NEW YORK LEGAL ASSISTANCE GROUP

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Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower, Empire State Plaza, Rm. 2438
Albany, New York 12237-0031
regsqna@health.state.ny.us

Re: Comments on Notice of Revised Rulemaking -
Immediate Needs for PCS 18 NYCRR § 505.14
I.D. No. HLT-43-15-00003-P (State Register, Oct. 28, 2015)

Dear Ms. Ceroalo:

NYLAG submits these comments on the proposed regulations implementing the statutory amendment to Social Services Law adding new subdivision 12 to section 365a. L. 2015, Ch. 57. Sec. 51. This amendment requires procedures for local districts to make an expedited Medicaid eligibility determination within seven days for those determined to have Immediate Needs for Personal Care Services ["PCS"] or Consumer Directed Personal Assistance Program ["CDPAP"] services. The proposed regulation was also drafted in direct response to the Order of Justice Joan Madden, Supreme Court, New York County, in *Konstantinov v. Daines*, dated July 13, 2015, directing the State to establish a procedure for Medicaid recipients to obtain immediate temporary PCS, and to provide them with notice of the availability of these services. That order amended earlier court orders directing promulgation of regulations.

About NYLAG: Since its founding in 1990, the New York Legal Assistance Group's free civil legal services have directly benefited over 76,000 low-income New Yorkers. NYLAG reaches even the most isolated populations by placing its attorneys directly in over 100 community centers, courts, hospitals and community-based organizations across New York City as well as Long Island, Westchester, and Rockland, and also operates the Mobile Legal Help Center, a legal services office and courtroom on wheels formed in partnership with the NYS Courts' Access to Justice Program. Practice areas include health care, public benefits, VA benefits, family law, housing, immigration law, employment law, consumer law, disaster relief, special education, and advance planning. Within its practice areas, NYLAG legal staff provide advice and extended representation in administrative proceedings, hearings and court, community outreach, Continuing Legal Education, trainings for social workers and other professionals, technical assistance, and impact litigation.

GENERAL NOTE: All comments to the 505.14 amendments are intended to apply to those for 505.28 re **CDPAP**.

Section 7 - Procedure and Criteria for Determining Who Has "Immediate Need" for Personal Care or CDPAP services

1. ***Notice of Availability of Forms and Information about Procedures*** - Consistent with prior *Konstantinov* court orders, **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 for immediate needs services. If the Exchange lacks a mechanism to make a determination of expedited 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.

   Information about the procedures and forms needed to obtain these services --the physician's order and attestation of lack of other available formal or informal services –must be posted on NYS Health and Office of the Aging websites, as well as local district websites, and must be provided to any person who inquires about applying for Medicaid and/or personal care or CDPAP services. Also, information about these procedures and forms must be publicized and available through the New York Connects program counselors and websites.

2. ***Expedited Means of Communication with Applicant -*** These forms or the Medicaid application should request expedited ways of contacting the applicant or his/her representative – cell phone, e-mail address or fax. Given the short turn-around times, using regular mail will not be practical and will prevent meeting the seven-day statutory deadline. Districts should be required to telephone and e-mail or fax when communicating with the applicant or his or her representative, such as for requesting additional information.

3. **People in Hospitals and Nursing Homes who may have Medicaid applications pending Must be Eligible to Apply for Immediate Need PCS and Obtain an Expedited Seven-Day Medicaid Determination**.

   While the proposed regulations do not bar people in hospitals and nursing homes from applying, they should be modified to specifically require local districts to accept and process their applications. Barriers currently exist for these individuals.

   Any person in a hospital or nursing home for whom a Medicaid application is pending should be eligible to file a separate Medicaid application for purposes of being approved for immediate need PCS upon discharge. This is especially critical for those who filed institutional Medicaid applications. Notwithstanding the legal time limit of 45 days for processing those applications, they commonly take six months or more to be approved. In New York City, and perhaps other districts, HRA refuses to process a community Medicaid application if an institutional Medicaid application is pending. This puts those who need Medicaid to pay for a temporary rehabilitation stay beyond 29 days in limbo, preventing their discharge home when medically appropriate, and violates the *Olmstead* requirements. While we realize that HRA's and other district policy against processing more than one Medicaid application at a time arises from a concern about inconsistent determinations, or some other systems problem, there should be a way using computer technology to prevent such outcomes. Moreover, the absence of a five-year lookback in community Medicaid means its outcome may indeed be different than the institutional Medicaid determination anyway.

Additionally, people who are in a NH or hospital who could be discharged home if PCS/CDPA was available should be considered to have an immediate need if the person's health or safety would be at risk if they were discharged without such services.

4. **Criteria for Determining Whether Immediate Need Exists to Warrant Expedited Seven-Day Medicaid Determination.** The proposed definition establishes two types of criteria for who is eligible to receive an expedited 7-day Medicaid eligibility determination: (1) medical or functional need for services and (2) lack of availability of other services. We do not disagree that both types of criteria are appropriate but have comments on some elements of these definitions.

   We commend the Department for omitting its previous proposal to require eligibility for adult protective services, as well as other burdensome criteria that were proposed earlier.

   a. **Medical/Functional Criteria** -

   Proposed section (7) requires a physician's order that "documents that the recipient needs assistance with toileting, transferring from bed to chair or wheelchair, turning or positioning in bed, walking, or feeding, and that such assistance is essential to maintaining the recipient's health and safety in the recipient's home…"

   While the activities of daily living listing are important and must be considered, the proposal omits other key activities: assisting with medications, food shopping and meal preparation, bathing and dressing are significant activities necessary to maintain health and safety in the home. Rather than limiting the scope of immediate needs by creating a new standard for the provision of personal care or CDPAP, we recommend that the physician's order need only state that the applicant/recipient requires Level II personal care services, as defined in § 505.14 (a)(6)(ii) of these regulations. This definition under the State Medicaid Plan should apply here rather than a limited scope of services devised for this particular group of individuals.

   b. Attestation of Lack of Other Available Services

   The applicant must attest about lack of availability of other services. We recommend the changes below, which are explained below the recommended language.

   (i) no voluntary informal caregivers are available, able, and willing to provide <u>or continue to provide</u> assistance to the applicant with the personal care services functions <u>to the extent needed as</u> documented in the physician's order;

   (ii) <u>payment is not available for a</u> ~~no~~ home care services agency ~~is providing~~ <u>to provide or to continue to provide</u> assistance to the applicant with the personal care services functions <u>to the extent needed as</u> documented in the physician's order;

   (iii) adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers, or wheelchairs, are not in use to meet or cannot meet the applicant's need for assistance with the personal care services function <u>to the extent needed as</u> documented in the physician's order.

(iv) third party insurance or Medicare benefits are not available to pay for assistance with the personal care services functions to the extent needed as documented in the physician's order.

The added language "to the extent needed" in each subparagraph clarifies that even if the alternative assistance is available to assist with the necessary functions documented by the physician, it is not available to the extent needed. Medicare home health benefits, for example, are far more limited in amount, duration and scope than Medicaid personal care. They are commonly authorized for at most 8-12 hours per week, which would be totally inadequate for an individual with more extensive needs. The regulation must be drafted to ensure that receipt of such benefits – whether Medicare, EISEP, or informal assistance from family – does not preclude eligibility for Medicaid immediate need PCS or CDPAP.

Paragraph (ii) regarding availability of services from a home care services agency is unclear. Home care services agencies do not simply provide free home care services. They must be hired and paid to provide services –by a family member, a guardian, or in rare cases, a non-profit organization or charity. A statement that continued funding is unavailable should be sufficient.

Moreover, family members or others who may be paying for private home care often do so in reliance on expectation of being reimbursed by Medicaid once the application is approved and services are initiated. Yet Medicaid reimbursement is denied because most privately paid home care is not provided by a Medicaid provider but by a licensed home care services agency. The proposed language would deny immediate need PCS if a home care agency is providing services, yet the appellant is denied reimbursement for paying for those very services. Instead of closing the gap caused by delay in MLTC enrollment, this will exacerbate it.

c. **People who are in a Nursing Home or hospital** who could be discharged home if PCS/CDPAP was available shall be considered to have an immediate need if the person's health or safety would be at risk if they were discharged without such services. This criterion should be incorporated into the regulations, which as now proposed require a physician's order that documents that assistance with certain ADLs "is essential to maintaining the applicant's health and safety in the applicant's home." Proposed 18 NYCRR 505.14(b)(7)(i)(a)(2). This language could be misinterpreted as precluding a finding of immediate need if a person has not yet returned home from a nursing home or hospital because PCS/CDPA is not in place. Such an interpretation would be a change to current policy which contemplates providing expedited authorization for PCS to individuals, "whether located in the community or a nursing facility…" GIS 15 MA/011 (emphasis added). The language needs to be modified to encompass persons whose health or safety would be at risk if discharged home from a hospital or nursing home without services.

Indeed, failing to provide PCS/CDPA on an expedited basis to individuals seeking to transition home from a hospital or nursing home would be a violation of both the reasonable promptness provision of the Medicaid Act, 42 USC § 1396a(a)(8) and the Americans with Disabilities Act's integration mandate as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999). We have had a number of clients who have been discharged from hospitals to nursing homes and/or unnecessarily confined to nursing homes simply because PCS/CDPA has not been arranged to allow them to go home. Often this problem occurs because of delays in MLTC enrollment.

5. **Expedited 7-Day Medicaid Determination Should Include Spousal Impoverishment Protections.** Spousal impoverishment allowances should be taken into account in determining whether a married applicant (whose spouse is not applying for or receiving Medicaid) has excess income or resources. It has been the Department's policy to use spousal impoverishment protections only post-eligibility after enrollment in an MLTC plan. However, CMS has now issued guidance on the federal law extending spousal impoverishment protections to all waiver programs.[1] This federal guidance expressly states that for those who need home-and-community-based services [HCBS], which include PCS and CDPAP, "the statute does not require that they actually receive the HCBS for which they are eligible." Id. at pp. 3-4. "…This means that a State would determine a married applicant's need for the relevant HCBS within the underlying Medicaid eligibility process in order to determine if spousal eligibility rules apply." Under this CMS guidance, an applicant's indication on the Medicaid application that they need or receive long term care services should trigger a determination of the need for PCS or CDPAP and also use of spousal impoverishment rules.

   This CMS policy directive remedies a severe barrier to married individuals seeking Medicaid home care services in MLTC plans. Those with "excess" assets or income under regular Medicaid rules, for whom eligibility would be denied or subject to complicated spend-down procedures, may be fully eligible using spousal protections. In that regard, a married applicant with excess assets should be provided 45 days to transfer any assets to the spouse as a CSRA, and be granted eligibility in the meantime.

6. **Sec. 7 - Timing and Processing of Medicaid Eligibility Determination for Those in Immediate Need**

   The amended statute requires that "a final eligibility determination be made within seven days of the date of a complete medical assistance application." SSL 366a-a, Subd. 12. We recognize that this time limit presents a challenge for the local districts and appreciate the Department's efforts to achieve this, including the permitted use of attestation of resources for those in immediate need of PCS. We have some questions and suggestions for how this time limit can be achieved.

   a. **Definition of "Complete" Medicaid Application allows Attestation of Resources** – We commend the Department for utilizing Attestation of resources, since it will save time in obtaining bank statements and the homestead equity valuation. Paragraph (i)(b) requires the district to request documentation to verify resources where there is a material inconsistency with "information subsequently obtained by the commissioner or the district from other sources." It is unclear as drafted what is meant by "subsequently obtained." If that occurs within the 7-day processing time, we request that the language clarify that the request for additional documentation may not delay the Medicaid eligibility determination past seven days.

[1] CMS State Medicaid Director Letter No. 15-001, "Affordable Care Act's Amendments to the Spousal Impoverishment Statute," May 7, 2015, available at http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf.

b. Additionally, regulations should clarify that districts must use MAGI budgeting, without requiring any information regarding resources, for those Medicaid applicants seeking immediate PCS/CDPA who are eligible for a MAGI eligibility category.

7. **Manner of Requesting Further Information to Complete Medicaid Application -** Within three calendar days the local district is required to both determine whether there is an immediate need for PCS/CDPAP and whether a complete Medicaid application has been filed, as defined for this purpose. If not, the district must notify the applicant of the need for additional information. Given the short timelines, the applicant or his/her representative should be notified of any additional documentation needed by phone, e-mail or fax. This contact information should be added to the attestation form or Medicaid application.

Section 8 – Criteria and Procedures for Authorizing Immediate Need PCS or CDPAP for Medicaid recipients

1. **Medicaid recipients in hospitals or nursing homes must be eligible to apply for immediate need PCS/CDPAP** – We commend the Department for specifically including those who are not exempt or excluded from MLTC but who are not yet enrolled in an MLTC plan. In our comments regarding section 7 above, we stated that people with Medicaid applications pending in hospitals or nursing homes must be given an expedited determination for community Medicaid eligibility in order to access these services. Similarly, the regulations should further clarify that Medicaid *recipients* in hospitals or nursing homes – whether for short-term or long term stay--must be given the opportunity to request immediate need PCS/CDPAP. Again, though the proposed regulations do not prohibit such applications, the longstanding barriers for people in nursing homes or hospitals necessitate clarification that they are eligible.
2. **Timing of Assessments and Determination – 12 Day Time Frame is Excessive.** The proposed regulations require the local district to determine eligibility for and authorize immediate need PCS/CDPAP within twelve (12) days of filing the physician's order and attestation of need. For those who already had Medicaid, this means the authorization should be completed within 12 days. For those who simultaneously applied for Medicaid, this 12-day period would be in addition to the 7-day expedited Medicaid determination, for a total of 19 days.

   We believe that 19 days is excessive and can be shortened by making several changes in the proposed procedures.

   a. For Medicaid applicants, the 12-day period should be shortened by **3 days** because the local district already took 3 days at the beginning to determine that there is an immediate need for PCS, based on the physician's order and attestation of need.

   b. Assessments of Need – The proposed regulations require both a social and nursing assessment and also the local medical director determination in 24-hour care requests. The majority of people seeking these services will be individuals who are not excluded or exempt from MLTC but who are not yet enrolled in an MLTC plan.[2] For this majority of applicants, completing this full battery of assessments is not necessary, imposes an

[2] Section 18 NYCRR 505.14(b)(8)(i)(a)(2).

undue burden on the local district, and will cause harmful delay in initiating vital services. Anyone in the mandatory MLTC population will be transitioned within at most the next few months to an MLTC plan, which will undertake a full assessment of need. The LDSS should be able to authorize services using the physician's order and the attestation of need.

If an in-home assessment is deemed essential, then the State should utilize its contract with NY Medicaid Choice, which must conduct a Conflict Free eligibility assessment for all these people anyway when they seek to enroll in MLTC. Procedures would be established by which the DSS would contact NY Medicaid Choice to schedule the Conflict Free assessment for those found to have immediate needs pursuant to the physician's order and attestation. The referral to NYMC and the NYMC assessment would need to be scheduled on an expedited timeframe than is now in force. The CFEEC assessment utilizes the same Uniform Assessment Tool as the local districts use for the nurse's assessment, and if done correctly, also elicits the same information as the social assessment regarding availability of informal caregivers and other elements.

This utilization of NYMC to do the nurse's assessment using the Uniform Assessment Tool would cost little or no money, since NYMC is already contracted to conduct these assessments; the only cost would be in expediting them which may require more staff. Moreover, we have heard reports that local districts, because of moving their former PCS/CDPAP cases to MLTC, have so downsized their nurse assessment staff that they have no nurses to conduct these assessments at all, let alone expeditiously.

Finally, by having NYMC conduct the nurse's assessment, the same assessment then doubles as the CFEEC and can expedite transition to MLTC. This may require extending the expiration date of the CFEEC beyond 60 days. As we have reported to DOH, the 60-day expiration date has already posed a problem for MLTC enrollment and needs to be expanded in any case. We recommend it expire only after six months, the same time in which MLTC plans are required to conduct reassessments, unless there has been a substantial change in the individual's medical condition.

c. We ask how will the Department monitor district compliance with these timelines? And will districts have more resources to comply? Even the 19-day time line, which we believe is too long, is ambitious and unrealistic without added resources and monitoring.

3. **NOTICE** of the determination must be provided with expedited appeal rights. Persons applying for services under these regulatory provisions should receive priority in scheduling a Fair Hearing under 18 NYCRR §358-3.2(b)(9) (see more below).

4. **Initiation and Duration of Immediate Need PCS for those not Excluded from MLTC – Continuity Must be Ensured with Transition Services.** The proposed regulation requires the local district to "…authorize personal care services to be provided until such recipients are enrolled in such a plan or provider." The regulation must be more specific about the deadline to actually initiate the services in the home.

5. **90-Day Transition period to MLTC or Mainstream managed care** - Procedures must ensure a seamless transition from the Personal Care Services – whether temporary or the full services authorized by the LDSS after eligibility determination -- to MLTC or a mainstream managed care plan. The 90-day Transition Period should apply, requiring the MLTC or mainstream managed care plan to continue the same level of service and the same home care provider from the temporary or permanently authorized PCS period. These services must continue without interruption upon the day of enrollment in the plan. A communication mechanism must be established by which the MLTC, MAP, or FIDA plan or other provider will be apprised of the plan of care and of the home care agency providing immediate need services. The MLTC or other plan must be required to provide **transition services** under the same plan of care, as is otherwise required for people transitioning from Fee for Service long term care services to MLTC.

    a. If the MLTC or mainstream 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.
    b. If a mainstream managed care plan denies the request for PCS for a new member who had been authorized to receive them by LDSS – wither temporary or permanent PCS or CDPAP, 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.

6. **Special Considerations for CDPAP**

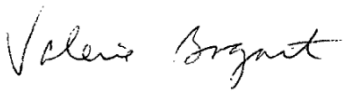
All of the above comments regarding assessments and procedures apply to CDPAP. For CDPAP, the local district must conduct an additional evaluation to assess the ability of the applicant or his or her family member, guardian or other person or entity to manage the CDPAP services. Amended section 505.28(l)(2) should specifically require that this unique part of the assessment also be expedited. Similarly, it would be helpful to establish an expedited procedure for prospective aides to qualify and register as aides with the fiscal intermediary under contract with the local district. This process can also cause delays in initiating care.

7. 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). Any 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.

Very truly yours,



Valerie J. Bogart, Director
Evelyn Frank Legal Resources Program
New York Legal Assistance Group
7 Hanover Square, 18th Floor
New York, NY 10004
tel 212.613.5047 (Direct Dial)
fax 212.714.7450
vbogart@nylag.org