NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

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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, March 2, 2016)

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**.

NYLAG appreciates many of the changes made in the regulations, which reflect thoughtful consideration of comments by stakeholders to the previously proposed regulations. The following comments support many of the changes and make recommendations to strengthen these procedures to implement state law that requires the Department to develop these procedures for Medicaid applications to be processed in seven days where there is an immediate need for personal care services.

MAIN CONCERN: We urge DOH to specify a time limit for districts to initiate PCS/CDPAP authorized based on immediate need.

Our main concern with this revised regulation is the provision that states,

> The social services district shall promptly notify the recipient of the amount and duration of personal care services to be authorized and issue an authorization for, and arrange for the provision of, such personal care services, which shall be provided as expeditiously as possible.

505.14(b)(8)(ii). The new language only asks the district to arrange for authorized services "as expeditiously as possible." An expedited Medicaid determination completed in 7 days, and an expedited authorization for services completed in 12 days is meaningless if the district then takes many more days or weeks to arrange and initiate services. The regulations must specify a time limit which is enforceable at fair hearings and by the Commissioner. It will be difficult enough to hold districts accountable for meeting the seven – and 12-day time limits, but with *no* time limit for initiating services there will be no means of enforcement or accountability.

Our other concerns are addressed below for sections 7 and 8 of the amended regulations.

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

1. **We support the revised simplification and improvement in process for determining whether an applicant has immediate need for personal care services:**

   We support the change that will use a standard physician's order rather than requiring a special new physician's order form that documents immediate need as to certain activities of daily living. 505.14(b)(7)(i)(a)(2)-(3)(Medicaid applicants) and xxx (Medicaid recipients requesting immediate need PCS). It is challenging enough to educate physicians about new versions of local physician's order forms, such as the New York City M11q form, let alone adopting a special version just for this purpose.

   A. **Form for attestation of immediate need for PCS** – The amended proposal dispenses with the requirement to use a state attestation form, though we hope that DOH will issue a model form which can make the process uniform statewide. We support not making a particular form mandatory to ensure that the requirement will not be a barrier to applicants who do not use the form but still convey the same information. 505.14(b)(7)(i)(a)(3). Also, the revised regulation has improved language for the content of the attestation as to the lack of other resources to provide care.

i. **The applicant will now attest to the lack of informal caregivers or a home care services agency to provide -- or third party insurance or Medicare to pay for -- "needed assistance."** This language is an improvement. We hope that the Department will clarify in subsequent implementing directives that this language does not preclude authorization of PCS for immediate need if non-Medicaid sources – whether informal care, Medicare home care, or other care -- may be providing *some* of the needed assistance, if they cannot provide all that is needed. As we pointed out in previous comments, Medicare home health care services are extremely limited in amount and duration, and even when provided will often not fully meet the need for PCS.

ii. **Attestation as to lack of informal caregivers** – We appreciate that DOH adopted a recommended change that provides for attestation that voluntary informal caregivers cannot "…continue to provide needed assistance to the applicant." 505.14(b)(7)(i)(a)(3). This is an improvement on the previous language that suggested that an applicant whose family is currently providing informal care is automatically disqualified from applying for immediate need PCS, even if this informal care cannot continue.

iii. **Third Party Insurance, Medicare or Home Care Services agency–** We support the change in which the attestor states that third party insurance or Medicare benefits "are not available to pay for needed assistance," or that "no home care services agency is providing needed assistance to the applicant." 505.14(b)(7)(i)(a)(3). We recommend clarification in future directives that this should be interpreted to mean that such coverage is not available or will not continue to be available, or that the coverage is limited in amount so does not cover to the extent needed. For services from a home care services agency, this could mean that the individual is receiving state-funded EISEP services that are inadequate in amount, or that a family member is privately paying for services, but cannot continue to do so.

B. **Automatic entitlement to "immediate need" status –** We appreciate the Department clarifying in the regulation and its responses to previous comments that local districts may not "look behind" an attestation of immediate need. 505.14(b)(7)(ii). The Department has clarified that as long as an applicant submits the requisite documents – attestation of need, physician's order, and Medicaid application – that he or she must be treated to be in immediate need for purposes of expediting the Medicaid application and for assessment and authorization of personal care/CDPAP. (Assessment of Public Comment, No. 2).

C. **The regulation or future directives should clarify that people who cannot be safely discharged home from a Nursing Home or hospital without PCS/CDPAP should be determined to have an immediate need**. The revised Regulatory Impact Statement projects cost savings from making immediate need PCS/CDPAP available to expedite discharge of people in institutional settings , since the average cost of PCS/CDPAP is substantially less than the cost of nursing home care. Yet 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. The need for home care services in order to return to

the community from a hospital or nursing home, where there is no other available care as provided for in the attestation of need, should constitute immediate need.

Whether through the regulation or in a future guidance, DOH should clarify the districts must accept requests for immediate need services from individuals in a hospital or nursing facility. This would be consistent with 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).

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.

Where a person in a hospital or nursing home has a Medicaid application pending for hospital or institutional care, and has an immediate need for PCS/CDPAP to return home, the regulations should require local districts to expedite processing those applications for community-based coverage within the 7-day timeframe, before the eligibility determination for institutional care is processed. Recently, staff from NYLAG and other consumer organizations met with NYC HRA and discussed this issue. Progress is being made in developing a procedure for HRA to process Medicaid applications on two tracks for people temporarily in a nursing home – a faster track for community-based eligibility, and the slower track for the institutional Medicaid determination. This is encouraging, but the time frame for such cases must be shortened to seven days from the existing 45-day limit where there is an immediate need for PCS/CDPAP.

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.

1. **We Support Deferral of District's Request for Further Information regarding Financial Resources until After Medicaid Eligibility Determination.** As we stated in earlier comments, we commend the Department for utilizing Attestation of resources, which will save time in obtaining bank statements and the homestead equity valuation. We further commend the Department for ensuring that any request by the district for additional documentation concerning the amount of resources be requested after the Medicaid eligibility determination, so as not to delay the Medicaid eligibility determination past seven days. 505.14(b)(7)(i)(b).

2. **MAGI** -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.

3. **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.

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

[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.

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 – Improvement in 12 Day Time Frame.** We commend the change made in this amended proposed regulation that directs local districts to process concurrently the Medicaid application and the assessment for PCS/CDPAP so that both are completed within twelve (12) days of filing a complete Medicaid application. This is an improvement over the prior version, in which the processes did not run concurrently so would take a total of 19 days.

3. **We do not oppose the change giving local districts four instead of three calendar days** to determine whether the applicant has immediate need for personal care services and whether the Medicaid application is complete, and if not, requesting additional documentation. We understand the concerns about a 3-day time limit conflicting with weekends and holidays.

    a. **Expedited Means of Communication with Applicant** – As a practical matter, the requirement that districts notify the applicant of additional documentation needed, and that the application will be decided in seven days, is unrealistic if e-mail or fax is not used as a preferred means for these communications. To that end, all forms and the Medicaid application should request the cell phone, e-mail address and fax for the applicant or his/her representative, 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.

4. **Recommendations to put less burden on local districts to assess need for PCS/CDPAP Abbreviate**

    a. Fewer Assessments – As we suggested before, we renew our recommendation to abbreviate the assessment process, at least for those 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 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.

    b. Alternately, we renew our recommendation for the State to utilize or expand its contract with NY Medicaid Choice to conduct the nurse's assessment for those found to have immediate needs pursuant to the physician's order and attestation. The Conflict-Free assessment performed by NY Medicaid Choice utilizes the same Uniform Assessment Tool as the local districts use for the nurse's assessment, and can also elicit the same information as the social assessment regarding availability of informal caregivers and other elements. This

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

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. We appreciate that the regulations now allow districts to contract out nurse's assessments, given that they may lack nurse assessors on staff. However, they still must make these contractual arrangements and find nurses to contract with.

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.

5. **As stated above, we urge DOH to specify a time limit for districts to initiate PCS/CDPAP authorized based on immediate need.** 505.14(b)(8)(ii). (See first section, above)

6. **Duration of Immediate Need PCS/CDPAP and Transition to MLTC/ Managed Care**

The revised regulation provides:

> With respect to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or managed care provider, the district shall authorize personal care services to be provided until such recipients are enrolled in such a plan or provider.

505.14(b)(8)(ii). The district's authorization should continue past enrollment into the plan and until the plan actually initiates services. Additionally, procedures must ensure a seamless transition from the PCS/CDPAP authorized by the LDSS 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. 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.

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.

7. **NOTICE 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). 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.

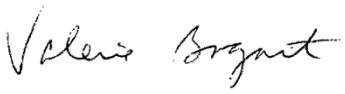
8. **Special Considerations for CDPAP -** All of the above comments regarding assessments and procedures apply to CDPAP. For CDPAP, the local district must conduct an additional evaluation to assess the ability of the applicant or his or her family member, guardian or other person or entity to manage 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.

9. ***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.

Thank you for the opportunity to comment on these important regulations, which will provide expedited access to crucial personal care and consumer-directed services.

Very truly yours,



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