NYLAG
New York Legal Assistance Group

DATE: Feb. 2, 2022

TO: Independent.assessor@health.ny.gov

FROM: Valerie Bogart, NYLAG vbogart@nylag.org

RE: Independent Assessor questions for DOH based on new slides posted on website

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We just learned about the NYIA website last Friday and for the first time saw the slide decks from December and Topic 1 for plans and LDSS. Here are some questions based on these slide decks and a quick look at Topic 2 for MMCO's. Questions sent to you previously remain – email Jan. 6, 2021 attached, and previous letter sent Dec 15, 2022 attached. At your request attached in WORD.

1. **NYIA has 14 calendar days to complete both the IA and the CA/PO, and 6 days for Expedited MCO assessments and Immediate Need** (December 20, 2021 - High Level NYIA Overview for LDSS – slides 10, 22)

    a. How is it possible to meet this 14-day deadline with conflict-free assessments still being scheduled 2 months after the call? When the CFEEC was launched, it was expected – and perhaps in NYMC's contract -- that the assessments would be scheduled within 2 weeks, and now it's around 2 months. There seems no reason to think that the NYIA assessments can be scheduled any more quickly. Is DOH monitoring reports to the MLTC TAC complaint line of these delays? On a recent complaint, I was informed that reports of CFEEC scheduling delays are not tracked as TAC complaints because Maximus is not necessarily at fault for the nursing shortage. Still, reports to DOH of these delays are clearly relevant to NYMC's capacity to launch the IA, and I hope are being tracked.

    b. Topic 2 1/26/22 MMCO slides 25, 31– says NYIA issues Options Notice within 2-3 business days after assessments finalized. Is that time period part of the 14-day limit for completion of the assessments (6 days for expedited/immediate need cases)? Or in addition?

    c. Even if it's possible to meet the 14-day deadline, how can MCO comply with standard **14-day deadline** in 42 CFR 438.210 to authorize services, subject to 14 day increase *only* if MCO, justifies a need for additional information and how the extension is in the enrollee's interest.

    d. Even if possible to meet 6-day expedited deadline, how can MCO comply with expedited **72-hour deadline** in 42 CFR 438.210 to authorize services on expedited basis, subject to 14 day increase *only* if MCO, justifies a need for additional information.

    e. No presentations give a deadline for MCO or LDSS to refer a request for services to the NYIA for these assessments. A deadline is needed, and must be shorter for expedited/immediate need requests.

f. Confirming call 2 days before – what if now not available? What is policy? Slide 22? Go to back of the line? WILL THEY TELL HOW TO SUBMIT MD EVIDENCE BFORE? What is process to submit through secure portal?

2. **The CA (IPP) exam**—

   a. Slide says consumer has option for in-person or by telehealth, but if choose in-person is deadline of 14 days or 6 days the same?

   b. If in-person, where is exam – in consumer's home? Or at physician's office? (12/20/21 slide 12)

   c. Who arranges and provides transportation if consumer needs assistance – MCO or LDSS or NYIA? What about consumers who are not yet in a plan to arrange transportation – then will NYIA arrange transportation?

   d. For telehealth, does consumer have option to use Facetime or other apps if cannot use or prefer not use Zoom? (same question for IA).

   e. What about consumers who cannot travel because of their disability but prefer in an-person exam?

   f. Slides 22-23 of 1/14/22 DSS – Physician's Order will include determination of whether self-directing and whether can safely receive CBLTSS at home, based on medical stability. The slide decks don't mention other content of physician orders currently in use. On the DOH-4359 the practitioner lists diagnoses, describes current medical/physical condition, current treatment plan and therapeutic goals, prohibited activities or functional limitations, ability to summon help, ability to ambulate, continence, prescriptions and ability to self-administer, dietary needs, all tasks, treatments or therapies received or required, assistance needed with skilled tasks, and contributing social, medical, and environmental factors. It is worrisome that every mention of the CA and PO do not describe these aspects of the exam.

3. **Timing for Independent Review Panel Assessment** – No deadline is given for plan/DSS to refer case to NYIA for this IRP, and then for the IRP to be scheduled and conducted, and its recommendation conveyed to plan//DSS. Does contract provide deadlines for these steps, and what are they? If not, policies are needed.

   a. What is the deadline for the plan's/ LDSS referral for this assessment?

   b. And the deadline for completion and transmission of the recommendation?

   c. Are these deadlines shorter for expedited/ Immediate Need requests?

4. **Referrals to IA by 3-way calls with LDSS/MCO and consumer are unworkable and will cause delays** - 1/14/22 LDSS presentation slide 17 says LDSS completes the new Expedited/Immediate Need assessment request and transmits to NYIA via secure portal. LDSS then places 3-way call with Dolly/consumer to NYIA Operational Support Unit (OSU).

   a. At the meeting with Medicaid Matters NY on April 19, 2021, DOH described the 3-way call as designed to help with a warm handoff, saying that it should not be a barrier, suggesting that it would be a preference but not be a requirement. Yet the

slides repeatedly say that the consumer *must* call with the DSS. This will inevitably cause delays and be a barrier.

b. In the Immediate need context, for example, why is it necessary to do this as a 3-way call? DSS has done its job to refer the case to NYIA to schedule the assessment. Presumably the new Expedited IA referral form has all contact info for member and their rep, and other content needed for the NYIA to schedule the assessments. NYIA OSU should reach out to consumer to schedule the assessments.

   If the 3-way call is intended to keep the LDSS or MMCO in the loop to know when the assessment is scheduled, there should be electronic way for NYIA to LDSS or MMCO apprised of when the assessments are scheduled and held, other than through insisting on 3-way phone calls.

c. Scheduling 3-way calls can be time consuming for all parties and often don't work – 2 parties call the 3rd and get a busy signal or must leave a voicemail, etc. Then when the message is returned, does NYIA then have to reach both the consumer and the MMCO/DSS?

d. How is the new automatic callback system going to handle callbacks to two parties that called together? Two-way calls are more likely to be effective and cause less delays.

e. What provision is being made for **interpreters** and for those with **hearing impairments** in these 3-way calls?

f. **What is policy for NYIA permitting a consumer's Power of Attorney or Designated Rep to be on the call instead of the consumer**? Plan or LDSS should have this designation on record – will plan/LDSS be required to include this information on the IA referral form, and NYIA to allow this person to speak for consumer? What sort of identity verification will be required – if this is burdensome it will cause further delays.

   a. If the NYIA says it has no record of designated representative, will there be a fax number or email address to send this?

   b. Even with no verification that a family member or friend are designated as rep, they should be allowed to schedule the appointments. This is just for scheduling. The NYIA assessor will still need to verify identity at the assessments. This should not be an obstacle to moving forward with the assessments.

g. For all of these reasons, we urge a 3-way call not be required in all of the instances now identified in the slide decks, which include at least these situations -

   a. Immediate Need (see above),

   b. LDSS or MCO referrals to NYIA for non-routine assessments after hospital or nursing home discharge (12/21 presentation slides 23-24).

c. Mainstream plan member requests for authorization of PCS/CDPAP – 1/14/22 MMCO presentation slide 16 – "NOTE Consumer must be on the call with the plan to begin the process of scheduling." Again, that slide is inconsistent with an earlier comment on the same slide that says the consumer or the plan can call the NYIA helpline to initiate a request.

5. Opportunity for Consumer to submit medical records or other documents –

a. If the IA and/or CA are conducted in-person, policies should require that the assessing nurse or medical practitioner review and consider any medical documents presented by the consumer.

b. If the IA and/or CA are conducted by telehealth, the consumer must be provided a way to submit any medical records to the NYIA in advance of the visits, to be considered by the assessors. Submission should be possible by fax, email and/or a portal.

c. Whether telehealth or in-person assessment is used, any medical records provided to NYIA assessors or staff must be included in the consumer's record. If the NYIA finds consumer ineligible for CB-LTC, these records must be part of the evidence packet for the hearing. If the NYIA finds the consumer eligible, the NYIA should transmit these records to plan in which consumer is enrolled, if any, or to DSS. The consumer should not be expected to realize that medical records submitted to the NYIA would have to be submitted again to their plan or LDSS. They have a right to rely on these records being transmitted to the entity to which they requested services.

6. IMMEDIATE NEED – Other questions (in addition to 3-way call above)

a. 12/20/21 slide 22 – slide says consumer applies to DSS and provides a "'Statement of Need' for PCS/CDPAS along with a prescription for assistance with personal care tasks from a physician who knows the individual's condition" (see 16 OHIP/ADM-02 attachment –OHIP-0103 rev. 8/16)" The reference to OHIO-0103 is to the *Attestation of Immediate Need* form signed by the applicant.

a. Is the Statement of need the same as the Attestation form or a new form?

b. Is the "prescription for assistance" a new form or existing form like the M11q or the DOH-4359 Physician's Order?

c. If either or both of these are a new form, when will they be made available to the public and announced to LDSS in a directive – time is needed for LDSS to operationalize using these new forms and procedures.

b. **Slides are inconsistent about how consumer can initiate Immediate Need request**. The 1/14/22-DSS slides 13 and 15 says consumer can call NYIA directly – "FFS individuals can call NYIA at any time to request an initial assessment for CBLTSS." (Slide 15 says "consumer and/or the LDSS calls" the NYIA.) However, 1/14/22-DSS slide 15 says "NOTE: Dolly must be on the call with the LDSS to begin the process of scheduling." And the 12/20/21 slide 22 says consumer "must start

the process at the LDSS. If they present to the NYIA, they will be referred to the LDSS prior to scheduling the CHA or CA."

Please clarify whether consumer who already has Medicaid can initiate an Immediate need request to the IA. Is slide 15 (1/14/22 DSS) saying that the consumer may initiate the request to the IA, but if they do initiate it with the LDSS, then when the LDSS calls the IA to schedule, it must be a 3-way call. If so, please see our objections to 3-way calls above.

c. Slide 22 – It's good that DSS can refer to NYIA while Medicaid determination is still pending, as the Immediate Need regulations require, but what is deadline for DSS to make that referral to NYIA?

d. Again, no mention of the Independent Medical Review for cases requiring more than 12 hours on average. This will be presumably covered in another presentation, but the timeline is unclear. What is the deadline for DSS to refer those to NYIA, and for NYIA to schedule, conduct and transmit recommendation of this review? Is the deadline shorter for Expedited/Immediate Need requests than for standard requests?

7. Other mainstream MCO issues –

a. 1/14/22 MMCO presentation slide 17 – if NYIA finds consumer does not have active Medicaid they are referred to LDSS. The mainstream population mostly has Medicaid through NYSOH not LDSS. NYIA needs to make the right referral for consumers to apply for Medicaid or to fix any Medicaid eligibility issues. Otherwise more delay will result.

b. **What is the authority to assign NYIA, not the MMCO, with the duty to give notice of denial of eligibility for PCS/CDPAP services a member requested from from the plan**? (1/14/22 MMCO presentation slide 25). Has DOH obtained a waiver from CMS of the regulation requiring the plan to issue adverse notices of action if a service is denied (assuming that regulation can even be waived, which we do not concede). 42 CFR 438.210. We understand that the 1115 waiver provides for a conflict-free assessment for eligibility for enrollment in MLTC. But that outside eligibility determination does not extend to mainstream members regarding eligibility for services in the plan's benefit package. The regulations provide for the right of a member to receive notice from the plan and to appeal the plan's denial of services.

    a. If NYIA is the party that issues the adverse notice, which we do not concede is permissible, NYMC must open a new Appeals unit, with a dedicated phone line, fax and email address for consumer to request Evidence Packets, etc. The volume of hearings will significantly increase from the existing number of CFEEC appeals, even moreso if and when the 3-ADL minimum needs criteria go into effect.

c. If the NYIA determination finds member eligible, Slide 27 says that for a non-dual, "plan selected by Dolly will discuss their plan of care with them." This is confusing. Dolly is already a member of a mainstream plan, from which she requested authorization of PCS or CDPAP. Why would Dolly now be selecting a plan? And the

plan has not yet developed a plan of care until it reviews the NYIA assessments, so it cannot discuss the plan of care with Dolly. The timing of all this is confusing.

8. **MLTC Plan Enrollment Scenario** –

    a. Slide 30 – "Fred and/or LDSS call NYIA to request assessment. "Fred must be on the call with the LDSS to begin the process of scheduling." Why is LDSS involved at all in MLTC plan enrollment? The DSS was never involved before. Once the LDSS determined Medicaid eligibility, its job was done. This will be an extra burden for the LDSS and will delay the assessments by the NYIA.

    b. After NYIA outcome decision finds eligible for enrollment, and consumer contacts a plan to enroll, does plan still make pre-enrollment visit? Does it do its own assessment?

    c. May consumer enroll in an MLTC plan directly by calling NYMC or is the MLTC plan enrollment visit still required?

9. **The NYIA determines eligibility for PCS, CDPAP and MLTC only after completion of the CHA/IA and the CA/IPP.** (Slide 21 12/20/21). This is different than DOH told consumers at an April 2021 meeting with Medicaid Matters NY – that the eligibility determination would be made by the nurse based on the CHA/IA, and that notice could be issued at that point, with the CA/IPP scheduled after. Waiting for completion of both assessments will delay MLTC enrollment. Nurses have made these eligibility determinations for years. Why require an MD now? The eligibility determination is not the authorization for services, it solely finds the applicant meets the minimum requirements. There is no requirement in federal regulations that a PO is necessary to deny eligibility, only for a service authorization.

10. **1/14/22 LDSS Slides** --

    a. The slides do not spell out the different processes for two types of requests for services fielded by DSS –

        a. immediate need and

        b. requests for PCS/CDPPA by people who are exempt or excluded from MLTC or mainstream MMC. These are people enrolled in home hospice, or in the OPWDD, TBI or NHTDW waivers, and some other situations.

    The slides only discuss immediate need and not the other reasons for filing applications with the LDSS. One reason this is critical is that when the DSS refers the case to the NYIA for the assessments, the NYIA will "advise of eligibility for CBLDSS and MLTC options if appropriate." Slide 24. The outcome notice and options counseling from NYIA must be tailored to the individual. It will be confusing and misleading for NYIA to advise an applicant who is in the OPWDD waiver of options to enroll in MLTC, since they are excluded from MLTC.

    Each of these types of situations must be broken down with different processes and notices. The slides confusingly cross back and forth between LDSS and MMCO, even in a slide deck that is oriented to one or the other entity.

11. **Guidance on When Referral for IA is and is not required** - none of the webinars differentiate when the MCO or DSS is NOT required to make a referral for an IA and CA/IPP. The regulations specify that a change in social circumstances alone does not require this referral. This must be made clear in guidance. 18 NYCR 505.14(b)(4)(xii)(a)

12. **Call Center Capacity** – hours and phone number are the same as for Conflict-Free enrollment center except adding Sundays 10-6. How has DOH assessed call center capacity as adequate to handle the increased call volume?

    a. Callbacks – As I shared previously, a response dated 12/27/21 to a TAC complaint I filed about failure of NYMC to return calls when consumer left voicemail requesting a CFEEC, stated, "the manual callback procedure has been replaced with an automatic callback campaign to prevent recurrence." Does this automatic callback system make a robocall or a call by a person? Can the appointment be scheduled in that callback? What is the time frame for the callback?

    b. The phone number for the public call center is different than for the NYIA Operational Support Unit (OSU) available to the LDSS and MCO's. Are these the same units or separate units within NYIA? What is added capacity of these units and how has DOH assessed it to be adequate?

13. A **confirming call will be placed by NYIA 2 days before assessments.** (slide 22). What is procedure what if in that call, the NYIA rep finds a busy signal or reaches a voicemail? Will assessment proceed as scheduled if doesn't reach consumer directly but leaves a voicemail? What if in that call, consumer says they now are not available on scheduled date? How soon must the rescheduled date be scheduled? How does this affect the 14-day or 6-day time limit?

Topic 2: Initial Assessment Process - Communication, Notices and Reporting --January 26, 2022 - AM Session for MMCOs

1. Slide 15 – says MLTC plan decides if otherwise eligible for MLTC – isn't this determination made by NYMC?

2. Slide 17 – excerpt of notice shown says that consumer must require Nursing Home Level of Care for MLTC. Wasn't the NHLOC requirement eliminated long ago and the requirement of needing 120 days of CB-LTC services substituted?

3. Slides 18-20 - Options Notice – The excerpts of the notice shown do not indicate that the notice will give specific findings as to why this individual's medical condition is not stable enough for health and safety to be maintained with home care. Under well-established due process principles and regulations, these notices must state more than a broad conclusion – they must provide the specific facts and findings justifying that conclusion, in order for the consumer to be able to prepare for a fair hearing.

4. Slides 25, 31– says NYIA issues Notice within 2-3 business days after assessments finalized. Is that time period part of the 14-day limit described in the earlier slide decks for completion of the assessments (6 days for expedited/immediate need cases)? Or in addition? If this is additional time, it makes our earlier question even more urgent – about how an MMCO or LDSS can possibly comply with regulatory deadlines to authorize services.

5. Slides 28-29 – If eligibility to enroll in MLTC approved, Options notice tells consumer to call NYIA for counseling. Won't the letter also include a list of local MLTC plans, and tell consumer to contact plans for enrollment?

6. Slides 34, 36 – MMC – Favorable options notice says "You should call your plan to share your results." The burden to take the next step shouldn't be on member. Member already applied to their plan for the service, and plan referred them for the NYIA assessments.

    a. When NYIA has completed those assessments, doesn't notify plan that eligibility was approved? This should be done electronically as soon as NYIA completes the determination.

    b. Then the plan should follow through -- conduct any further assessment needed to develop the plan of care (per slide 42) and then issue a notice. Policy must make clear this is plan's responsibility.

7. Slide 39 – Weekly appointment schedule posted on NYIA site. Does that mean the schedule is posted only once per week? Expedited assessments must be conducted in only 6 days, so a weekly posting wouldn't be frequent enough to capture the timing of these. Does the schedule also indicate whether an assessment was completed? Does MCO/LDSS have to comb through a schedule of thousands of assessments to find their members/ recipients? Or how do they identify theirs?

8. Slide 50 – What are examples of a business need for which an MMCO would need to access case files for someone not a member?

9. Slides 42 – 68 –**Readiness Review of Systems -** These slides on how plans need to sign up for and learn how to use the UAS-NY data exchanges and portals raise questions on whether the State is conducting readiness review to determine each plan's and each LDSS' readiness to utilize these systems on a timely basis. This requires each plan and DSS to draft its own internal procedures, and train staff on them, not to mention making any changes in their IT systems. The slides stress the importance of plans properly entering enrollment records in the system so that the consumer will be reassessed annually. Staff must be trained to add/remove individuals to or from the UASNY case list. Testing of each plan and LDSS ability to handle these tasks on a timely and accurate basis is essential.

    With this webinar only conducted Jan 26, 2022, it is simply unrealistic to ask LDSS's and MMCO's to launch this March 1, 2022.

    Readiness review is also needed for each DSS/MMCO systems and training for making the referrals to the NYIA, for the NYIA to transmit results of the assessments back to the referrers, and for the referrers to retrieve these results.