 of the Laws of 2011 requires agencies to include a “cure period” or other opportunity for ameliorative action to prevent the imposition of penalties on a party subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one is not included. As these proposed regulations do not create a new penalty or sanction, no cure period is necessary.

**Professional Services:**

No new or additional professional services are required in order to comply with the proposed regulations.

**Compliance Costs:**

No capital costs would be imposed as a result of the proposed regulations. Nor would there be annual costs of compliance.

**Economic and Technological Feasibility:**

There are no additional economic costs or technology requirements associated with the proposed regulations.

**Minimizing Adverse Impact:**

As indicated above, the requirement for an independent assessor is mandated by statute, specifically Sections 2 and 11 of Part MM of chapter 56 of the Laws of 2020. The law prohibits CHHAs and LHCSAs from being selected as contractors to provide independent assessor services. The proposed regulations do not propose any further restrictions on the ability of CHHAs or LHCSAs to perform any of these functions, and include no restriction on the ability of the independent assessor to subcontract with CHHAs or LHCSAs.

Additionally, the Department has preserved certain LDSS and MMCO responsibilities in the proposed regulations at 505.14(b)(2)(iii) and 505.28(d)(3), such as the requirement to determine frequency of need for 24-hour cases, which are currently a source of contract work for CHHAs and LHCSAs. As such, under the proposed rule, CHHAs and LHCSAs could continue to perform this work. The Department has also elected to not prohibit the independent assessor from making arrangements with CHHAs and LHCSAs to perform assessment services. Together, these potentially mitigate much

the impact that may occur from the centralization of the functional assessment responsibilities.

The proposed regulations should not have an adverse economic impact on social services districts.

**Small Business and Local Government Participation:**

These proposed regulations arise from a change in State law pursuant to Chapter 56 of the Laws of 2020, Part MM. The initiatives were recommended by the MRT II following a series of public meetings where stakeholders had the opportunity to comment and collaborate on ideas to address the efficacy of these services. In addition, the MRT II was comprised of representatives of LDSS and MMCOs, among others. The Department of Health welcomes comments on the proposed regulations from local governments and businesses, among others.

**STATEMENT IN LIEU OF  
RURAL AREA FLEXIBILITY ANALYSIS**

A Rural Area Flexibility Analysis for these amendments is not being submitted because the amendments will not impose any adverse impact or significant reporting, record keeping or other compliance requirements on public or private entities in rural areas.

There are no professional services, capital, or other compliance costs imposed on public or private entities in rural areas as a result of the proposed amendments.



## **JOB IMPACT STATEMENT**

Sections 2 and 11 of Part MM of Chapter 56 of the Laws of 2020 require the Department to establish or procure the services of an independent assessor to take over, from LDSSs and MMCOs, the performance of assessments and reassessments required for determining individuals needs for personal care services. Under the proposed regulations, nurse assessors will continue to evaluate individuals to determine their functional need for long term care across the State.

Currently LDSS and MMCOs hire nurses directly or contract with LHCSAs and CHHAs to complete these assessments. Under the new structure, as a result of the statute, an independent assessor will now hire nurses or contract for nursing services to complete the assessments. However, these changes are not expected to affect the overall volume or distribution of individuals needing nurses to perform functional assessments for community based long term care services. Additionally, LDSSs and MMCOs remain responsible for certain evaluation requirements and developing the plan of care, roles which are currently by LDSS and MMCO employed or contracted nurse assessors. As such, the Department does not expect there to be a negative impact, regionally or overall, on nursing jobs in the State, and has reason to believe there may be a slight increase to the number of nursing jobs.