March 15, 2021

Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel
Reg. Affairs Unit - Room 2438
ESP Tower Building
Albany, NY 12237

RE: Personal Care Services (PCS) and Consumer Directed Personal Assistance Program (CDPAP) I.D. No. HLT-28-20-00019-RP

Dear Ms. Ceroalo:

The Home Care Association of New York State (HCA), Inc., on behalf of its 300-plus member home health agencies (HHAs), managed care plans and hospices serving several hundred thousand beneficiaries annually, appreciates the opportunity to provide comments on I.D. No. HLT-28-20-00019-RP (changes to Personal Care Services and Consumer Directed Personal Assistance Program).

Our perspective is unique and informed based on having members that provide home care services directly and members that are managed long term care plans that currently conduct assessments, monitor, oversee and coordinate services for their members.

Eligibility for PCS and CDPAP

While we understand that the proposed change in eligibility for PCS and CDPAP (requiring at least limited assistance with physical maneuvering with more than two activities of daily living or needing at least supervision with more than one activity of daily living for those with dementia) is based on the statute, it is not clear how or where individuals who require home care and do not meet these new criteria will be served.

We also are concerned about the rule's provision that "supervision and cueing are not standalone personal care services and may not be authorized, paid for or reimbursed except while providing assistance with nutritional and environmental support functions or personal care functions." We are concerned that this is going to create gaps for individuals with co-occurring conditions that require supervision and cueing sometimes distinctly. We seek information on how many individuals are currently receiving supervision and cueing only and how their service needs will continue to be met.

Independent Assessment (IA)

HCA greatly appreciates the extensive changes made by DOH to reduce a number of the IA proposal's serious barriers and restrictions on what should be the natural exchange of perspective and information in the assessment process. However, HCA continues to be very concerned that this external IA assessment process poses artificial layers, inappropriately distances the patient's provider clinicians and the plan's case managers from patient status and need determinations, and overall is regressive to the entire concept of integrated care.

HCA is concerned that the IA is replacing the assessment currently conducted by the entity that is most familiar with the patient – the Managed Long Term Care plan – and removing the plan's critical role in

assessing the functions and tasks required by the individual. Also, HCA questions how quickly the IA will be able to conduct a new assessment if the individual's condition changes. If not conducted timely, the patient's health and other needs may not be addressed when needed and his or her condition may deteriorate and/or the plan will have to change the service plan prior to a new assessment and face consequences later for such action.

We are also concerned that the costs that are projected to be saved in MLTC/provider assessment will in fact continue to be incurred by the plan and provider who, despite the IA, are professionally bound to ensure that their members/patients are provided appropriate care.

While the proposed rule requires a new assessment (and practitioner order) when there is a change in the individual's mental status or medical condition, there are no time limits proposed for the new assessment. Even though the IA can be conducted via telehealth modalities, certain assessments will require in-person visits and must be scheduled immediately.

Finally, if a certified home health agency (CHHA) is involved in serving the case, the CHHA is required under both federal and state regulatory requirements to conduct its own assessment of the patient via the federal OASIS assessment and the UASNY assessment. How are this separately required assessment and the IA assessment reconciled?

For all of the above reasons, HCA urges IA implementation to be tabled and withdrawn upon reconsideration by the Executive and Legislature.

Contracting with CHHAs and LHCSAs

HCA supports the continuation of allowing CHHAs and Licensed Home Care Services Agencies (LHCSAs) to complete assessments and to be allowed to contract with the IA to do so.

However, the proposed rule (see "Revised Regulatory Flexibility Analysis for Small Businesses and Local Governments") includes conflicting information on whether CHHAs or LHCSAs can subcontract with the IA to perform assessments. While the language on pages 150 and 152 allows for such assessments by CHHAs and LHCSAs, the response on page 202 states that LHCSAs will not be permitted to perform IA assessments, either as the IA or through a subcontract with the IA. This needs to be corrected to allow LHCSAs to subcontract with the IA to perform assessments.

Independent Medical Examination and Practitioner Order

HCA strongly supports the change to allow for a physician assistant (PA) or nurse practitioner (NP) to conduct the medical examination and to sign an order form. This will expand who can sign orders and address previous delays in obtaining physician orders.

However, we have concerns about the requirement that the medical professional who conducts the examination must not have "established a provider-patient relationship with the individual prior to the clinical encounter from which the practitioner order is completed." This would forbid those providers who have known and are most familiar with their patients from providing information crucial to the assessment process.

This also appears contradictory to the engaged role that physicians currently play for the patient, and that has been encouraged in the DOH State Improvement Plan, Advanced Primary Care and Patient Center Medical Home initiatives. In no other capacity in the health care system is the patient's attending physician precluded from being the ordering physician; actually, it is quite the opposite.

Resolving Mistakes and Clinical Disagreements

HCA supports the provision whereby social services districts or Medicaid managed care organizations (MMCOs) can raise "material" disagreements regarding the outcome of the independent assessment with the assessor. In such cases, the district or plan disputes a finding or conclusion in the independent assessment that is subject to the assessor's clinical judgement. Material is defined as one which would affect the amount, type, or duration of services authorized.

Upon submission of a disagreement, an independent assessor shall schedule and complete a new assessment within 10 days of receiving notice. However, the proposed rule does not address any recourse by the district or MMCO if the new assessment comes to similar findings as the original assessment. DOH needs to establish a process to address these circumstances, such as an independent arbitrator or fair hearing procedure.

HCA is opposed to the new section, entitled "sanctions for failure to cooperate and abuse of the resolution process," and believes it is not only unnecessary but will discourage districts and MMCOs from utilizing the resolution process. We do not foresee any "abuse" of this process and question the necessity for this language.

Independent Medical Review of High Needs Cases

We appreciate the Department's substantial work to try to streamline this process, and in particular to require panel review only the first time the 12+ hour case is identified by the IA. HCA remains concerned, however, that the requirement for independent medical review before 12+ hour cases can be authorized will lead to delays in authorizing such cases, lack of care for patients with major needs and delays in discharge of hospital patients who need such services. While we understand that the regulations permit a "temporary" service authorization to be granted prior to receipt of the IRP report (page 179), we question how often this will actually be done.

To further streamline this mechanism for all concerned, HCA had proposed a process analogous to "standing orders" that the panel could create and issue, with recommendations that would apply broadly to these 12+ hour cases, and for the major portion of them, serve to guide plan/provider consideration of the cases. Cases that either the IA or the plan feel have individual circumstances that merit individual panel review could be referred for such.

While HCA questions the necessity of requiring that every 12+ hour case of personal care or consumer directed care must go to an "independent medical review panel," HCA supports that the social services district or MMCO is not required to adopt, but must consider, the panel's recommendation in finalizing the plan of care and authorization.

HCA supports the provision that reauthorization of services on a 'high needs' case does not require another independent panel review for as long as the case remains a high needs one.

CDPAP

Designated Representatives

HCA MLTC members often encounter designated representatives who don't carry out their responsibilities "to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities . . ."

HCA supports the following language:

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.

While the proposed rule also includes language whereby the managed care organization may evaluate the ability and willingness of the individual's designated representative to assume the consumer's responsibilities, there is no provision that covers what an MMCO can do when it encounters a designated representative at the initial stage or sometime later who is not carrying out his or her responsibilities.

Language that covers this situation should be part of any final regulation.

FI Limits

HCA supports the provision that the social serviced district or MMCO shall not authorize services provided through more than one fiscal intermediary (FI) per consumer, and that a consumer (or designated representative) may not work with more than one FI. Allowing more than one FI to work with a consumer is confusing to all of the parties, leads to duplicative efforts and adds to administrative expenses.

Annual Notification

HCA also supports removing the requirement that recipients of personal care services, long term home health care program services, AIDS home care program services or private duty nursing services be notified annually of the availability of CDPAP. This has led to confusion among individuals who are not appropriate for or are not interested in consumer directed services and is an unnecessary administrative burden for local districts and MMCOs.

Caregiver Backup

While the current regulations (Title 18, 505.28) require the consumer to recruit and hire a sufficient number of individuals who meet the definition of consumer directed personal assistant, our MMCO and/or FI members sometimes find that the consumer does not identify any or a reliable back-up caregiver in case the primary caregiver is unavailable. We recommend that this be addressed in the proposed rule and made a condition of eligibility for CDPAP services or, if not, allow for the denial of CDPAP services in such cases.

Thank you for considering our comments. If you have any questions or need more information, I can be reached at 518-810-0662.

Sincerely,

Andrew Koski, Vice President
Program Policy and Services