SUMMARY OF EXPRESS TERMS

The proposed rulemaking would amend 18 NYCRR § 505.28, related to consumer directed personal assistance program (CDPAP) services, to implement recent statutory changes to section 365-f of the Social Services Law, as adopted in the State Fiscal Year 2024-25 Enacted Budget requiring the State to contract with a Statewide Fiscal Intermediary.

Section 505.28(a) establishes the purpose of CDPAP to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.

Section 505.28(b) defines terms used throughout this section and is amended to define Statewide Fiscal Intermediary (SFI) and statewide fiscal intermediary subcontractors for reference where these terms replace the term fiscal intermediary(ies) throughout the regulation. Clarifications and conforming edits were made in some definitions.

Section 505.28(b)(7) is added to define the Department as the Department of Health.

Section 505.28(b)(13) is added to define a local department of social services.

Section 505.28(b)(17) is amended as follows: *personal care services* means assistance with [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 clauses (5)(i)(a) and (5)(ii)(a) of this subdivision except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week.

Section 505.28(c) describes the eligibility requirements to participate in CDPAP; eligibility requirements are not changing as part of this proposed rulemaking.

Section 505.28(d) describes the assessment process and is clarified to indicate that the assessment process described in this subdivision is not applicable for participants in a Program of All-inclusive Care for the Elderly (PACE) plan.

Section 505.28(e) describes the authorization process for services under CDPAP; the authorization process is not changing as part of this proposed rulemaking.

Section 505.28(f) describes the reassessment and reauthorization processes; the reassessment and reauthorization processes are not changing as part of this proposed rulemaking.

Section 505.28(g) describes the timeframes for the assessment and authorization process; the timeframes are not changing as part of this proposed rulemaking.

Section 505.28(h) describes the responsibilities of the consumer and designated representatives; the responsibilities are not changing as part of this proposed rulemaking.

Section 505.28(i) describes the responsibilities of local departments of social services (LDSS) and Medicaid managed care organizations (MMCOs). This section is amended, per the below, to clarify responsibilities as they relate to the SFI.

Section 505.28(i)(7) is added as follows: MMCOs and LDSS are responsible for notifying the Department of any inappropriate fiscal intermediary services by the Statewide Fiscal Intermediary, its subcontractors or other unregistered entities.

Section 505.28(j)(1) is amended to further describe the responsibilities of the SFI. This section is amended, per the below, to clarify responsibilities as it relates to the SFI.

Section 505.28 (j)(1)(ix) is added to ensure that all SFI subcontractors register with the Department.

Section 505.28 (j)(1)(x) is added to direct the SFI to implement mechanisms to regularly gather feedback from consumers or their designated representatives about their experiences with the SFI and any subcontractors.

Section 505.28 (j)(1)(xi) is added to direct the SFI to comply with all Federal and New York State electronic visit verification laws, rules, regulations and guidance

Section 505.28 (j)(1)(xii) is added to require the SFI to ensure that consumers or their representatives verify the accuracy of their personal assistant's hours through the electronic visit verification system (EVV), signed timesheets, or other Department-approved methods.

Section 505.28(k) was renumbered and a new subdivision (k) added that describes the registration and responsibilities of subcontractors. All SFI subcontractors must register with the Department within 30 days of being selected. Registration will be in the format prescribed by the Department and include, but not be limited to, the work being performed, term of the subcontract, and attestation that the subcontractor has no, or has satisfactorily eliminated, any actual or perceived conflicts of interest. The Department shall notify the subcontractor of any incomplete information and allow 10 days for the submission of additional information. The Department will notify the subcontractor and SFI that the subcontractor may begin providing services; subcontractors may not provide services to the SFI until approval is granted by the Department. Subcontractors may not conduct any marketing or advertising related to CDPAP without approval from the SFI and the Department. The Department may immediately revoke a subcontractor's registration when the SFI notifies the Department a subcontracting relationship no longer exists. The Department may revoke, suspend or otherwise limit subcontractor registration with 30 days' notice if the subcontractor fails to comply with its obligations.

Section 505.28(l) was renumbered and amended to describe the process for payment of administrative fees to the SFI. The three tier payment mechanism was eliminated and replaced with a per consumer per month payment established in the SFI contract.

Section 505.28 (m) was repealed and a new subdivision added to provide requirements for cost reporting by existing fiscal intermediaries (FI) and the SFI. FI's in operation in 2024 shall submit a cost report in conformance with section 505.14 of this Part and section 3612(8) of Public Health Law. An SFI with cost experience is required to submit an annual cost report in a manner directed by the Department. Inaccurate or incomplete submissions by the SFI shall be corrected within 30 days from notice of the deficiency. The SFI's costs report shall be completed in accordance with generally accepted accounting principles and contain a certification by a person with authority to certify on behalf of the SFI.

Section 505.28 (n) and (o) were added to describe the process for calculation of direct care payment rates for an SFI with cost experience and an SFI without cost experience. When cost experience exists, the rates will be calculated based on allowable costs. Allowable costs are defined as costs that are necessary for the SFI's operation, are directly or indirectly related to recipients' care, and are not expressly declared to be nonallowable by Federal or State law or regulations. Examples of allowable costs and non-allowable costs are detailed in this section. Allowable costs are subject to the ceiling in section 505.14(h)(7)(ii)(6) of this Part. The SFI is required to reduce reported costs that are not properly chargeable to patient care. SFI's without costs experience shall submit estimated costs and the Department shall use estimated costs or a hybrid approach of estimated and regional costs to determine direct care payment rates.

Section 505.28 (p) was renumbered and describes the process for immediate need determinations. The immediate need process does not change as a result of this rulemaking.

Pursuant to the authority vested in the Commissioner of Health by Social Services Law sections 363-a, 365-a(2) and 365-f and Public Health Law sections 201(1)(v) and 206(1)(f), section 505.28 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is amended, to become effective on the 60th day following publication of a Notice of Adoption in the New York State Register, to read as follows:

505.28 Consumer directed personal assistance program.

(a) Purpose. The consumer directed personal assistance program is intended to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.

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

(1) *Activity of daily living* means those activities recognized as activities of daily living by the evidence based validated assessment tool in accordance with [section 2-a of part MM of chapter 56 of the laws of 2020] Social Services Law 365-a(2)(e)(v).

(2) [*c]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[;].

(3) [*c]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[;].

(4) [*c]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, or the consumer's designated representative shall [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 social services 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) *[c]Consumer directed personal assistance program* or *consumer directed program* or the program means the program provided for under section [356-f] 365-f of title 11 of article 5 of the Social Services Law.

(6) [*c]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.

(7) *Department* means the New York State Department of Health.

[(7)] (8) [*d]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 (h) 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 shall [may] not be the consumer directed personal assistant or a [fiscal intermediary] Statewide Fiscal Intermediary employee[, representative or affiliated person;] or subcontractor employee.

[(8) *fiscal intermediary* means an entity that has a contract with 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 (j) of this section*;*]

(9) [*f]Fiscal intermediary administrative costs* means the allowable costs incurred by [a fiscal intermediary] the Statewide Fiscal Intermediary for performance of Statewide [f]Fiscal [i]Intermediary services under section 365-f(4-a) of the Social Services Law and Statewide F[f]iscal I[i]ntermediary responsibilities under subdivision (j) [(i)] of this section.

(10) [*h]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[;].

(11) [*l*]*L**ive-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[;].

(12) *Local Department of Social Service* (LDSS) or *Social Service District* (SSD) means the county Department of Social Services or the New York City Department of Social Services.

[(12)] (13) *Medicaid Managed Care Organization* or MMCO means an entity[, other than an entity approved to operate a Program of All-inclusive Care for the Elderly (PACE) plan,] 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 44 of the Public Health Law; or (ii) licensed under article 43 of the Insurance Law[;].

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

[(14)] (15) [*m]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[;].

[(15)] (16) [*p]Personal care services* means assistance with [the] nutritional and environmental support functions, personal care functions, or both such functions, that are specified in clauses (a)(5)(i)(a) and (a)(5)(ii)(a) of 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.

[(16)] (17) [a *s]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]their consumer directed personal assistance; understands the impact of these choices; 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[;].

[(17)] (18) [*s]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[;].

[(18)] (19) [*s]*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.

(20) "Statewide Fiscal Intermediary" (SFI) means the entity that has a statewide contract with the New York State Department of Health to provide statewide wage and benefit processing for consumer directed personal assistants and other Statewide Fiscal Intermediary responsibilities specified in subdivision (j) of this section.

(21) *Statewide Fiscal Intermediary subcontractor or subcontractor* means any entity that has an approved subcontract with the Statewide Fiscal Intermediary that delegates any of the fiscal intermediary functions set forth in subdivision (j) of this section.

(c) Eligibility requirements. To participate in the consumer directed personal assistance program, an individual [must] shall meet the following eligibility requirements:

(1) be eligible for medical assistance;

(2) be eligible for long term care and services provided by a certified home health agency, 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;

(3) have a stable medical condition;

(4) be self-directing or, if non self-directing, have a designated representative;

(5) need assistance with one or more personal care services, home health aide services or skilled nursing tasks;

(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;

(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.

(d) Assessment process. Other than for participants in a Program of All-inclusive Care for the Elderly (PACE) plan, [T]the assessment process includes an independent assessment, a medical examination and practitioner order, an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required under paragraph (5) of this subdivision, a referral to an independent review panel. The independent assessment, medical exam and independent review panel may utilize telehealth modalities for all or a portion of such assessments provided that the individual is given an opportunity for an in-person assessment and receives any necessary support during the telehealth assessment, which may include the participation of an on-site representative or support-staff. 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] shall 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, including an assessment of whether the individual meets minimum needs requirements;

(b) a discussion with the individual or, if applicable, the individual's designated representative to determine the individual's perception of [his or her]<u>their</u> 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] <u>shall</u> 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]<u>their</u> care.

(iii) The independent assessment [must] <u>shall</u> assess the consumer where the consumer is located including the consumer’s home, a nursing facility, rehabilitation facility or hospital, provided that the consumer’s home or residence shall be evaluated as well if necessary to support the proposed plan of care and authorization or to ensure a safe discharge. This provision shall not be construed to prevent or limit the use of telehealth in the assessment of a consumer.

(2) Independent medical exam and practitioner order.

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

(ii) The medical professional who examines the individual [must] shall 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.

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

(iv) The medical professional [must] shall examine the individual and accurately 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.

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

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

(vii) The medical professional [must] shall sign the practitioner order form, certify that the information provided in the form accurately describes the individual's medical condition and regimens 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 is medically stable.

(viii) The practitioner's order form [must] shall be completed and made available by the medical professional to the social services district or any MMCOs as appropriate after the medical examination and independent assessment.

(ix) The practitioner 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 individuals' documented needs are provided or ordered.

(3) Social services district or MMCO responsibilities.

(i) Before developing a plan of care or authorizing services, a social services district or MMCO shall review the individual's most recent independent assessment and practitioner order, or in the case of participants in a Program of All-inclusive Care for the Elderly (PACE) plan, the MMCO may use the

individual's most recent independent assessment, and may directly evaluate the individual, to determine the following:

(a) whether services [can] may 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] may maintain the individual's health and safety in [his or her]their 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 (h) of this section and, if applicable, the ability and willingness of the individual's designated representative to assume these responsibilities;

(c) the individual's preferences and social and cultural considerations for the receipt of care;

(d) 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]may be monitored appropriately and more cost-effectively by personal emergency response services provided in accordance with section 505.33 of this Part;

(e) whether the individual [can]may 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;

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

(g) whether the individual's needs [can]may be met through the use of telehealth services that [can]may be demonstrated and documented to reduce the amount of services needed and where such services are readily available and [can]may be reliably accessed;

(h) whether the individual [can]may 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;

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

(j) whether the consumer's needs [can]may 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.

(ii) The social services district or MMCO [must]shall first determine whether the individual, because of the individuals' medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For individuals who would be otherwise

eligible for personal care services, the social services district [must]shall then determine whether, and the extent to which, the individual [can]may be served through the provision of services described in clauses (i)(d)- (j) of this paragraph.

(a) If a social services district or MMCO determines that an individual [can] may be served appropriately and more cost-effectively through the provision of services described in clauses (i)(d) - (g) of this paragraph, and the social services district or MMCO determines that such services are available in the social services district to the individual, the social services district or MMCO [must] shall consider the use of such services as well the individuals identified preferences and social and cultural considerations described in clause (i)(c) of this paragraph in developing the individual's plan of care.

(b) If a social services district or MMCO determines that other formal services are available or the individual’s needs [can]may be met using available adaptive or specialized medical equipment or supplies or voluntary assistance from informal caregivers, as described in clauses (i)(h) -(j) of this paragraph, the social services district or MMCO [must]shall include these in the individual’s plan of care. To ensure availability of voluntary informal supports, the social services district or MMCO [must]shall confirm the caregiver’s willingness to meet the identified needs in the plan of care for which they [will]shall provide assistance.

(iii) 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]shall 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]shall 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 social services district [must]shall send the consumer a timely and adequate notice of the proposed reduction.

(iv) 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 practitioner 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, [5]five hours daily of uninterrupted sleep during the aide's [8]eight hour period of sleep.

(v) The social services district or MMCO is responsible for developing a plan of care in collaboration with the consumer or, if applicable, the consumer's designated representative that reflects the assessments and practitioner order described in this subdivision. In the plan of care, the social services district or MMCO [must]shall identify:

(a) the personal care services, home health aide services and skilled nursing functions or tasks with which the consumer needs assistance;

(b) the amount, frequency and duration of services to be authorized to meet these needs;

(c) how needs are met, if not met through the authorization of services; and

(d) any other descriptions and documentation provided for in this section.

(vi) Upon the development of a plan of care, the social services district or MMCO shall refer high needs cases described in paragraph (5) of this subdivision to the independent review panel; provided, however, that an MMCO should not refer a

case unless and until the individual is enrolled or scheduled for enrollment in the MMCO. When a case is referred to the independent review panel:

(a) the social services district or MMCO shall provide the individual's plan of care and any clinical records or other documentation used to develop the plan of care, such as records from treating providers and the results of any review or evaluation performed pursuant to this paragraph to the 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 panel's recommendation in finalizing the plan of care and authorization. However, the social services district or MMCO is not required to adopt the recommendation, either in full or in part, and remains responsible for determining the amount and type of services medically necessary.

(4) Coordinating the independent assessment, practitioner order and LDSS or MMCO responsibilities.

(i) The social services district or MMCO [must]<u>shall</u> coordinate with the entity or entities providing independent assessment and practitioner services to minimize disruption to the consumer and in-home visits.

(ii) The social services district or MMCO [must]<u>shall</u> inform the entity or entities providing independent assessment and practitioner services when a new assessment or practitioner order is needed pursuant to subparagraph (f)(1)(ii) and

paragraph(2) of this section, in accordance with department guidance, using forms as may be required by the department.

(a) When the social services district or MMCO receives an initial or new request to participate in the consumer directed personal assistance program, it shall refer the individual to the entity providing independent assessment services and provide assistance to the individual in making contact in accordance with department guidance; provided however that the social services district or MMCO may not pressure or induce the consumer to request an assessment unwillingly.

(b) If needed, the MMCO shall also refer the individual to the social services district to determine the individual's eligibility for medical assistance, including community-based long term care services.

(iii) The entity or entities providing independent assessment or practitioner services may request that the social services district or MMCO confirm or update a consumer's record in the assessment database designated by the department. The social service district or MMCO shall respond within one business day and confirm or update the relevant record within three business days after receipt of request.

(iv) Resolving mistakes and clinical disagreements in the assessment process.

(a) If the social services district or MMCO identifies a material mistake in the independent assessment that [can]may be confirmed by the submission of evidence, the social services district or MMCO shall advise the independent assessor. A mistake is an error of fact or observation that

occurred when the assessment was performed that is not subject to the independent assessor's clinical judgment. A mistake is material when it would affect the amount, type, or duration of services authorized. When identifying the mistake, the social services district or MMCO [must]shall provide evidence of the mistake to the independent assessor. The independent assessor shall promptly issue a corrected assessment or schedule a new assessment in accordance with clause (c) of this subparagraph as appropriate.

(b) After reviewing the independent assessment, practitioner order and the result of any social service district or MMCO assessment or evaluation, if the social services district or MMCO has a material disagreement regarding the outcome of the independent assessment, the social services district or MMCO may advise the independent assessor. A disagreement occurs when the social services district or MMCO disputes a finding or conclusion in the independent assessment that is subject to the independent assessor's clinical judgment. A disagreement is material when it would affect the amount, type, or duration of services authorized. When submitting a disagreement to the independent assessor, the social services district or MMCO [must]shall provide the clinical rationale that forms the basis for the disagreement.

(c) Upon submission of a material disagreement, an independent assessor shall schedule and complete a new assessment within 10 days from the date it receives notice from the social services district or MMCO. This

shall not pend or otherwise affect the timeframes within which the social services district or MMCO is required to make a determination, provide notice, or authorize services.

(v) Sanctions for failure to cooperate and abuse of the resolution process.

(a) The Department of Health may impose monetary penalties pursuant to Public Health Law section 12 for failure to coordinate with the entity or entities providing independent assessment and practitioner services in accordance with the provisions of clauses (a) - (c) of this subparagraph or engaging in abusive behavior that affects the coordination of the assessment process. In determining whether to impose a monetary penalty and the amount imposed, the department shall consider, where applicable, the following:

(1) the frequency and numerosity of violations, both in absolute terms and relative to other MMCOs;

(2) the responsiveness of the MMCO to requests for coordination;

(3) the history of coordination between the MMCO and the entity or entities;

(4) the good faith demonstrated by the MMCO in attempting to coordinate;

(5) whether the MMCO provides a justification for the violation and whether it has merit, as determined by the department;

(6) whether the violation resulted or could have resulted in injury or other harm to the consumer; and

(7) other relevant facts or circumstances.

(b) The Department of Health may revoke, or impose other restrictions on a social services district's or MMCO's privilege to request reassessments on the basis of a material disagreement where the department determines that the social services district has abused this privilege, including the use of the mistake process for issues subject to clinical judgment or improperly pressuring consumers to request a new assessment. In determining whether a social services district or MMCO has abused this privilege, the department shall consider, where applicable, the following:

(1) the frequency and numerosity of disagreements, mistakes, and reassessment requests submitted to the independent assessor, both in absolute terms and relative to other social services districts and MMCOs;

(2) whether the clinical rationale provided for the disagreement has merit, as determined by the department;

(3) whether the disagreement, mistake, and reassessment requests are made as a matter of course, instead of upon review of the clinical record;

(4) the outcome of the reassessment as compared to the assessment it replaces; and

(5) other facts or circumstances that tend to provide evidence for or against abuse.

(c) Nothing in this section shall be construed to limit the authority of the department or other agencies to seek other remedies, sanctions or penalties, including other monetary penalties.

(5) Independent medical review of high needs cases.

An independent medical review of a proposed plan of care shall be obtained before a social services district or MMCO may authorize more than 12 hours of personal care services or consumer directed personal assistance, separately or in combination, per day on average (high needs cases). The review shall result in a recommendation made to the social services district or MMCO, as described in this paragraph.

(i) The independent medical review [must]<u>shall</u> 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 "independent review panel").

(ii) The case review shall be coordinated by a physician (the "lead physician") who shall be selected from the independent review panel. The lead physician may not be the same person who performed the initial medical examination or signed the individual's practitioner order.

(iii) The lead physician [must]<u>shall</u> review the independent assessment, practitioner order, any other assessment or review conducted by the social services district or MMCO, including any plan of care created.

(iv) The lead physician may evaluate the individual, or review an evaluation performed by another medical professional on the independent review panel. The

medical professional may not have performed the initial medical examination or signed the individual's practitioner order.

(v) The lead physician and panel members may consult with or interview other members of the independent review panel, the ordering practitioner, the individual's treating or primary care physician, and other individuals that the lead physician deems important and who are available to assist with the panel's review.

(vi) The lead physician and panel members may request such additional information or documentation, including medical records, case notes, and any other material the lead physician deems important to assist the panel's review and recommendation.

(vii) After review, the independent review panel shall produce a report, signed by the lead physician, providing a recommendation on the reasonableness and appropriateness of the proposed plan of care to maintain the individual's health and safety in [his or her]<u>their</u> own home, in accordance with the standards and scope of services set forth in this section. The report may suggest modifications to the plan of care, including the level, frequency, and duration of services and whether additional, alternative, or fewer services would facilitate the provision of medically necessary care. The report may not, however, recommend a specific amount or change in amount of services.

(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. The entity designated by the Department of Health to provide independent assessment services shall be responsible for determining whether individuals meet minimum needs requirements for services.

(ii) The authorization [must]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]shall 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]shall 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.

(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 social services district or MMCO [must]shall authorize consumer directed personal assistance according to the consumer's plan of care. The district or MMCO [must]shall not authorize consumer directed personal assistance unless it reasonably expects that such assistance [can]may 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] only authorize services provided through [more than one fiscal intermediary per consumer] the Statewide Fiscal Intermediary.

(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 social services district or MMCO determines that any of the services or supports identified in clauses (d)(3)([j]i)(*h*)-(*i*) 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.

(2) The social services district or MMCO may authorize only the hours or frequency of services that the consumer actually requires to maintain [his or her]their health and safety in the home.

(3) The duration of the authorization period [must]shall 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]shall 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) The social services district or MMCO may not authorize more than 12 hours of personal care services per day on average prior to considering the recommendation of the independent review panel in accordance with procedures outlined in paragraphs (d)(3) and (5) of this section, unless such authorization is ordered pursuant to a fair hearing decision or by another court of competent jurisdiction. Pending review of the independent

review panel’s recommendation and if necessary to comply with federal or state timeliness requirements, including immediate needs cases, the social services district or MMCO may authorize and implement services based on a temporary plan of care which provides for more than 12 hours of personal care services per day on average.

(5) No authorization [may]<u>shall</u> exceed 12 months from the date of the most recent independent assessment or practitioner order, whichever is earlier.

(6) The social services district or MMCO [must]<u>shall</u> 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) Nothing in this subdivision precludes the provision of the consumer directed personal assistance program in combination with other services when a combination of services [can]<u>may</u> appropriately and adequately meet the consumer's needs; provided, however, that no duplication of Medicaid-funded services would result.

(f) Reassessment and reauthorization processes.

(1) Prior to the end of the authorization period, the social services district or MMCO [must]<u>shall</u> 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 social services district or MMCO [must]<u>shall</u> 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]<u>shall</u> 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) Neither an independent assessment nor a practitioner order shall be required to reauthorize or continue an authorization of services, except:

(a) prior to or in conjunction with a discharge from an institutional or in-patient setting, provided that this provision shall not be construed to prohibit a safe discharge from occurring;

(b) as provided in paragraph (2) of this subdivision;

(c) that an individual in receipt of services may request a new independent assessment; and

(d) an individual in receipt of services [must]shall receive an independent assessment and practitioner order at least annually to maintain authorization.

(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]shall reauthorize consumer directed personal assistance in accordance with the authorization process specified in subdivision (e) of this section. When the social services district or MMCO determines that the consumer is no longer eligible to continue to participate in the consumer directed personal assistance program, the social services district or MMCO [must]shall 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 <u>social services</u> district's or MMCO's intent to discontinue consumer directed personal assistance on forms required by the department.

(2) The social services district or MMCO [must]<u>shall</u> reassess the consumer when an unexpected change in the consumer's social circumstances, mental status or medical condition occurs during the authorization 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]<u>shall</u> review the independent assessment, document the consumer's changed social circumstances and make changes in the authorization or reauthorization as needed. A new practitioner order and 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]<u>shall</u> obtain a new independent assessment and practitioner order.

(3) When there is any change in the individual's service needs, [a]the 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.

(g) Timeframes for the assessment and authorization of services.

(1) The independent assessment and practitioner order processes shall be completed at least annually and in sufficient time such that social services districts and MMCOs may have an opportunity when needed to comply with all applicable federal and state timeframes for notice and determination of services, including but not limited to immediate needs.

(2) A social services district [must]shall make a determination and provide notice with reasonable promptness, not to exceed seven business days after receipt of both the independent assessment and practitioner order, or the independent 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 (p)[(l)] of this section.

(3) An MMCO [must]shall 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 [s]State statute or regulation.

(h) Consumer and designated representative responsibilities.

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

(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;

(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;

(iii) timely notifying the Statewide [f]Fiscal [i]Intermediary of any changes in the employment status of each consumer directed personal assistant;

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

(v) transmitting the consumer directed personal assistant's time sheets to the Statewide [f]Fiscal [i]Intermediary or its subcontractor(s) according to its procedures;

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

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

(viii) entering into a department approved memorandum of understanding with the Statewide [f]Fiscal [i]Intermediary], subcontractors, 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]shall make themselves available to ensure that the consumer responsibilities are carried out without delay. In addition, designated representatives for non self-directing consumers [must]shall 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. Where more than one fiscal intermediary is serving the same consumer at a given time, the consumer is required to select a single fiscal intermediary to work with in accordance with guidance provided by the department.

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

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

(2) receiving and promptly reviewing, the Statewide [f]Fiscal [i]Intermediary notification to the social services district or MMCO pursuant to subparagraph (j)(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;

(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;

(4) notifying consumers of the social services district's or MMCO's decision to authorize, reauthorize, increase, reduce, discontinue or deny services under the consumer directed personal assistance program. The Department of Health may require the use of forms it develops or approves when providing such notice;

(i) S[s]ocial services districts or MMCOs that deny, reduce or discontinue services based on medical necessity [must]shall identify and document in the notice and in the consumer's plan of care the factors that demonstrate such services are not medically necessary or are no longer medically necessary. Any such denial or reduction in services [must]shall 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.

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

(a) the consumer's health and safety cannot be reasonably assured with the provision of consumer directed personal assistance. The notice [must]shall

identify the reason or reasons that the consumer's health and safety cannot be reasonably assured with the provision of such assistance;

(b) the consumer's medical condition is not stable. The notice shall identify the consumer's medical condition that is not stable;

(c) the consumer is not self-directing and has no designated representative to assume those responsibilities;

(d) the consumer refused to cooperate in the required assessment;

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

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

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

(h) the consumer's need(s) [can]may 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.

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

(a) the consumer's medical or mental condition or economic or social circumstances have changed and the district determines that the consumer directed personal assistance provided under the last authorization or reauthorization are no longer appropriate or [can]may be provided in fewer hours. This includes, but is not limited to, cases in which: the consumer's health and safety [can]may no longer be reasonably assured with the provision of consumer directed personal assistance; the consumer's medical condition is no longer stable; the consumer is no longer self-directing and has no designated representative to assume those responsibilities; or voluntary informal supports that are acceptable to the client have become available to meet some or all of the client's needs. The notice [must]shall identify the specific change in the consumer's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the assistance should be reduced or discontinued as a result of the change;

(b) a mistake occurred in the previous authorization or reauthorization for consumer directed personal assistance. The notice [must]shall identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior assistance is not needed as a result of the mistake;

(c) the consumer refused to cooperate in the required reassessment;

(d) the consumer's needs may be met, in whole or part, by a technological development, which the notice [must]shall identify, that renders certain assistance unnecessary or less time-consuming, including the use of readily available telehealth services or assistive devices that are accessible to the individual and that [can]may 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]shall identify, which are responsible for the provision of needed assistance;

(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]may be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice [must]shall identify;

(h) 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.

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

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

(7) MMCOs and LDSS are responsible for notifying the department of any inappropriate fiscal intermediary services by the Statewide Fiscal Intermediary, its subcontractors or other unregistered entities.

(j) Statewide Fiscal I[i]ntermediary responsibilities.

(1) The Statewide Fiscal [i]Intermediary shall have the following responsibilities with respect to the consumer directed personal assistance program:

(i) processing each consumer directed personal assistant's wages and benefits including establishing the amount of each assistant's wages; processing all income tax and other required wage withholdings; and complying with worker's compensation, disability and unemployment insurance requirements;

(ii) ensuring that the health status of each consumer directed personal assistant is assessed prior to service delivery pursuant to 10 NYCRR section 766.11(c) and (d) or any successor regulation;

(iii) maintaining personnel records for each consumer directed personal assistant, including time sheets and other documentation needed for wages and benefit processing, and a copy of the medical documentation required pursuant to 10 NYCRR section 766.11(c) and (d) or any successor regulation;

(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;

(vi) complying with the department's regulations at section 504.3 of this Title [18 NYCRR section 504.3], or any successor regulation, that specify the responsibilities of providers enrolled in the medical assistance program;

(vii) entering into a contract with the Department of Health and entering into administrative agreements with MMCOs for the provision of Statewide [f]Fiscal [i]Intermediary services; [and]

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

(ix) ensuring that all Statewide Fiscal Intermediary subcontractors register with the department as required in subdivision (k) of this section;

(x) implementing mechanisms to gather regular feedback from consumers or their designated representatives regarding their experiences with the Statewide Fiscal Intermediary and any subcontractors the consumer works with;

(xi) complying with all Federal and New York State electronic visit verification laws, rules, and regulations; and

(xii) ensuring consumers or their designated representatives, as applicable, attest to the accuracy of the hours their consumer directed personal assistant(s) have

worked either through the electronic visit verification data system, by signing the personal assistant's time sheet, or by any other manner authorized by the department.

(2) The Statewide Fiscal I[i]ntermediary[ies] is [are] not responsible for fulfilling responsibilities of the consumer or, if applicable, the consumer's designated representative. Nothing in this section shall diminish, however, the Statewide F[f]iscal I[i]ntermediary's failure to exercise reasonable care in properly carrying out its responsibilities under the program.

(k) Registration and responsibilities of subcontractors.

(1) All subcontractors of the Statewide Fiscal Intermediary shall register with the department within 30 days of being selected as a subcontractor. Subcontractors shall not provide subcontracted services under the consumer directed personal assistance program unless registered with the department.

(2) Registrations shall be submitted in a format prescribed for all subcontractors.

(3) The registration form may include, but not be limited to the following (where applicable):

(i) the name of the entity with any d/b/a information, address, tax identification number and other applicable identifications, including MMIS or NPI number(s);

(ii) the work being performed by the subcontractor;

(iii) the term of the subcontract;

(iv) the region of the state covered by the subcontract, by county;

(v) an attestation that the subcontractor does not have, or has eliminated to the satisfaction of the department, any actual or perceived conflicts of interest;

(vi) an attestation that the subcontractor has a business associate agreement in place with the Statewide Fiscal Intermediary related to personal health information (PHI) and personal identifiable information (PII).

(4) The registration form shall be signed by a person legally authorized to bind the subcontractor.

(5) The department shall review the registration submission for completeness. The department shall notify subcontractors of any deficiencies in the registration form and allow 10 business days for submission of additional materials. Once complete, the department shall notify the subcontractor and Statewide Fiscal Intermediary of the subcontractor's ability to begin providing services. Subcontractors shall not provide services to the Statewide Fiscal Intermediary until such approval is granted by the department.

(6) Subcontractors shall not conduct any marketing or advertising activities related to the consumer directed personal assistance program without the express approval of the Statewide Fiscal Intermediary and the department.

(7) A subcontractor registration shall not be transferable to any other person or entity.

(8) A subcontractor registration may be immediately revoked upon notice from the Statewide Fiscal Intermediary that a subcontracting relationship no longer exists between the Statewide Fiscal Intermediary and the registered subcontractor entity.

(9) A subcontractor registration may be revoked, suspended or otherwise limited by the department upon 30 days' notice to the subcontractor and Statewide Fiscal Intermediary

when such subcontractor fails to comply with its obligations under this regulation or violates and other State or Federal rules, and regulations.

(l) [(k)] Payment for Administration.

(1) The department [will]shall pay the Statewide F[F]iscal I[I]ntermediary[ies] that [are] is enrolled as a Medicaid provider[s and have contracts with social services districts for the provision of consumer directed personal assistance services] at rates that the department establishes and that the Director of the Division of the Budget approves.

(2) No payment to the Statewide F[f]iscal I[i]ntermediary [will]shall be made for authorized services unless the Statewide F[f]iscal I[i]ntermediary['s] is supported by documentation of the time spent in provision of services for each consumer.

(3) [As authorized by paragraph (1) of this subdivision, and notwithstanding any portion of section 505.14 of this Part, t]The rates of reimbursement for Statewide F[f]iscal I[i]ntermediary administrative costs shall solely be made on a per consumer per month basis, as established through the Statewide Fiscal Intermediary contracting process. [with three tiers of payments. Each tier shall represent a range of authorization levels based on the number of direct care hours of consumer directed personal assistance services authorized for that consumer in a particular month and the different levels in fiscal intermediary administrative costs associated with each tier of authorization. The tiers of payment for fiscal intermediary administrative costs shall be as follows:

Tier	Direct Care Hours Authorized Per Month	Monthly Rate per Consumer
Tier 1	1 – 159	$145
Tier 2	160 – 479	$384
Tier 3	480+	$1,036

(4) Nothing in paragraph (3) of this subdivision shall impact wages or wage related requirements for consumer directed personal assistants nor impact the ability of Medicaid managed care organizations to reimburse fiscal intermediaries for fiscal intermediary administrative costs pursuant to their provider contracts.]

(m) Cost Reporting.

(1) Fiscal Intermediaries in operation in Calendar Year 2024 cost report submission.

(i) Fiscal Intermediaries that were in operation for all or a portion of Calendar Year 2024 shall complete and submit the 2024 Home Care Cost Report per requirements set forth under section 505.14 of this Part and section 3612(8) of the Public Health Law.

(2) SFI with cost experience submission of required cost reports.

(i) An SFI with cost experience is defined as an SFI that can report its actual operating costs for the full rate year specified in the required cost report.

(ii) The SFI shall complete and submit to the department an annual cost report in a manner and format determined by the department. The SFI shall complete the cost report by reporting the SFI's actual costs of providing home care services for the full rate year specified in the cost report. The SFI Home Care Cost Report (HCCR) shall include data for all subcontracted entities.

(a) The department shall furnish the SFI with the cost report form. The cost report form shall specify the date by which the SFI shall submit the completed report to the department; however, the SFI shall have at least 90 calendar days to submit the report after its receipt.

(b) The department may grant the SFI an additional 30 calendar days to submit the cost report when the SFI, prior to the date the report is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the SFI cannot submit the report by the date the report is due for reasons beyond the SFI's control.

(iii) SFI submission of inaccurate or incomplete cost report.

(a) If the department determines that the cost report submitted by the SFI is inaccurate or incomplete, the department shall notify the SFI in writing. The notice shall advise the SFI of the corrected or additional information that the SFI shall submit.

(b) The SFI shall submit the corrected or additional information within 30 calendar days from the date the SFI receives the department's notice. The department may grant the SFI an additional 30 calendar days to submit the corrected or additional information when the SFI, prior to the date that the corrected or additional information is due, submits a written request to the department for an extension and establishes to the department's satisfaction that the SFI cannot submit the corrected or additional information by the date the information is due for reasons beyond the SFI's control.

(iv) Lack of certification by the owner or officer of the SFI with authority to do so, as required pursuant to paragraph (4) of this subdivision, shall render a cost report incomplete.

(3) The SFI shall complete the cost report in accordance with generally accepted accounting principles applicable to the SFI, unless the department specifies otherwise on the cost report form.

(4) The cost report shall be certified by the owner or an officer of the SFI with authority to do so. The cost report form shall include a certification form specifying who is certifying the report.

(5) Cost Reporting Timeline.

(i) The rates for a calendar year (CY) shall be determined by audited cost report data gathered from two calendar years prior. For example, CY 2025 rates shall be determined with CY 2023 cost report data, and CY 2027 rates shall be determined with CY 2025 cost report data.

(ii) If the cost report data is incomplete, in the sole discretion of the department, the department may use either the most recently audited cost report data or a hybrid approach.

(n) Direct Care Payment Determination for SFI with Cost Experience.

(1) The department shall determine the SFI's payment rate based on the cost report submitted by the SFI.

(i) The SFI shall report its personnel and non-personnel operating costs as specified in the cost report.

(ii) The department shall consider only the SFI's operating costs that are allowable, as defined in paragraph (2) of this subdivision and as adjusted by the SFI in accordance with paragraph (3) of this subdivision.

(iii) The department shall adjust the SFI's allowable costs by any statutory requirements.

(iv) The department shall determine whether the SFI's allowable costs exceed the ceilings that the department has established for such costs in accordance with paragraph (4) of this subdivision and, if so, consider only such of the SFI's allowable costs that do not exceed such ceilings.

(2) Allowable cost determinations.

(i) Allowable costs are defined as an SFI's documented costs that are necessary for the SFI's operation, are directly or indirectly related to recipients' care, and are not expressly declared to be nonallowable by Federal or State law or regulations.

(ii) Allowable costs shall be determined in accordance with reimbursement principles developed for determining payments under title XVIII of the Federal Social Security Act (Medicare). These reimbursement principles are set forth in the Medicare Provider Reimbursement Manual, Part l, entitled "HCFA Pub. 15-1 Thru T. 365," which is published by the Health Care Financing Administration of the United States Department of Health and Human Services (HHS). The department has incorporated by reference Chapters 1 - 14, 21 - 23 and 26 of such manual, as revised effective January 1, 1992.

(iii) Allowable costs include the following:

(a) a monetary value assigned to services provided by religious orders and for services rendered by an owner or operator of the SFI;

(b) the portion of the dues the SFI pays to any professional association that has been demonstrated, to the department's satisfaction, to be allocable to expenditures other than for public relations, advertising, or political contributions;

(c) costs allocated to the SFI from a related organization when the costs are reasonably related to the efficient provision of personal care services and the bases of allocation of such costs are consistent with regulations applicable to the cost reporting of the related organization. An organization is related to the SFI when the SFI, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. To a significant extent means that:

(1) the SFI or an officer, director or partner of such SFI has an ownership interest, as defined in section 502.2(i) of this Title, in such organization equal to five percent or more; has an indirect ownership interest, as defined in section 502.2(g) of this Title, in such organization equal to five percent or more; has a combination of an ownership interest and an indirect ownership interest in such organization equal to five percent or more; has an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by such organization if that interest equals at

least five percent of the value of the organization's property or assets; or is an officer, director or partner of such organization or otherwise has the power, directly or indirectly, significantly to influence or direct the actions or policies of such organization; or (2) the organization furnishing the services, facilities or supplies to the SFI, or an officer, director or partner of such organization has an ownership interest, as defined in section 502.2(i) of this Title, in the SFI equal to five percent or more; has an indirect ownership interest, as defined in section 502.2(g) of this Title in the SFI equal to five percent or more; has a combination of an ownership interest and an indirect ownership interest in the SFI equal to five percent or more; has an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by the SFI if that interest equals at least five percent of the value of the SFI's property or assets; or is an officer, director or partner of the SFI or otherwise has the power, directly or indirectly, significantly to influence or direct the actions or policies of the SFI;

(d) reasonable compensation for owners or operators, their employees and their relatives for services actually performed and required to be performed. A relative is defined in accordance with section 902.5 of the Medicare Provider Reimbursement Manual as follows: the spouse; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-

law, daughter-in-law, brother-in-law and sister-in-law; and grandparent and grandchild of an owner or operator. The amount of allowable costs for reasonable compensation is equal to the amount of compensation normally required to be paid for the same services provided by a nonrelated employee, as determined by the department. Allowable costs do not include compensation for any services which owners or operators and their employees and relatives are not authorized to perform under State law or regulation;

(e)costs of advertising, public relations or promotion when such costs are specifically related to the provision of personal care services and are not for the purpose of attracting patients; and

(f) such other costs as are determined to be allowable in accordance with reimbursement principles specified in the Medicare Provider Reimbursement Manual.

(3) Allowable costs do not include the following:

(i) amounts in excess of reasonable or maximum costs authorized under title XVIII of the Federal Social Security Act or in excess of customary charges to the general public. This provision does not apply to services furnished by the SFI free of charge or at a nominal fee;

(ii) expenses or portions of expenses reported by the SFI that the department determines are not reasonably related to the efficient provision of personal care services because of either the nature or the amount of the particular item;

(iii) costs that are not properly related to patient care and that principally afford diversion, entertainment, or amusement to owners, operators, their employees or relatives;

(iv) any interest paid by the SFI that is related to rate determinations or penalties imposed by governmental agencies or courts, except tax penalties that are imposed through no fault of the SFI, and the costs of insurance policies that the SFI obtains solely to insure against the imposition of such penalties;

(a) costs of contributions or other payments to political parties, political candidates, or political organizations;

(b) any element of cost as determined by the department to have been created by the sale of the SFI;

(c) the amount of the personal care services provider assessment required by section 367-i of the Social Services Law or section 3614-b of the Public Health Law; or

(d) such other costs as are determined to be unallowable in accordance with reimbursement principles specified in the Medicare Provider Reimbursement Manual.

(4) Ceilings on payment for allowable costs.

(i) The ceilings on payments for SFI allowable costs shall be determined by section 505.14(h)(7)(ii)(6) of this Part.

(5) Recoveries of expenses.

(i) The SFI shall reduce its reported operating costs by the costs of services or activities that are not properly chargeable to patient care. When the

department determines that it is not practical to establish the costs of such services or activities, the SFI shall reduce its reported operating costs by the income received from such services or activities. Examples of such income include, but are not limited to, the following:

(a) any amount the SFI receives as a discount on purchases;

(b) any amount the SFI receives from tuition payments or from other payments made to the SFI for educational services or other services not directly related to personal care services;

(c) any amount the SFI receives from a lease of office or other space to concessionaires that provide services not related to personal care services; and

(d) any amount the SFI charges for the use of telephone, telefax or telegraph services.

(o) Estimated Cost Submission and Payment Determination for SFI Without Cost Experience.

(1) An SFI without cost experience is defined as an SFI that cannot report its actual operating costs for the full rate year specified in the required cost report.

(2) Estimated Cost Submission.

(i) The SFI shall submit estimated costs, in a manner and timeframe determined by the department.

(a) The estimated cost submission shall include estimated costs for provision of services on a regional basis.

(ii) The SFI shall follow any and all requirements for allowable and non-allowable costs, as defined in subdivision (n) of this section.

(iii) The estimated costs submission shall be certified by the owner or administrator of the SFI. The estimated costs submission shall include a certification form specifying who is certifying the report.

(3) Direct Care Payment Determination.

(i)The SFI shall submit estimated regional costs for the provision of services.

(ii) The estimates shall be used in accordance with the methodology established for an SFI with cost experience, and wherein needed as determined by the department, a hybrid of estimated and regional costs may be implemented.

(4) Once a full year of costs are available, the rates shall be calculated prospectively in accordance with subdivision (n) of this section, with rates calculated from two-year old costs. For example, CY 2027 rates shall be determined with CY 2025 cost report data.

(p) [l] 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 sections 505.14(b_(6) and (7) 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.

[(m) Prior to October 1, 2022, and notwithstanding provisions of this section to the contrary, where the Department of Health has not contracted with or designated an entity or entities to provide independent assessment and practitioner services, or where there is limited access to timely assessments and medical exams in accordance with this subdivision, as determined by and the Department of Health, then, in accordance with written direction from the Department of

Health, assessments may be performed by the social services district or MMCO in accordance with the provisions of this section in effect as of January 1, 2021. The Department may limit such directive to a particular geographic region or regions based on the need for timely assessment and medical exams and may require that social service districts and MMCOs first attempt assessment and authorization pursuant to the provisions of this section currently in effect. Notwithstanding the forgoing, upon becoming effective, the provisions of paragraph (4) of subdivision (i) shall remain in effect, and may not be pended pursuant to this paragraph.]

REGULATORY IMPACT STATEMENT

Statutory Authority:

Social Services Law ("SSL") § 363-a and Public Health Law ("PHL") §§ 201(1)(v) and 206(1)(f) 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 and enforce the standards of 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 the consumer directed personal assistance program (CDPAP). Pursuant to NYS Social Services Law Section 365-f, the Department must contract with a Statewide Fiscal Intermediary that delivers the best value for providing fiscal intermediary services to participants of CDPAP. 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 CDPAP.

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-f the Medicaid program authorizes CDPAP as a State plan benefit for eligible consumers. The State Fiscal Year 2024-25 Enacted Budget (Chapter 57 of the Laws of 2024, Part HH) authorized the Commissioner to contract with a single statewide fiscal

intermediary to provide fiscal intermediary services to CDPAP consumers. The Commissioner is also authorized to promulgate regulations necessary to carry out the objectives of the program including minimum safety health and immunization criteria, training requirements, the registration process and other regulations necessary to ensure adequate access to services. These regulations, as amended, establish a Statewide Fiscal Intermediary, contracted with the Department, and describe the role and responsibilities of the Statewide Fiscal Intermediary regarding CDPAP. These provisions further establish reporting and compliance requirements, payment determination and processes, and subcontracting requirements for the Statewide Fiscal Intermediary.

Needs and Benefits:

The Department has promulgated regulations governing CDPAP at 18 NYCRR § 505.28. Amendments to these regulations are essential to implementing requirements of the State Fiscal Year 2024-25 Enacted Budget (Chapter 57 of the Laws of 2024, Part HH), which established a Statewide Fiscal Intermediary for CDPAP and described the role and responsibilities of the Statewide Fiscal Intermediary. These amendments will help ensure Medicaid beneficiaries continue to receive services that are required to appropriately meet their needs and are paid for and administered per requirements put forth by the Department.

By centralizing the administrative functions, the changes will bring efficiencies and consistency to the administration and payment of CDPAP. In particular, the direct contracting with the Department will enhance Department monitoring and oversight and enable monitoring and reporting of State Fiscal Intermediary compliance with Federal and State regulations and standards related to program objectives.

The Department is also proposing to clarify and reinforce subcontracting requirements that will ensure cultural and linguistic competencies and will allow for greater oversight and monitoring of entities that provide services as subcontractors to the Statewide Fiscal Intermediary to ensure no conflicts of interest exist and better protect the interests of CDPAP participants.

The Department is also proposing to clarify and reinforce cost reporting requirements to better monitor costs associated with CDPAP and determine appropriate service rates that reimburse for allowable costs.

COSTS

Costs to Private Regulated Parties:

These regulatory amendments governing CDPAP at 18 NYCRR § 505.28 do not impose any additional costs to regulated parties. There are no costs imposed on the Statewide Fiscal Intermediary or any of its subcontractors. There are no fees associated with required registrations by subcontractors. In fact, in centralizing the administrative fiscal intermediary functions, the costs to private regulated parties are reduced. Furthermore, local departments of social services (LDSS) and MMCO administrative burdens are reduced by only needing to contract with a single entity.

Costs to Local Government:

The proposed regulations require that social services districts engage with a single entity regarding CDPAP authorizations and consumer inquiries and the LDSS no longer need to

maintain a contract(s) with fiscal intermediaries. 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 associated with establishing a mechanism for the review of registrations required by Social Services Law § 365-f and then implementation of a Statewide Fiscal Intermediary (SFI). However, those costs will be managed within existing resources. The overall savings associated with the implementation of an SFI in CDPAP will grossly offset any cost associated with implementation of the new registration system.

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 and reporting requirements, but regulated parties are familiar with and already use such forms. There will be a new form associated with the registration of subcontractors to the SFI.

Duplication:

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

Alternatives:

Part HH of Chapter 57 of the Laws of 2024 amended Social Services Law § 365-f to require the State to contract with a Statewide Fiscal Intermediary (SFI) and create a registration process for subcontractors to the SFI. These amended regulations make the changes necessary to implement that law and therefore adoption of these amended regulations is necessary.

Federal Standards:

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

Compliance Schedule:

The regulations will become effective on the 60th day following publication of a Notice of Adoption in the New York State Register.

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STATEMENT IN LIEU OF REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment is necessary to implement amendments to Social Services Law § 365-f that create a Statewide Fiscal Intermediary (SFI) and require certain entities that subcontract with the SFI to register with the Department. As such, the amendments do not impose an adverse economic impact on small businesses or local governments. This rule would not impose any new reporting, record keeping or other compliance requirements on local governments. This rule will have a positive impact on local governments because local governments will no longer need to contract with and monitor performance of fiscal intermediaries since there will now be only one Statewide Fiscal Intermediary and the contract will be held and managed by the State. The only small businesses that will be impacted by the registration requirement in the proposed regulation are less than approximately 50 small businesses statewide that will be compensated as subcontractors to the Statewide Fiscal Intermediary. This registration process will be streamlined to ensure Medicaid consumers can access their services quickly. There is no fee for registration. The process will be similar to the requirements imposed under the vendor responsibility sections of State Finance Law section 163, which have been utilized by all agencies in contracts over $50,000 to assure State funds are not paid to non-responsible entities.

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. The proposed amendment is necessary to implement amendments to Social Services Law § 365-f that create a Statewide Fiscal Intermediary (SFI) and require certain entities that subcontract with the SFI to register with the Department. The only small businesses that will be impacted by the registration requirement in the proposed regulation are less than approximately 50 small businesses statewide that will be compensated as subcontractors to the Statewide Fiscal Intermediary. The vast majority of these small businesses are private entities and are not operating exclusively in rural areas; rather they are operating across multiple counties throughout the state. There are two private entities operating exclusively in rural areas. Even for entities operating in rural areas, the registration process required will not impose any significant reporting or compliance requirement. This registration process will be streamlined to ensure Medicaid consumers can access their services quickly. There is no fee for registration. The process will be similar to the requirements imposed under the vendor responsibility sections of State Finance Law section 163, which have been utilized by all agencies in contracts over $50,000 to assure State funds are not paid to non-responsible entities. As such, the amendments do not impose an adverse impact or significant reporting, record keeping or other compliance requirements on public or private entities in rural areas.

JOB IMPACT STATEMENT

The State Fiscal Year 2024-25 Enacted Budget (Chapter 57 of the Laws of 2024, Part HH), requires that the Department contract with a Statewide Fiscal Intermediary to provide services to participants of consumer directed personal assistance program (CDPAP). The Statewide Fiscal Intermediary will subcontract with facilitators in every region of the State to provide services to participants of CDPAP. The Statewide Fiscal Intermediary is also opening a call center and multiple offices to serve consumers and their personal assistants; the call center and offices will create additional jobs. As such, the Department does not expect there to be a significant negative impact, regionally or overall, on jobs in the State.