NEW YORK LEGAL ASSISTANCE GROUP

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Re: Comments on Notice of Proposed Rulemaking -
Immediate Needs for PCS 18 NYCRR §§ 360-3.7 and 505.14.
I.D. No. HLT-28-14-00008-P

Dear Ms. Ceroalo:

Thank you for the opportunity to comment on the proposed regulations regarding Immediate Needs for Personal Care Services ["PCS"] which would amend 18 NYCRR §§ 360-3.7 and 505.14. The proposed regulation was drafted in direct response to the Order of Justice Joan Madden, Supreme Court, New York County, in *Konstantinov v. Daines*, 2010 WL 7746303 (N.Y. Sup.) directing the State to establish a procedure for Medicaid applicants and recipients to obtain immediate temporary PCS, and to provide them with notice of the availability of these services.

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These comments are in two parts. First, we address the need to consider a different model for implementing temporary PCS, given the shift from the local districts to Managed Long Term Care (MLTC) and mainstream managed care for the authorization and delivery of all PCS. This new model has created new delays in initiating services, beginning after Medicaid is approved, which exacerbate the delays addressed by *Konstantinov* and these proposed regulations. Second, we raise some specific concerns about the regulations as proposed.

As a preliminary matter, the statutory authority of the regulations should also state NY Social Services Law § 133, the N. Y. Constitution Article XVII. § 1 Aid to the Needy clause, and the Due Process clauses of the state and federal constitutions.

PART I. An Alternate Model for Authorization and Delivery of Temporary PCS Using the Conflict-Free Assessor, MLTC plans, CDPAP agencies and CHHAs Would Allow for a Seamless Transition to the MLTC Delivery System and Reduce Burden on LDSS

The shift to mandatory MLTC has created a new system for assessing the need for and providing PCS, in which the local district has no role after determining Medicaid eligibility. Therefore, we question the resurrection of the former assessment process administered by the local districts as neither practical nor cost-effective for either the local district or for consumers. The Department is about to launch a new Long Term Care Evaluation and Enrollment Center ("LTCEEC") to conduct conflict-free initial eligibility assessment for MLTC plans, as required by CMS. We suggest an alternative model using the new LTCEEC in conjunction with MLTC plans, certified home health agencies (CHHA), and the Consumer-Directed Personal Care Program (CDPAP) fiscal intermediaries. Our proposed model can address not only the need for temporary services pending the Medicaid determination, but also the new gaps in services *after* the Medicaid determination. Because enrollment is limited to the first of the month, and must be finalized two weeks in advance of that, there are new systemic delays in initiation of services for people already determined eligible for Medicaid.

The Regulatory Impact Statement acknowledges the reality that local districts "may no longer have adequate staff to assess Medicaid applicants and recipients for 'immediate temporary PCS' nor sufficient contracts with personal care vendors to provide the services" because of the transition to mandatory MLTC and the addition of personal care to the benefit package for mainstream managed care plans. NYS Register, July 16, 2014 at p. 23. Indeed, the number of people receiving "home attendant" (personal care) from the NYC Human Resources Administration (HRA) has plummeted from 40,182 in May 2009 to only 3,409 people in June 2014.[1] The function of HRA and the other LDSS has drastically changed since the first *Konstantinov* order was issued in July 2010. In September 2012, enrollment in Managed Long Term Care (MLTC) plans became mandatory for adult dual eligibles in New York City who need community-based long-term care services. Since then, the role of the Local Department of Social Services (LDSS) in mandatory MLTC counties is to determine Medicaid eligibility and authorize Medicaid within 45 days (up to 90 days if a disability determination is required). The LDSS no longer has any role in determining eligibility for or authorizing PCS for the vast majority of Medicaid recipients. Once the LDSS approves an application for Medicaid, the individual enters an entirely new system for accessing PCS This new system creates a new second gap in services; even after Medicaid is approved, it is another two or three months, and often longer, until the individual is enrolled in an MLTC plan and services are commenced. In the fall of 2014, another step will be added which may cause even further delays, with the new LTCEECs that will determine whether the individual qualifies for MLTC.

Two Gaps in Services – The *Konstantinov* decision and the law it implements addresses one gap in services -- the need for home care services while the Medicaid application is pending. This is indeed a critical need. Now, however, there is a second gap in services – the period after Medicaid eligibility is determined until enrollment in an MLTC plan is effective and the plan commences services. Developing a system for temporary PCS is essential not only to satisfy the *Konstantinov* order but also to close the second gap that has developed as a result of the mandatory MLTC system. At the time of the first

[1] See HRA Facts, June 2014, available at http://www.nyc.gov/html/hra/downloads/pdf/facts/hra_facts/hrafacts_2014/hra_facts_2014_06.pdf. The cited figure excludes people receiving Housekeeping (Level I personal care services), who continue to receive services through HRA and other local DSS offices.

Konstantinov order was issued in July 2010, the "Medicaid-pending" gap in services ended when Medicaid was approved. The HRA CASA offices in NYC, like other districts, simultaneously processed the Medicaid application while conducting the battery of personal care assessments pursuant to 18 NYCRR 505.14. Upon Medicaid approval, HRA assigned the case to a home care agency under contract to commence services. These services could begin within a week or even less.

Now, since the "front door closed" to apply to LDSS for personal care in September 2012 (in NYC, later in other districts), the vast majority of applicants for personal care must go through two lengthy processes, one to apply to the LDSS for Medicaid, and the second to enroll in an MLTC plan once Medicaid is approved. The LDSS still processes PCS applications for the few people exempt from MLTC or mainstream managed care, but the staffing and infrastructure needed to expand it as proposed would be daunting. The example below shows that the delays after Medicaid is approved can be even longer than the delay while the Medicaid application is pending. In October 2014, this process will be lengthened when the LTCEECs commence operations. While consumers welcome conflict-free assessment, it will inevitably cause delays which can and must be addressed.

Typical Timeline for Applying for Medicaid and Personal Care

<table>
<tr><th>Date</th><th>Old Pre-MLTC Model</th><th>MLTC Model</th><th>GAP in CARE</th></tr>
<tr><td>January 1st</td><td>File Medicaid application with DSS</td><td>File Medicaid application with DSS</td><td>GAP 1: MEDICAID PENDING GAP – 45 days+</td></tr>
<tr><td>Feb. 15th</td><td>Medicaid approved (earliest possible – there are often delays)</td><td>Medicaid approved (earliest possible – there are often delays)</td><td rowspan="9">GAP 2: GAP after Medicaid approved and pending enrollment in MLTC plan – in this example, gap is 2.5+ months, which is typical. Can be longer, in rare cases can be shorter, rarely less than 45 days. Also unknown what additional delay will be caused by LTCEEC.</td></tr>
<tr><td>Feb. 16th</td><td rowspan="8">Home Care commences.

NO GAP TWO.</td><td>Applicant referred to LTCEEC to assess eligibility for MLTC.</td></tr>
<tr><td>March 1st</td><td>While time limit for LTCEEC assessment not yet announced, unlikely to be less than two weeks.</td></tr>
<tr><td>March 1st - March 20th</td><td>Individual contacts MLTC Plans to send nurse to assess needs, plans conduct assessments, negotiate with consumer for enrollment and plan of care</td></tr>
<tr><td>March 20th</td><td>Enrollment agreement signed with MLTC plan.</td></tr>
<tr><td>March 20th</td><td>Miss deadline of the 19th to submit enrollment for April 1st, so enrollment effective May 1st. OR errors in "eligibility codes" (spend-down, etc.) often delay enrollment</td></tr>
<tr><td>May 1st</td><td>MLTC ENROLLMENT EFFECTIVE</td></tr>
<tr><td>May 7th</td><td>Services commence after plan does assessment, if not already done pre-enrollment, and assigns case to contractor home care agency</td><td></td></tr>
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The proposed regulations would revive the old pre-MLTC assessment system, with the LDSS required to conduct the assessments under 18 NYCRR 505.14 – requiring a huge increase in staffing and infrastructure for the sole purpose of assessing need for and authorizing temporary services that will last only until the MLTC enrollment is effective.

In addition to being burdensome, the proposed system threatens to disrupt continuity of care. The temporary services would presumably be provided by home care agencies that the LDSS will contract with. Once the MLTC plan takes over, the consumer will likely lose the home care aide provided through the temporary agency, and be transferred to a different home care agency under contract with the MLTC plan. This disruption in care should be avoided if possible.

We propose that instead of recreating the old assessment and delivery system solely for temporary PCS, which is burdensome for the local districts and will lead to disruptions in care for consumers, that instead the system developed for MLTC assessment and delivery be used for temporary PCS. After an expedited Medicaid presumptive eligibility determination by the LDSS and a simultaneous home care eligibility determination by the LTCEEC, the consumer could choose either early enrollment in an MLTC while the Medicaid application is pending, or referral to a personal care or CDPAP LTDSS contractor or a CHHA for temporary home care services. A possible scenario would be as follows:

1. **Medicaid Determination**. The LDSS makes a determination of presumptive Medicaid eligibility. See section II(e) of these comments below at page 6, which apply here, regarding attestation as to resources and income, using spousal impoverishment rules, etc .
2. **Simultaneous Expedited LTC Assessment and Authorization.** Determination of eligibility for and authorization for long-term care services by three alternate processes:
    a. In NYC and other counties with an operating LTCEEC, an application for Medicaid by the LDSS, with a request for temporary PCS, would trigger a simultaneous referral by the LDSS to the LTCEEC, including transmission of a physician's order or request for temporary PCS. The LDSS referral to the LTCEEC would occur behind the scenes, not requiring a separate application by the consumer. The LTCEEC would determine eligibility for and immediate need for long-term care on an expedited basis, under a specified time limit. The nurse conducting the assessment would also authorize a plan of care including PCS and/or CDPAP.
    b. In counties with mandatory MLTC but no LTCEEC, a new presumptive eligibility code would be created that would allow MLTC plans to assess and enroll a Medicaid applicant.
    c. In counties where MLTC is not yet mandatory, or at option of the local district in mandatory counties, the local district would determine both Medicaid and home care eligibility and authorize temporary PCS pursuant to these regulations. (See comments below).

NYS HEALTH EXCHANGE & MAINSTEAM MANAGED CARE – Applicants on the NYS Health Exchange as well as those newly determined eligible for Medicaid on the Exchange must be notified of the availability of temporary PCS and referred for LTC assessment and authorization through one or more of the paths described above. Most of these applicants will be required to enroll in mainstream Medicaid managed care plans which will be responsible for authorizing PCS and CDPAP. Delays they confront may be less lengthy than for MLTC, because of generally quick Exchange Medicaid eligibility determinations, and lack of eligibility coding problems caused by spend-down, etc. However, there are still delays -- enrollment in mainstream plans can still occur only on the first of the month, and then the member must learn how to initiate a request for prior authorization of

PCS, which the plan has 14 days to process. In our advocacy, we have observed long delays in these authorizations.

3. **Commencement of Immediate PCS -- Consumer Options for Delivery.** Upon a determination of long-term care eligibility by the LTCEEC, the MLTC plan, or the LDSS, an applicant or person directing her care will be counseled on options for immediate need PCS. These options would include:

    a. **MLTC plan enrollment – pro-rate capitation to allow enrollment other than 1st of the month.** The MLTC plan of the applicant's choice may enroll the applicant immediately, without regard to the 1st of the month. Payment of the capitation rate would be pro-rated based on the date of enrollment. MLTC plan commences personal care and/or CDPAP services as authorized by the LTCEEC, if any, or as authorized by the MLTC plan.

    b. **Temporary Fee-for-service PCS or CDPAP services** as authorized by the LTCEEC or LDSS assessment, which would be provided by a home care or CDPAP provider under contract with the LDSS.

    c. **CHHA –** While CHHAs may already provide services while Medicaid is pending, the 2011 changes in reimbursement to a prospective payment system ("PPS") led to a drastic decline in CHHA willingness to provide Medicaid-pending services. PPS was designed to discourage perceived abuse by some CHHAs of the fee-for-service [FFS] system, in part by retaining short-term cases on a long-term basis that should have been converted to long-term personal care or CDPAP, at lower cost. Now that long-term CHHA recipients are mandatorily transitioned to MLTC, the opportunity for abuse of FFS payment is greatly reduced. Hence, CHHA's should be able to bill on a FFS for basis for Medicaid-pending services. Use of the LTCEEC to authorize a plan of care would further reduce the opportunity for abuse of FFS payment.

    Temporary PCS, CDPAP or CHHA services would continue until either an MLTC or mainstream managed care plan actually commences services.

4. **Medicaid approval and transition to MLTC or mainstream managed care.** Once Medicaid is approved, and the eligibility billing code is changed from presumptive eligibility to full eligibility, the transition to MLTC or mainstream managed care depends on how the temporary home care services were delivered.

    a. **MLTC Plan early enrollment** – If early enrollment in MLTC is possible while Medicaid is pending, the transition is seamless. There is total continuity of care, with no disruption in services, since the home care provider for both temporary and long-term services is the MLTC's subcontractor. The MLTC plan bills for and receives full payment for presumptive and full eligibility period from State.

    b. **Fee-for-service care by a personal care or CDPAP contractor or a CHHA** – The temporary services by any of these providers would continue while Maximus initiates the auto-assignment process by sending consumer the 60-day MLTC "choice" letter (or 30-day letter for mainstream managed care). The services would continue until the MLTC or mainstream MCO enrollment is effective and the MLTC or mainstream managed care plan commences services.

        i. **Transition Period and Continuity of Care** -Once the consumer is enrolled in an MLTC or mainstream plan, the **90-day Transition Period** should apply, which entitles the consumer to continuation of the plan of care. Also, MLTC or mainstream plan should be required to ensure **continuity of care** by contracting with the home care,

CHHA, or CDPAP provider that provided temporary services, for a period of six months.

5. **If Medicaid is denied by the LDSS**, then the MLTC, personal care, CDPAP, or CHHA services terminate, subject to appeal rights of the consumer with advance written notice and Aid Continuing. If the denial is final, any reconciliation of payment for the temporary services between the LDSS, State and providers can be handled on the back end.

The proposed system expedites the assessment and authorization process that the new LTCEEC and MLTC plans must conduct anyway, avoiding the necessity of superimposing an entirely separate duplicative assessment bureaucracy and network of home care contractors. Where the consumer chooses to enroll in an MLTC plan for the temporary PCS or CDPAP, it is the MLTC plan arranging for these services, before and after Medicaid is approved, allowing for a seamless transition for the consumer. They continue receiving the same services, avoiding disruption in home care aides and, most importantly, closing the long gap that exists now during the long process of enrolling in an MLTC plan. The system ensures that Medicaid is not paying for services for people found ineligible for Medicaid, and reduces the administrative burden for the local districts.

PART II Alternately, if the Proposed Regulations Using an LDSS-Based Presumptive Eligibility System are Adopted, Changes are Needed.

a. If the Department of Health decides to resurrect the previous system in order to provide immediate PCS, consumer protections to **ensure a seamless transition to MLTC with continuity of care** must be implemented. For example, the 90-day transition period must apply when a person receiving temporary PCS transitions to MLTC, and the continuity of care requirements must be invoked requiring the MLTC to contract with the same home care or CDPAP agency that provided the temporary services for a minimum period of six months.

b. **CDPAP** – CDPAP services should be available on a temporary basis based on presumptive eligibility, using a fiscal intermediary that contracts with the LDSS.

c. Consistent with the *Konstantinov* court order, **written notice of the availability of immediate need personal care** must be provided to all applicants for Medicaid – not only those filing Medicaid applications at HRA's dedicated Home Care Services Program or similar units in other counties, but those who file applications through other community Medicaid offices or through the NYS Health Exchange. There must be a mechanism to refer applicants through the Exchange immediately to the appropriate LDSS entity or LTCEEC for evaluation for immediate needs services. If the Exchange lacks a mechanism to make a determination of presumptive Medicaid eligibility, and refers this determination to the LDSS, the LDSS must use MAGI-like budgeting, with no resource test to people in the MAGI category.

d. **(f)(1) Definition of immediate need** - §360-3.7(f)(1)(i) proposes to limit eligibility to those who have an "immediate need for PCS," defined as "… a need for assistance with one or more personal care functions, as set forth in clause (a)(6)(ii)(a) of Section 505.14 of this title, that, unless met within five business days, is reasonably expected to seriously jeopardize the individual's health and safety such that the individual would require temporary placement in a hospital or nursing facility to protect the individual's health and safety.

We have two objections to this definition:

a. First, a reasonable expectation that absence of personal care assistance would "jeopardize the individual's health and safety" is sufficient, without having to prove that placement in a hospital or nursing facility would be imminent. Also, the word "serious" as in "serious jeopardy" to health and safety is redundant and confusing. By definition, PCS prevent falls, dehydration, and other emergencies, and ensure stability of medical condition by providing assistance with medications and meals. The risks inherent in the absence of this assistance is implicitly "serious" jeopardy. Individuals should not have to be on the brink of a medical emergency to be determined in immediate need of PCS.

b. Whether the individual needs services within 5 business days is irrelevant and should not be a criterion. The determinative factor is whether the individual would be harmed if services do not commence until Medicaid is approved (a 45-day period) and then until an MLTC plan commences services, which can be many months more, as discussed above.

e. (f)(2) PRESUMPTIVE ELIGIBILITY CRITERIA -§360-3.7(f)(2)

i. (2)(i)(a) – Requirement that individual has applied to the district for Medicaid – Should be revised to include those who applied on the NYS Health Exchange, through fiscal intermediaries, or any other way, with a referral mechanism for people applying on the Exchange or otherwise outside of the local district.

ii. (2)(i)(b) – Presumptive financial eligibility

i. Attestation of Resources and Income -- Because delays in receipt of immediate temporary PCS would endanger an applicant's health or safety, applicants subject to a Medicaid resource test (non-MAGI) should be allowed to attest to their resources upon application for Medicaid as is permitted for individuals applying for community-only coverage. A final eligibility determination would require resource documentation. Attestation of Social Security income is already permitted for applications, and this should be extended to other forms of income.

ii. Excess-Income/ Spend-down -- Clarify that individuals with Excess Income can be financially eligible for presumptive eligibility**.** If the applicant has excess income (spend-down), after allocation of spousal impoverishment rules for married applicants, presumptive eligibility should be granted. If medical bills are not presented that meet the spend-down for the current month, then the LDSS should bill the individual for the spend-down and not require pay-in of the spend-down.

iii. Spousal Impoverishment -- In determining whether an applicant reasonably appears to be financially eligible for Medicaid, the budgeting methodology should be the same as what will be used to determine full Medicaid eligibility, including use of spousal impoverishment rules, and MAGI-like rules.

iii. (2)(i)(c) and (d) --REQUEST FOR TEMPORARY PCS -- The requirement that individual has submitted BOTH a written request for immediate need PCS AND a physician's order documenting an immediate need is burdensome and redundant. Requiring both documents is burdensome. This section should be consistent with section 505.14(b)(5)(iv)

and just require immediate need to be documented in the physician's order. Also, the physician's order form should be designed to specifically prompt the physician to indicate whether there is an immediate need and to explain it. Forms must be developed and provided to every applicant and be available online

iv. (2)(i)(e) - (g) – Functional Criteria for Authorizing Temporary PCS (stable medical condition and medication)

i. (i)(e) – The regulatory definition of a stable medical condition has been interpreted to mean that there are no skilled needs. This should not apply if applicant seeks CDPAP services, which must be an option. Also, if temporary PCS is delivered through an MLTC plan as we propose in Part I above, the plan can authorize private duty nursing, CDPAP or CHHA services, alone or in conjunction with PCS, for someone with skilled needs or an unstable condition.

ii. (i)(g) Remove or modify self-administration of medication requirement - The requirement that only individuals who can self-administer needed medications should be removed as it is not a prerequisite for the receipt of PCS under 18 NYCRR § 505.14. A PCS aide may not be permitted to "administer" a medication, meaning put a pill in the consumer's mouth or eyedrops in her eyes, but a PCS may assist with self-administering medications, including "by prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration." 18 NYCRR § 505.14(a)(6)(ii)(a)(9). The regulation should cross-reference this section of 505.14 for the definition of "self-administration."

Also, the requirement fails to account for individuals who obtain immediate temporary PCS through CDPAP whose aides are permitted to administer medication.

v. (2)(h) -- Determination that immediate need cannot be met "in whole or part" by alternative means:

i. The words, "in part" should be removed from proposed sections 360-3.7(f)(2)(i)(h) and 360-3.7(f)(2)(ii). Only alternative means of meeting needs that wholly eliminate an immediate need for PCS should be considered in determining presumptive eligibility for immediate temporary PCS. If an immediate need for PCS can be met only partially by alternative means, then the individual, by definition, continues to have unmet immediate needs for PCS that must be addressed and for which that person should be found presumptively eligible.

ii. Available income and resources of individual and relatives:

a) The *applicant* cannot be required to use exempt resources or income, e.g. if applicant has $10,000 of savings or an IRA in pay-out status, this cannot be required to be used as it is an exempt resource. The same is true for exempt resources of a legally responsible relative.

b) Where the applicant has a *spouse* who is not applying for Medicaid, the spousal impoverishment allowances should be taken into account in determining whether the applicant has excess income or resources, since what would

otherwise be excess income or resources may be allocated to the spouse as a community spouse monthly income allowance (CSMIA) or community spouse resource allowance (CSRA). The applicant should be provided 45 days to transfer any assets to the spouse as an CSRA, and be granted presumptive eligibility in the meantime.

c) This section purports to allow consideration of the income and resources of a NON-LEGALLY RESPONSIBLE relative. This is not permissible under Medicaid rules, and must not be permitted for presumptive eligibility.

iii. Informal supports -- While consideration of availability of informal supports has always been a factor in assessing the need for PCS, the existing regulations at 18 NYCRR 505.14(b)(3)(ii)(b) define "availability" to include the "ability and motivation of informal caregivers to assist in care, … the extent of informal caregivers' potential involvement," and, importantly, the "… acceptability to the patient of the informal caregivers' involvement in his/her care." The proposed regulation should incorporate these important considerations, so that only voluntary care acceptable to the applicant is considered.

iv. The Protective Services for Adults ["APS"] program - A referral for APS should not be used to slow down assessment for and authorization of temporary personal care. APS eligibility is conditioned on having no one able to assist the individual responsibly. 18 NYCRR 457.1(c). Thus APS would decline to serve an individual whose family member is willing and able to *direct* his or her care, as defined in 505.14(a)(4)(ii), but who is not able to directly *provide* PCS.

vi. **(f)(3) -- Assessment and Authorization Process**.

i. **TIMING -** The language requires a determination "As expeditiously as possible, but no later than five business days after receipt of the Medical Assistance application and physician's order, the social services district." We propose that this be changed to "as expeditiously as the applicant's situation requires, but no later than five days." See Proposed 360-3.7(f)3)(v) and 505.14(b)(5)(iv)(c).

ii. **Assessments** – section (f)(3) requires a social and nursing assessment, along with a Local Medical Director assessment if continuous 24-hour personal care is required. In part I of our comments above, we propose an alternative assessment procedure that would delegate assessment to the LTC Assessment Center and/or the MLTC plans, and obviate the need for this burdensome series of assessments. In the event that a particular LDSS chooses to conduct the presumptive eligibility determination for PCS, we propose that this series of assessments be abbreviated so as to expedite the process. Now that all local districts are using the Uniform Assessment Tool, expedited completion of this tool would encompass the factors formerly elicited in the social and nursing assessments. A referral to the Local Medical Director should not delay the temporary PCS authorization, and can be done later.

vii. **(f)(4) Date the presumptive eligibility period ends** – Must be adapted to ensure continuity of care and a seamless transition to the model of home care services to which the individual transitions. Our comments on behalf of consumers do not address who is responsible for paying for the temporary services. Regardless of how payment is reconciled between the local district and the

State, it is imperative that a **90-Day Transition period** be required, to provide a seamless transition from the temporary PCS to the home care services ultimately approved when Medicaid is approved.

i. **MLTC** - For someone determined eligible for Medicaid, who is subject to enrollment in MLTC, the proposed regulation ends the presumptive eligibility period "on the day that the MLTC plan…determines whether the individual is eligible for PCS." The language should extend the presumptive eligibility period until the individual is enrolled in the plan and *actually begins receiving services* from the MLTC plan.

   a) The 90-day Transition Period should apply, requiring the MLTC plan to continue the same level of service and the same home care provider from the temporary PCS period. If the plan decides to reduce services below the amount authorized through temporary PCS, the plan must provide advance written notice with Aid Continuing rights before reducing services after the transition period. This will ensure there is no disruption in services in the transition.

ii. **Mainstream Managed Care** -For someone determined eligible for Medicaid, who is subject to enrollment in a mainstream Medicaid managed care plan, the proposed regulation requires that the individual has "submitted a service request for PCS to such entity," and ends the presumptive eligibility period "on the day that the … managed care provider determines whether the individual is eligible for PCS."

   a) The district should be required to inform the applicant of the need to submit a service request for personal care to the managed care plan, once they are enrolled. Further, the temporary services should continue until the plan actually begins providing PCS, to ensure that there is no gap in services. The 90-Day transition period requirement should apply, requiring the managed care plan to provide services in the same amount for 90 days, and using the same providers. The plan must provide advance written notice with Aid Continuing rights if the plan determines to reduce services after the 90-day period.

   b) IF the managed care plan denies the request for PCS, the plan's notice of denial should be framed as a notice of termination, with aid continuing rights, since the plan's action results in discontinuance of authorized services.

iii. **Fee-for-Service** - The proposed regulation lacks any provision regarding the presumptive eligibility period for individuals who are not mandated into MLTC or mainstream managed care. Although fewer and fewer people fall into this category, the clarification is required for those who do. For those who will receive PCS through FFS Medicaid, the presumptive eligibility period should end on the day the person is found eligible for Medicaid and authorized for home care services. The local district must be required to continue the same level and amount of PCS that person was receiving temporarily. If the local district determines to authorize a lesser amount, then it should be required to provide advance written notice of the reduction with Aid Continuing rights.

viii. **(f)(5) Fair hearing and Aid Continuing rights** –

i. AID CONTINUING MUST BE PROVIDED. We are pleased to see that the regulations afford hearing rights to individuals denied presumptive eligibility for temporary PCS. However, we object to the lack of the right of Aid Continuing pending a fair hearing to challenge the discontinuance of temporary PCS based on the denial of presumptive Medicaid eligibility.

The right to "aid continuing" is one of the most fundamental rights guaranteed by the Due Process clause of the Fourteenth Amendment. In Goldberg v. Kelly, 397 U.S. 254 (1970) the United States Supreme Court held that recipients of benefits are entitled to notice and a hearing before their benefits are reduced or terminated. Anyone receiving temporary PCS has been found to be at risk of jeopardy to their health and safety without services, and as a result would face further jeopardy without Aid Continuing.

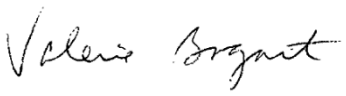
Moreover, many individuals who will be eligible for immediate temporary PCS would face temporary or permanent hospitalization or nursing home placement without such care. Even what may start out as a temporary institutionalization, could become permanent as individuals must have the means and ability to avoid losing their homes in the community by, among other things, paying rent on time while in a hospital and nursing home. At a time when New York State has declared its commitment to integrating people with disabilities in the community by reducing and preventing institutionalization, the failure to provide aid-continuing to individuals who may be at risk of institutionalization undermines that effort

ii. Fair Hearings Should Be Automatically Expedited

Social Services Law Section 133 creates a right to an expedited hearing to appeal a denial of emergency needs care. Therefore, all individuals who are denied, in whole or in part, immediate temporary PCS must be informed of their right to an expedited hearing and be granted an expedited hearing if requested. Individuals who are in receipt of immediate temporary PCS and subsequently found ineligible for Medicaid should automatically receive an expedited hearing under 18 NYCRR 358-3.2(b)(9). By definition, a person who has been found to need immediate temporary PCS has health needs that would be seriously jeopardized absent PCS. Such individuals should therefore be presumed to have an "urgent need for medical care, services or supplies," 18 NYCRR 358-3.2(b)(9), justifying an expedited hearing.

Thank you for the opportunity to comment on these important regulations, which will provide expedited access to crucial personal care services. We urge the Department of Health to establish a system of immediate needs PCS that can be easily integrated into the current structure of personal care authorization and delivery.

Very truly yours,



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