Follow up questions to this letter sent on Jan. 6, 2022 are appended at page 10 of this PDF

NYLAG New York Legal Assistance Group

Medicaid Matters New York

December 15, 2021

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Susan Montgomery, Director, Division of Long Term Care
Jonathan Bick, Director, Division of Managed Care
NYS Department of Health, Office of Health Insurance Programs

By email

Dear Brett, Susan and Jonathan:

We were distressed to learn last week that the Independent Assessor is moving ahead to be implemented beginning March 1, 2022. Consumer advocates have serious concerns about the extensive guidance, procedures, training, technology, and readiness review that are needed for plans, local districts, and Maximus to implement what DOH acknowledges are "significant changes .. which will require time to implement… [T]he Department agrees that it is important to allow sufficient time for stakeholders to learn and implement the various changes." P. 209.[1] Whether through Medicaid Matters New York or otherwise, we ask to meet with DOH to discuss these and related issues.

We note there are already misunderstandings and confusion about implementation of the various MRT changes. A Greene County HIICAP counselor reported that the Greene County Department of Social Services [DSS] *has already turned away applicants for Level 1 Housekeeping assistance*, misunderstanding that the Minimum Needs criteria are not yet implemented.

The questions and comments below address only the Independent Assessor procedures and the related changes in developing a plan of care. We are not addressing here the new standards for reductions and other changes addressed in 21-ADM-04 and MLTC Policy 21.06 that were just issued this week, which we have not yet fully reviewed. Nor does this letter address the minimum ADL needs criteria, about which we have previously raised questions.

We understand DOH is conducting a webinar on December 20 or 21, 2021. We request an opportunity for consumer advocates to provide input and to fully discuss the procedures.

What follows are our questions and concerns regarding IA implementation.

[1] All page references are to the regulations posted at https://regs.health.ny.gov/regulations/recently-adopted.

I. Independent Assessor (IA) – including Independent Practitioner Panel (IPP) and Independent Review Panel (IRP)

A. Maintenance of effort

Does DOH have any further confirmation from CMS that the IA procedures do not violate the MOE requirements of the American Rescue Plan Act (ARPA)? And whether the Minimum Needs criteria violate the MOE?

B. 1115 waiver approval

What is the status of the request to CMS for approval to amend the waiver to transition to the IA, IPP and IRP procedures for mainstream and MLTC plans, and to apply the minimum needs criteria to MLTC enrollment? The Special Terms and Conditions were amended in October 2021 and do not appear to include the IA changes or minimum needs criteria.

C. Implementation should be phased in

Implementation should be phased in for many reasons. Maximus' capacity to have sufficient nursing and medical staff to conduct all these assessments is a huge concern, especially considering the documented capacity issues for conflict free assessments. Systems readiness for plans, local districts, and NY Medicaid Choice is another concern, both the technology and systems for communications between these entities and development of procedures and training of staff. Phase-in should be used to test systems and procedures and adjust them as needed for broader implementation.

> Regarding Maximus capacity, how and when will DOH determine its capacity to begin assessments in each county as described in 505.14(b)(8) (P. 72)? DOH is well aware of the delays in scheduling and conducting CFEECs. Those assessments are generally required once per enrollee. The new assessments must be done as an initial CFEEC and then annually for every enrollee and more often if an enrollee requests a mid-year increase or is hospitalized (more than 300,000 per year). Given this volume, we question the capacity requirements in contract for the IA, IPP and IRP and how capacity will be measured. Additionally, DOH is aware of Maximus Call Center issues, which signal problems with needed communications from LDSS and plans to schedule IAs. Just for the CFEEC, let alone for the new battery of assessments, there is lack of capacity to answer phones and return voicemail messages.

Here are various ways this roll-out could be phased in.

1. **Phase in implementation with a demonstration in one NYC borough or one county**.

   For both local districts and MCOs, implementation should start in one NYC borough or one or two counties, just as DOH has done for every other MLTC initiative, such as the original roll-out of mandatory MLTC and the roll-out of the Conflict-Free Evaluation and Enrollment Center (CFEEC). For the same reasons those gradual start-ups were needed -- in order to test systems, monitor and ensure capacity, train staff and adapt procedures -- a phased-in start must be used here, particularly since the IA procedures present a far more massive change for the local districts, the

plans, and Maximus, than the earlier MLTC roll-outs. On a smaller scale, more resources can be devoted to ensure that the roll-out goes smoothly. As new procedures are developed and tested, it will be easier to adapt them as needed on a smaller scale than trying to do that in 62 local districts and in every plan statewide. It will be more possible to prevent the delays we fear are inevitable in the new system in a roll-out with a smaller scope.

2. **The three new assessments – IA, IPP, and IRP—could also be phased in, introducing just one new assessment at a time**. An initial launch of just the IA, without the IPP and IRP, to test the referral and communication systems between plans and local districts and Maximus would be prudent, especially in light of capacity concerns discussed below.

   Is DOH separately determining capacity for NY Medicaid Choice to conduct each of the three new assessments in each county? Have these determinations been made, and if so which counties have capacity and which don't for each assessment?

3. **The assessments could be phased in to start only with annual re-assessments**, since these are the least time-sensitive assessments because the members are already receiving services. Delays are less likely to harm the consumer than for new applications, consumer requests for mid-authorization increases, and for hospital discharges, both of which are usually based on a negative change in the consumer's condition. Both of these should be phased in later, after procedures have been tested and improved. See questions below about Maximus capacity for all of these assessments.

4. Finally, **phase-in could begin with fee-for-service applications to certain local districts, not with MLTC or mainstream plans**. Again, this would limit the demand on Maximus' capacity and allow for developing, testing, and adjusting systems. Also, as stated above, we question whether CMS has approved implementing the IA in MLTC and mainstream plans.

D. Readiness review

1. What readiness review is DOH conducting? Is capacity being measured in each county? If so, how? Readiness must be determined for each of the three new assessments and in each different context – for new applications, annual reassessments, and for mid-year changes and hospital discharges.

2. Section 505.14(b)(8) suggests that instead of specifying clear dates on which the IA system goes live in each county, "the Department may … require that social services districts and MMCOs first attempt assessment and authorization pursuant to the provisions of this subdivision currently in effect," and, if unsuccessful, then conduct the assessment using the procedures that existed on Jan. 1, 2001 (P. 72). We strongly oppose leaving it up to each county and plan to "first attempt" to refer an application or request for an increase to the IA. How would DOH define an unsuccessful attempt to make such a referral? Obviously, the time taken attempting to use the new process, and then switching to the old procedures, will cause huge

delays for consumers. Either DOH has found through a valid readiness review that Maximus has capacity to conduct the IA, IPP, and IRP in a particular county, or it does not. It is not appropriate for each plan and local district to test the "readiness" for these assessments on the back of each consumer.

E. Time needed for issuance of guidance, development and testing of procedures and systems, staff training, and public education

Even after guidance is issued, complex workflows must be developed and tested between NY Medicaid Choice, plans and the local districts. Adequate time is needed for stakeholder input and education prior to implementation. In publishing the regulations, DOH correctly recognized that it must "issue guidance as needed in accordance with 505.14(b)(8) and 505.28(m) to pend implementation of the IA or minimum needs criteria *and if needed to provide time to ensure stakeholders have been appraised of their roles in this process."* (Pp. 262-63, P. 209). DOH agreed that a seamless transition between the role of the local districts and managed care plans regarding assessments and the IA is essential, "but disagrees that the regulations further specification regarding how the Department will manage that transition. Such specification and clarification will be managed through guidance, information, and training to LDSS and MMCO." (P. 259.)

It is less than three months until the projected start date, and no state guidance has been issued. There is simply not enough time for local districts to develop procedures and systems to comply with this guidance and train staff before March 1, 2022.

We understand that just updating a call center script for NY Medicaid Choice to inform callers of the option of applying for Immediate Need services, given the delays in scheduling CFEECS, is a huge lift. That task pales in comparison to the job required of all entities to implement the three new IA assessments. Every LDSS, NY Medicaid Choice, and plans must each develop internal procedures, technology, communications channels with the other entities, notices and staff training (P. 231).

DOH acknowledged the need for guidance to managed care plans and local districts regarding data feeds and procedures on how and when they should be transmitting information and sending files to the IA (P. 261). Health plan commenters sought particular guidance regarding how and when files get transmitted in the course of the member enrollment process (P. 253). Responding to concern expressed by the local districts, "The Department will continue to refine the points of contact between MMCOs or LDSS and the IA to ensure a smooth and clear communication process and may issue guidance if needed." (P. 260)

Technology – Since the local districts and plans have not needed to communicate with Maximus before to schedule any assessments, let alone three assessments, to receive the results, and to file disputes about the IAs, what assessment has DOH done to determine what technology is needed in each county? What is the availability for any technology needed by the local districts, including NYC HRA?

F. Preventing delays

1. Guidance and procedures are needed to ensure timely completion of the new IA, IPP and IRP, as well as decisions by plans and local districts. Responding to consumer advocates' concerns about the lack of deadlines for the new assessments and likely delays of services, DOH said it will "further solidify these timeframes through guidance and contractual requirements, as it works to accommodate the needs of LDSS, MMCOs, and consumers through this significant statutory change in the assessment process." (P. 163)

2. **Declining to specify sanctions for IA lateness on assessment, "the Department will issue guidance and instructions to Medicaid Managed Care Organizations (MMCOs) and LDSS** with regard to the channels necessary to ensure timely completion of the CHAs and practitioner orders that will inform the plan of care and service authorization process. Additionally, the Department will hold the IA accountable through its contact with the IA to ensure that timely completion occurs, given the importance of CHA and practitioner order completion on the development of the plan of care." (P. 162)

   Since time limits and sanctions for lateness in the Maximus contract impact consumers' right to timely authorizations under federal and state law and regulations, DOH should make public these sections of the contract with Maximus.

   What "channels" will managed care plans and local districts have to ensure timely completion of the IA and IPP?

3. **Procedure for plans/LDSS to challenge IA based on a "Material" dispute** - Guidance is needed to narrowly define "material dispute" and set deadlines for filing such challenges, to minimize the number of disputes and delays for the consumer. We still fail to see how, if NY Medicaid Choice has ten days to schedule a repeat assessment if such a dispute is filed, how that will not prevent the plan from meeting deadlines in federal regulations at 42 CFR 438.210 (Pp. 252-53, 111).

4. **We urge DOH to reconsider the policy that the consumer is not entitled to a copy of the disputed IA or IPP** (P. 200). DOH denies this on the basis that a disputed assessment was not used as a basis for the service authorization. It is hard to imagine a more stark violation of due process than to deny a consumer a copy of an assessment conducted pursuant to the State procedures in response to their request for services, which the managed care plan or local district believed contained an error. The consumer is not entitled only to documents relied upon in making the adverse decision, but to their entire "case file, including medical records, other documents and records…" (42 C.F.R. 438.406(b)(5)). Guidance must require that the plan or the local district provide copies of the notification from the plan or local district to the IA that communicate its disagreement or identify an alleged mistake, with its clinical rationale and any documents, and copies of any corrected or revised assessments. Any colloquy between the local district/managed care plan and the

independent assessor about any alleged mistakes or factual inaccuracies must be memorialized and be available to the consumer, along with the original assessment and any re-do or correction.

5. **Discretion to authorize temporary plan of care pending IRP review** –

   In cases where the managed care plan/local district has determined more than 12 hours per day is necessary, "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." 505.14(b)(4)(vi), 505.28(e)(4) (pp. 53-54, 121). As stated above, the language is inconsistent – the plan/local district "may" authorize a temporary plan of care if "necessary" to comply with timeliness requirements. If such a plan of care is necessary, then the regulation or guidance must *require* it to be authorized.

   Further policy guidance is needed to guide plans/local districts for how to determine if it is "necessary" to comply with federal or state timeliness requirements, such as for Immediate Need cases, or expedited requests to managed care plans. Plans and local districts should be required to develop electronic methods to set alerts for deadlines under state and federal requirements, so that if a case has been referred to the IRP past those deadlines, or with little time left before the deadline, then the temporary authorization must be provided.

   Consumers should be given information on their right to a temporary plan of care in certain circumstances, notice of a decision not to authorize a temporary plan of care, and have the right to appeal the failure to authorize a temporary plan of care.

   DOH should monitor timeliness of decisions in cases referred for IRP review, and impose sanctions on plans and local districts that do not comply with applicable deadlines and fail to authorize a temporary plan of care. Otherwise there is no incentive for a plans/local districts to authorize these temporary plans, and the regulatory language only says that they "may" do so. DOH is relying on the availability of these temporary authorizations to avoid delays that "might cause an increase in institutional care" and violate the ADA (Pp. 164, 229, 231). If these authorizations are to be relied on in this way, some enforcement teeth must be developed.

G. IA procedure details

1. **Who gives notice if eligibility for PCS/CDPAP is denied - IA or DSS or MMCO?** "To ensure that each entity understands its roles in every context, the Department will issue guidance on its website prior to the implementation of the IA and new ADL criteria, as it has committed to do for other components of the regulations, to ensure that all stakeholders understand their expected roles and responsibilities, have enough time to develop notices for these purposes, and that these regulations comply with applicable MOE requirements." (P.262)

Right to have family member or other representative present at IA and IPP – "The Department agrees that person-centered planning requirements at the federal and state level require that an individual may request the participation of family members, caregivers, and professionals in their care plan development. The Department confirms that neither the current nor proposed regulations prohibit the participation of representatives in the assessment process." (Pp. 190, 254)

The right for the consumer to have a family member or other person participate in the IA or any other assessment should be made clear in guidance. That no regulations prohibit their participation is not sufficient to protect the consumer's right to have a loved one or professional participate. It is DOH's responsibility to ensure that rights in the personal care services program are made clear in guidance, not left to the consumer to point out that nothing prohibits this participation.

CDPAP – The person directing care should not be required to be physically present at CDPAP assessments. Phone/telehealth should be acceptable (P. 255). Nearly thirty years ago, the State Medicaid agency made clear that the person directing care for a non-self-directing person did not need to reside with the consumer but need only to have "substantial daily contact," which was not necessarily in person (NYS 92 ADM-49). That directive applies to personal care generally, not specifically CDPAP but the same principle applies. If anything, 28 years later, technology makes virtual or remote communication more feasible.

Consumer opportunity to submit medical records from treating physician – In the commentary published with the regulations, DOH states, "…the IA, IPP, and IRP is already permitted and encouraged to consult available medical records in completing the CHA, PO, and high needs recommendation. The regulations permit an individual to share their medical records with the IA nurse assessor or practitioner during the assessment or medical examination process, respectively. Moreover, the MMCO will have access to this medical information to inform the development of the plan of care" (pp. 187-88).

a. Guidance should require NY Medicaid Choice to notify the consumer, at the time the various assessments are scheduled, and to require the plan or DSS, at the time of the request for services, that the consumer has the right to submit medical records at the IA and IPP assessments. It is not enough to "permit" the assessors to consult available medical records.

b. We recommend development of a form that the consumer has the option to submit on which the treating physician indicates diagnoses, medications, and functional limitations and needs. A standardized form will promote consistency and efficiency.

c. Guidance should require that NY Medicaid Choice transmit to the IPP and the IRP any medical records presented by or on behalf of consumer to the IA or IPP.

d. Guidance should require that NY Medicaid Choice transmit any medical

records presented at any assessment – the IA, the IPP or the IRP to the DSS or MCO. This must be done on a timely basis so that the DSS or MCO can take such records into consideration in developing the plan of care. The consumer must not be required to submit the same records both to NY Medicaid Choice assessors and to the plan or LDSS. From the consumer's perspective, they are being assessed for home care, and are submitting medical records to the assessor. They cannot be expected to understand that the assessor is a separate entity from the LDSS or plan.

The regulation states that the DSS or MCO must forward to the IRP "… any clinical records or other documentation used to develop the plan of care, such as records from treating providers." (505.14(b)(2)(iii)(f)). The flow of records must go both ways, with the IA also forwarding any records received to the DSS or MCO to be used to develop the plan of care. Since the DSS and MCO retain the sole responsibility to assess night-time needs, such records are essential.

Telehealth - We appreciate that the DOH commentary says that only synchronous telehealth, and not telephone assessments, will be acceptable, and that DOH plans to work with interRAI, the developer of the CHA/UAS tool, to study the accuracy and quality of remote assessments (Pp. 265-267). However, if telehealth is permitted, guidance is needed to clarify the "informed consent" process for the consumer to consent to telehealth in lieu of an in-person visit. This must include requirements for obtaining written consent and specify the narrow circumstances where oral consent is permitted (P. 256). DOH commentary suggests that the telehealth procedure in COVID guidance -- asking for consumer's ID and explaining telehealth -- constitutes adequate informed consent. We disagree.

Given there are now three assessments by NY Medicaid Choice, along with any assessments the plan and LDSS need to fill the gaps in the assessments (see below), guidance should specify for which assessments telehealth may be used. It may be appropriate to require in-home assessments for the IA and IPP but permit telehealth for others (once interRai has studied the accuracy of the tool conducted remotely). This should all be specified in guidance.

II. Developing Plan of Care – Assessment of informal caregivers, night-time needs, consumer preferences, and time needed between unpredictable tasks

Now that the LDSS and plans are no longer doing the core CHA assessment used to develop the plan of care, specific guidance is needed requiring these entities to specifically assess both the availability of informal caregivers and extent of night-time needs, document the findings, transmit such findings with any referral for **IFR**, and incorporate the findings in any notices.

A. Informal supports - DOH response to comments at page 241 states "The plan of care development process already requires the MMCOs and LDSS to document days and times of available informal supports and ensure that the recipient is willing to have the caregiver serve in that role and that the caregiver is both willing and available to serve." We are unaware where this specific information regarding availability of informal supports must be

documented by plans or LDSS. Guidance should clarify this and require specific forms and procedures to document it, and to include these specific details regarding availability in any consumer notices. As we have pointed out, this detailed information is not elicited in the UAS, which simply asks simply whether family is involved. Because of that omission from the UAS/CHA, it falls to the LDSS and plan to assess and elicit this information, which is more difficult now that their own nurse is no longer conducting the assessments.

B. **DOH has acknowledged that the CHA assessment, does not specifically elicit night-time needs, requiring the LDSS and plan to assess these needs outside of the CHA and use those findings in the plan of care.** "The Department has maintained the responsibility to assess frequency of needs with the MMCOs and LDSS because the current CHA tool does not ask these questions, and the Department does not have another evidence-based validated assessment tool that can be used for this purpose, as is required under Section 365- a(2)(e)(v) of the Social Services Law." (Pp. 241-242, emphasis added). Guidance must clarify the LDSS and MMCO responsibility to assess these needs.

C. **Also, DOH commentary published with the regulations says a technical amendment was made to section 505.14(a)(5)(iii) which we don't see in the final language quoted above on page 14.** This references a "technical change to clarify that it should not be construed as prohibiting the authorization of services for times between intermittent unpredictable tasks, such as may be needed and practical to ensure assistance with night-time toileting." (157-58, 166, 171). If this language was inadvertently omitted from the final regulation, a correction should be made. Whether in the regulation or guidance, it should clarify that such services must – not may -- be authorized as "needed and practical to ensure assistance with night-time toileting."

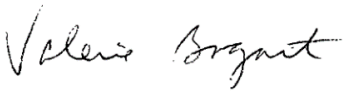
D. **Consumer preferences -** We commend DOH for specifying in the regulation that the plan/LDSS must assess "the individual's preferences and social and cultural considerations for the receipt of care." (505.14b)(2)(iii)(a)(3)). However, the language still requires MMCOs and LDSS to use alternate services if "more cost effective," even contrary to the individual's preferences. Preferences must be taken into account in determining whether use of commodes or other equipment, adult day care or informal caregiver support, could reduce the need for services. Currently, plans often decide unilaterally that the consumer could use a bedside commode – or incontinent pads -- at night instead of providing an aide to assist to and from the bathroom. In its commentary, DOH explained that it declined to re-state the federal CFCO requirements regarding consumer preference and other factors because it is duplicative (P. 147). On the contrary, it is DOH's job to incorporate federal requirements into clear standards and procedures, to ensure consistent implementation and compliance by plans and districts with these requirements. Again, we request that guidance specifically require that the MCO or LDSS consider consumer preferences in developing a plan of care, particularly when alternate services or informal caregivers are relied on, as required by the CFCO regulations and policies.

E. **Referral to IRP if Plan of Care more than 12 hours/day -** We repeat our request for guidance requiring that the referral by the LDSS or MCO include both the plan's or LDSS' proposed care plan and the consumer's requested care plan. Otherwise, the IRP cannot

recommend or determine if an individual is capable of safely living in the community. As an example, an MCO approves a plan of care of 24-hour live-in for a consumer who has a documented history of pressure sores, is incontinent, needs turning and positioning every two hours, and has no informal supports. The IRP reviewer should find that plan of care unsafe. The IRP 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. **Guidance must clarify that the language permitting the IRP to recommend additional services includes recommendation of a different form of 24-hour care, such as recommending continuous 24-hour care rather than live-in.** If the consumer's proposed plan of care of continuous 24-hour care in two shifts is presented, the IRP will be able to say that one plan does not ensure health and safety but the other does. The goal must be for the IRP to approve a plan of care, not to simply proclaim what plan of care is not safe.

Thank you for hearing our concerns.

Very truly yours,



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Follow up questions sent to DOH on Jan. 6, 2022 after meeting with Medicaid Matters NY on Jan. 4th, 2022 about Independent Assessor

Thanks for meeting with MMNY this week. You asked for a copy of our letter of 12/15/22 in WORD, which is attached. There was not enough time to get to many questions in the attached letter, and we would appreciate the information requested, whether in any Q&A that the Department plans to release or otherwise.

1. We appreciate that you will share with us the webinar presented to the plans and LDSS on Dec. 20-21. If a recording is available we would appreciate that, as well as the Powerpoint and any other information shared. And we look forward to presentations you mentioned later this month.
2. We would welcome the opportunity to review and provide feedback on drafts of the ADM and MLTC guidance being developed.
3. Sue asked for this question in writing – I had received a TAC complaint response concerning lack of callbacks on calls to NYMC requesting conflict free assessments. The response dated 12/27/21 stated, "the manual callback procedure has been replaced with an automatic callback campaign to prevent recurrence." We'd like to know more about this automatic callback system – is it a robocall back or a call by a person? Can the appointment be scheduled in that callback? What is the time frame for the callback?
4. There wasn't time enough for DOH to walk through the "flow chart" for the various scenarios in which the IA will apply. It was a little confusing because some different scenarios were conflated due to lack of time. Perhaps this was covered at the webinar in December, so we will see it with those materials. If not, it's important for the public to understand how it will work in various situations:
    a. LDSS applications –
        i. Request for Immediate Need services - Whether this begins March 1, 2022 or later, consumers and their representatives must know the new procedures, which of course must be operationalized by the LDSS. Now that the consumer will no longer be submitting a physician's order, which until now has initiated the application, how will the application be initiated?
        ii. Request for PCS/CDPAP services for people exempt or excluded from mainstream or MLTC
        iii. Request for PCS/CDPAP services for people who are in the mandatory MLTC category – who don't realize they needed to apply at NYMC. (This seems to be the scenario that was used as an example at the meeting, which is actually the least common scenario).
    b. Mandatory MLTC population who call NYMC for CFEEC to enroll in MLTC – what are steps to enrollment and service authorization?

c. MLTC or mainstream members who request from their plans increases (concurrent reviews) of PCS/CDPAP services or prior approval of a new PCS/CDPAP service they were not receiving

d. Annual renewals – I think it was Sue that explained NYMC will send 60-day letters to consumers to schedule the IA but then what happens?

e. Hospital or Nursing home discharges – the regs appear to require a new IA for these situations, and naturally these must be expedited. 505.14(b)(4)(xi)(c). Reg language is:

> (c) Neither an independent assessment nor a practitioner order shall be required to reauthorize or continue an authorization of services, except:
>
> (1) 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;…

The guidance should provide for waiving the requirement for a new IA and PO if it delays a safe discharge.

5. I appreciate Brett's offer to follow up on NYLAG's FOIL request related to the SPA approval. It is FOIL # 21-07-192 filed July 13, 2021.

6. Re **Independent Review Panel – IRP** (also referred to as Independent Medical Review) -- This is to confirm a few points made at the meeting for follow-up in guidance or elsewhere:

a. Which current consumers receiving > 12 hours/day will be GRANDFATHERED and don't NEED TO BE REFERRED FOR IMR?

Language of the regulation: 18 NYCRR 505.14(b)(4)(xi)(b) (p. 62 of the posted regulation)

> (b) Where an independent review panel previously reviewed a high need case, reauthorization of services shall not require another panel review for as long as the case remains a high needs. If service levels are reduced below the high needs threshold and 505.14(b)(4)(xi) subsequently increased to become a high needs case again, another review by the independent review panel is required.

At the meeting, you confirmed that the intended meaning of this regulation is that anyone authorized for > 12 hours/day at the time these assessments begin would not be subject to the IRP/IMR review. As we pointed out, this language does not exactly express the Department's expressed intent that "the IRP reviews a plan of care only when the consumer crosses the high-hours threshold." Reg. p. 216. The language could be interpreted to mean that such consumers would only be grandfathered if an IRP previously reviewed the case. The first time the IA is done, that can't be true, so no one would be grandfathered. We ask you to clarify that such consumers should not be referred for the IRP/IMR review in guidance.

b. Clarify Plan/LDSS Must authorize > 12 Hours/day if ordered by an External Appeal.

Language of the regulation: 18 NYCRR 505.14(b)(4)(vi)(pp. 53-54 of the posted regulation)

> (vi) 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 (2)(iii) and (2)(v) of this

subdivision, **unless such authorization is ordered pursuant to a fair hearing decision or 505.14(b)(4)(vi) by another court** of competent jurisdiction.

I believe it was Chris Chase at the meeting who acknowledged this point and said it would be looked into. We ask that guidance clarify that districts and MMCO's may also authorize more than 12 hours/day where ordered pursuant to a decision made in an External Appeal filed under Title II of Article 49 of the NYS Insurance Law.

c. Clarify ALJ can order > 12 hours/day if found Medically Necessary, even without IMR review

The same paragraph of the section 18 NYCRR 505.14(b)(4)(vi) quoted above re External Appeals also could be interpreted by an ALJ, or by DFS in an External Review, as prohibiting an ALJ from ordering > 12 hours because no IMR was done. This needs to be clarified.

At the meeting, Brett expressed DOH's intent that an ALJ can approve over 12/hours without an IRP/IMR and we ask that this would be made clear in guidance. Otherwise, ALJs will either affirm a denial of an increase for lack of an IRP/IMR or remand it to the plan/LDSS, which could launch an endless cycle of remands.

d. Not raised at the meeting directly, but if the IRP says not a safe plan of care, and this is relied on by plan or LDSS to deny/discontinue services or deny an increase, Maximus should be a party to the plan appeal, fair hearing, or external appeal. All of their records must be included for the record (in any case even where they find it a safe plan).

There are many more questions and suggestions in the attached letter.