Department of Health

Personal Care/CDPAS Regulation Changes Overview

Regulatory Provisions Effective

November 8, 2021

- **This webinar, which has been pre-recorded, is a high-level overview of the PCS and CDPAP regulatory changes that are effective November 8, 2021**
- **DOH will provide additional guidance by way of an ADM and MLTC policy**
- **Questions regarding these regulatory changes should be sent to:**

  Independent.assessor@health.ny.gov
- **Emailed questions may be held and answered in an FAQ document to be posted on the Department's MRT II website**

AGENDA:

- Overview of Regulatory Process
- Regulatory Provisions in Effect November 8, 2021
- Regulatory Provisions Not in Effect November 8, 2021

Regulatory Process Overview

November 2021

Regulatory Process Timeline

- Proposed regulations first published July 2020
- Comment period closed September 2020
- Department reviewed over 400 comments on the regulations, responding to each one
- Revised proposed regulations published December 2020 with an additional 45-day review/comment period
- Additional 350 comments received and reviewed
- Final Notice of Adoption published on September 8, 2021 in the NYS Register, with a 60-day notice period prior to implementation on November 8, 2021

Regulation Implementation Timing

- **Sections 505.14(b)(8) and 505.28(m)**
  - Added to allow the Department of Health to permit the current assessment process to continue until such time as the Independent Assessor, Independent Practitioner Panel and Independent Review Panel have been implemented.
  - Until such time, all current assessment processes except those identified in this presentation (e.g., routine reassessment timing and practitioner order sign-off), or later written guidance from the Department, will remain in effect.

Regulations Effective Date Overview

- Regulatory provisions outlined in detail in this presentation are effective as of November 8, 2021.

- At the end of the presentation, a high-level overview of those provisions that will not go into effect on November 8, 2021, and go into effect no earlier than January 2022, will be given. The effective date for those provisions has not yet been announced.

- Please see letter, posted here, that outlines all provisions and their effective dates.

Regulatory Provisions Effective November 8, 2021 – Slides 9 through 24

Definitions

- **Sections 505.14(a)(7) and 505.28(b)(12)**
  - Added to define the term Medicaid Managed Care Organization (MMCO)
  - Throughout the proposed regulations, MMCO has been added to be included with the existing references to LDSS
  - Codifies existing MMCO policies and practices required in other areas, such as federal law, model contract provisions and Department policies
  - "MMCO" does not include PACE plans
- **Sections 505.14(a)(8) and 505.28(b)(13)**
  - Added to define that "medical assistance" or "Medicaid" or "MA" are used interchangeably and refer to the same program throughout the regulations
- **Section 505.28(b)(5)**
  - Added to define that "consumer directed personal assistance program" or "consumer directed program" or "the program" are used interchangeably and refer to the same program throughout the regulations

Definitions cont.

- **Section 505.28(b)(16)**
  - Amended the definition for "self-directing consumer" to include the capability of performing the consumer responsibilities outlined in section 505.28(g)
- **Section 505.28(b)(4)**
  - Amended to align the definition of "consumer directed personal assistant" with state law, including clarifying who may and may not be a PA
  - Definition: "*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, 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 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.*"

Ordering Practitioners

- **Sections 505.14(b)(2)(ii)(g) and 505.28(d)(2)(vii)**
  - Effective November 8, 2021, ONLY to the extent necessary to expand the licensed medical professionals who may sign forms for PCS and CDPAS (e.g., current forms DOH-4359 and HCSP-M11Q)
  - Titles that may sign the orders include:
    - Medical Doctor (MD)
    - Doctor of Osteopathy (DO)
    - Nurse Practitioner (NP)
    - Physician Assistant (PA)
    - Specialist Assistant

  All as defined in State Education Law

Routine Reassessment Timing

- **Sections 505.14(b)(4)(vii) and 505.28(e)(5)**
  - Effective November 8, 2021, ONLY to the extent that such provisions permit services to be authorized for a period of up to 12 months
  - Assessments conducted on or after November 8, 2021 will be effective for 12 months for PCS and CDPAS
  - Reassessment requirements for the following programs are not impacted by this change:
    - Programs for All-Inclusive Care for the Elderly (PACE)
    - Assisted Living Programs (ALP)
    - Adult Day Health Care (ADHC)

CDPAP Notification

- **Section 505.28(h)(1)** has been repealed
  - Removed the requirement that the LDSS annually notify individuals in receipt of personal care, long term home health care programs, AIDS home care program or private duty nursing services of the availability of consumer directed personal assistance program and affording them the opportunity to apply for the program
  - Any consistent MMCO policies and contract terms are also repealed
  - It is expected, however, if an individual receiving the services outlined above asks about the availability of CDPAS/CDPAP, the LDSS or MMCO will continue to provide information about the program and, if eligible for CDPAP, a listing of fiscal intermediaries with which the LDSS or MMCO has a contract

CDPAP – One FI Per Consumer

- **Section 505.28(e)(1)(v) and (h)(3)**
  - Added to prohibit the authorization of services by the LDSS or MMCO through more than one fiscal intermediary per consumer
  - LDSS and MMCOs will be directed to work with consumers to pare down any duplication of FI services
  - An ADM and MMCO Policy are being developed to inform the LDSS and MMCOs around timeframes for both contacting the affected consumers and working with them to choose only one FI
  - LDSS or MMCO may need to select an FI for the consumer if they do not choose one for themselves within the instructed timeframes

CDPAP – Designated Representative Responsibilities

- **Section 505.28(h)(2)**
  - Added to require designated representatives to:
    - Make themselves available to ensure that the consumer responsibilities are carried out without delay; and
    - For non-self-directing consumers, 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

Supervision and Cueing

- **Section 505.14(a)(5)(ii)**
  - Added to codify Supervision and Cueing (S&C) as forms of assistance
    - Current policies GIS 03 MA/003 and MLTC Policy 16.07 outline that S&C are forms of assistance with personal care functions (Level 2 services)
    - New regulatory provision expands allowable S&C to include assistance with Nutritional and Environmental support functions (Level 1 services) as well
      - NOTE: the 8-hour cap on services for those who need only Level 1 services is not affected by this rulemaking
    - Consistent with longstanding policies, S&C cannot be authorized or reimbursed unless provided as a means of assistance with a recognized service, even though it now includes Level 1 and 2 services

Requirements for the Continuation, Denial, Reduction or Discontinuation of Services

- **Section 505.14(b)(4)(viii)(b) and 505.28(i)(4)**
  - Amended to include that the Department may require the LDSS or MMCO to use forms it develops or approves when providing notice
- **Sections 505.14(b)(4)(viii)(c)(1) and 505.28(i)(4)(i)**
  - For actions based on Medical Necessity, the provisions codify longstanding policies that the LDSS or MMCO must identify, in the notice and plan of care, the factors that demonstrate why services are not or are no longer medically necessary
  - Notices for denials or reductions in services must clearly indicate a Clinical Rationale:
    - Showing a review of the individual's specific clinical data and medical condition
    - If applicable, showing the basis on which the individual's needs do not meet specific benefit coverage criteria
  - The notices must be sufficiently clear and understandable to enable review of the action on appeal

Requirements for the Continuation, Denial, Reduction or Discontinuation of Services Cont.

- **Sections 505.14(b)(4)(viii)(c)(2) & (3) and 505.28(i)(4)(ii) & (iii)**
  - Updated and added examples of appropriate reasons and notice language for use by LDSS and MMCOs when denying or reducing services
  - NOTE: The lists provided in regulation are not exhaustive. Other reasons and notice language may be used, provided all other applicable notice requirements are met and the rationale constitutes a justifiable basis for action, which may include determinations based on other statutory or regulatory requirements for the provision of services. The lists are codified in regulations to assist and guide LDSS and MMCOs toward permissible reasons for taking action.

Denial and Reduction Reason Changes

Reasonable Assurance of Health and Safety

- **Sections 505.14(b)(4)(viii)(c)(2)(i), (3)(i) and 505.28(i)(4)(ii)(a), (iii)(a)**
  - Codifies existing guidance from DOH: https://www.health.ny.gov/health_care/medicaid/redesign/docs/final_personal_care_guidelines.pdf (at III.e.iii.6)
  - MMCOs and LDSS need only have a reasonable assurance based on clinical assessment and judgment that health or safety can be maintained
  - Authorization of services does not require MMCOs or LDSS to eliminate all doubt as to whether PCS or CDPAP services, in conjunction with other formal or informal services and supports, will maintain the individual's health and safety

Denial and Reduction Reason Changes Cont.

Technological Development

- **Sections 505.14(b)(4)(viii)(c)(2)(vi), (3)(iv) and 505.28(i)(4)(ii)(e), (iii)(d)**
  - Updated rationale to clarify that:
    1) The technology or device used may meet some or all of the identified needs, and
    2) Applicable technologies includes the use of telehealth services or assistive devices provided that:
       - the service or device must be readily available to the individual, and
       - the LDSS or MMCO must document that the device reduces the individual's service needs
         - e.g., by indicating in the notice and plan of care which Level 1 or Level 2 task(s) the technology is being used to address.

Denial and Reduction Reason Changes Cont.

Residents of facilities responsible for providing needed care

- **Sections 505.14(b)(4)(viii)(c)(2)(vii) and (3)(v)**
  - Updated rationale for those in facilities or other programs that otherwise meet the individual's PCS/CDPAS service needs
    - In using this rationale, the LDSS or MMCO should have determined, and indicate in the notice, that either:
      - the individual is not seeking to transition to a less restrictive setting, or
      - the individual's health and safety cannot be reasonably assured in a less restrictive setting

Denial and Reduction Reason Changes Cont.

Voluntary Informal Supports

- **Sections 505.14(b)(4)(viii)(c)(2)(ix) and (3)(i) and 505.28(i)(4)(ii)(h) and (iii)(a)**
  - May deny or reduce services where informal supports, or other supports or services, can meet the individual's needs
    - LDSS or MMCO must document the alternative services (e.g., informal supports) and what needs they meet in the plan of care and notice
    - Informal support must be voluntary and acceptable to the individual
  - This rationale is based on existing requirements (see 505.14(a)(3)(iii)) that prohibit the authorization of service when voluntary assistance, other formal services or supports, or adaptive or specialized equipment are available, cost-effective, and meet the individual's needs

Reduction Reason Only Changes

MMCO Initial Determination after Continuity of Care Period

- **Sections 505.14(b)(4)(viii)(c)(3)(vii) and 505.28(i)(4)(iii)(h)**
  - Following an applicable continuity of care period, as described in the next slide, an MMCO may determine to reduce services based on its assessment of medical necessity
    - The MMCO must support its determination based on medical necessity, including adherence to 505.14(b)(1)(viii)(c)(1) and 505.28(i)(4)(i). That means the notice must:
      - Include the clinical rationale, including any applicable coverage criteria, as related to the individual's specific clinical condition
      - Be sufficiently clear to enable judicial review
    - In these cases, the MMCO is supporting its own initial determination of services, and a reduction or termination of services for the member does not require evidence of a change in condition

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Reduction Reason Only Changes Cont.

MMCO Initial Determination after Continuity of Care Period Cont.

- Applicable continuity of care periods include but may not be limited to:
  - PHL 4403-f(7)(g)(i) and 1115 waiver – permit an MLTC Plan to enroll a person receiving home and community-based services from an LDSS without doing an assessment, provided they continue the services upon enrollment until an assessment has been performed
  - MLTC Policy 17.02 requires MLTC plans to maintain a continuity of care period of 120 days after enrollment, or until a new assessment and plan of care is agreed to, in certain situations:
    - Plan closures, Plan Service Area reductions, and Plan Mergers, Acquisitions or other similar arrangements

Provisions NOT Effective on November 8, 2021

Additional Regulation Implementation Timing

- As outlined earlier in the presentation, the regulations allow the Department to pend certain provisions, as well as continue with the current assessment process until such time as the Independent Assessor, Independent Practitioner Panel and Independent Review Panel have been implemented.

- The following slides give a high-level overview of provisions that will go into effect after November 8, 2021, but not earlier than January 2022. The effective date for the provisions in slides 26-29 has not yet been announced.

Minimum Needs Criteria and Related Changes

- Minimum Needs Criteria:
  - 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
  - Will be implemented, at some point after January 1, 2022, upon additional notification from the Department. Implementation is contingent upon:
    - Independent Assessor's ability to launch these provisions
    - Continued MOE restrictions under FFCRA/ARPA such that continuation of any FPE and spending plans will inform, and could further delay, implementation
- Added a definition of "activity of daily living" to align with State law

Independent Assessor and Related Changes

- The Department has contracted with Maximus to provide these services and will notify all plans and LDSS once an implementation date has been established.
- Until such time, all assessment processes except those identified in this presentation (e.g., routine reassessment timing and practitioner order sign-off) will remain in effect. Those processes and related changes pended include:
  - Independent Assessment Process
  - Independent Practitioner Panel for Practitioner Orders
  - Independent Review Panel for plans of care that, for the first time, are 12 or more hours per day, on average
  - Removed the requirement for LDSSs to maintain contracts for the provision of nursing services
  - Removed references to the nursing assessment and clarify that the LDSS and MMCO are responsible for determining nursing supervision frequency

Fiscal Intermediary Changes

- Definition of “fiscal intermediary” revised to mean an entity with a contract with the New York State Department of Health

- Fiscal intermediary responsibilities revised to remove the requirement that fiscal intermediaries enter into contracts with LDSS and replace it with the requirement that a fiscal intermediary enter into contract with the Department of Health and into administrative agreements with MMCOs

QUESTIONS??

Independent.assessor@health.ny.gov