NYLAG
New York Legal Assistance Group

DATE: March 25, 2022

TO: Independent.assessor@health.ny.gov

FROM: Valerie Bogart & Peter Travitsky, NYLAG vbogart@nylag.org ptravitsky@nylag.org

RE: Second set of Independent Assessor questions for DOH about slides posted on NYIA website (supplements 2/2/22 memo) - **Topics 2 and 3.**

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Comments and questions on PowerPoints posted on the NYIA website follow. The comments are in the order of the slides, not in order of importance.

Topic 2 questions – see page 2 (This incorporates and supplements the questions on Topic 2 in the 2/2/22 memo)

Topic 3 questions – see page 8.

Preliminarily, many new forms are excerpted in the slides – most of which are needed for NYIA to start on May 1, 2022. In the past, DOH has often provided an opportunity for Medicaid Matters NY and other consumer advocates to review drafts of new notices and recommend edits, such as in the Part 438 Workgroup on exhaustion, and the nursing home carve-out notices. We are concerned that so many new notices and other documents are being rolled out without any input from consumer advocates. Also, it is not possible to review the content of these documents from the excerpts on the slides, and the notices and forms should be posted for public comment before they are finalized. All final documents should be publicly issued with an ADM/GIS.

The new notices and forms include, but are not limited to the following, many of which raise concerns:

1. Expedited/Immediate Need assessment request (1/14/22 LDSS presentation slide 17)
2. Immediate Need – per 12/20/21 slide 22 – applicants must now submit a new "'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 (slide references 16 OHIP/ADM-02 attachment –OHIP-0103 rev. 8/16 but that is OHIP-0103). If the "prescription" is a new form, and not the existing M111 of physician's order, this must be announced with an ADM/GIS and publicly posted with enough time to inform the public and local districts of new procedure.
3. Physician's Order (for C.A.)
4. Initial Assessment Outcome Notice (1/26/22 MMCO presentation slides 11 etc.)(see comments below)
5. Variance Request Form by LDSS/MMCO,
6. Independent Review Request Form – by LDSS/MMCO
7. IRP Report & Recommendation form
8. Notice to consumer that variance requested – by NYIA and/or plan? etc.

Topic 2: Initial Assessment Process - Communication, Notices and Reporting --January 26, 2022 - additional questions supplementing 2/2/22 NYLAG memo (Slide numbers below refer to MMCO presentation -- Slides -- unless indicated otherwise)

Initial Assessment Outcome Notice - slides 10-24

1. **Slides 13 – 17. "Your Assessment Showed."** We're glad to see that the Outcome notices will vary and be tailored depending on the population and outcome, particularly the "Your assessment showed" section, with the example listed of MLTC Plan enrollment eligibility depending on if applicant is a Dual or Non-Dual. However, the excerpts of the notice shown contain incorrect or misleading information, and conflate various populations – suggesting that the notices will actually not be tailored sufficiently. This will cause confusion if not corrected, as described in examples below.

    a. Slide 14 – Outcome notice says either "You are eligible for Medicaid CBLTSS or "You **may be eligible** for Medicaid CBLTSS." Why isn't this a YES or NO question – you are eligible or not? Maximus is delegated the duty to determine this eligibility. Why would NYIA determine that someone "may be" eligible? The slide explains this language is used if it is determined that the service cannot be rendered safely in the community. It is unclear what CBLTSS, in that situation, the consumer is eligible for.

    b. Slide 15 – Outcome notice says, "You MAY qualify to receive LTSS through MLTC…The MLTC plan you choose will discuss your Plan of care with you.. we can help you choose a plan or connect you with your LDSS if you choose not to join a plan at this time." This language is false and misleading as it suggests that a consumer has the option of choosing MLTC enrollment or to obtain LTSS through LDSS. This may be true for those under age 21, but is only true for dually eligible adults age 21+ if they apply for Immediate Need, or apply for a waiver, which is not obtained through LDSS. Referring the consumer back to the LDSS will only cause confusion because the vast majority are required to enroll in MLTC. See DOLLY example, below. The letter should explain Immediate Need and waiver options. What does DOH advise the LDSS to do or advise the consumer who contacts them after receiving this notice?

    c. Slide 15 also says, "MLTC plans are required to determine if the individual meets other plan enrollment criteria." The listed criteria pertain to eligibility for the voluntary MLTC populations -- those ages 18-20 or for non-duals, and are not new. Hasn't this eligibility determination historically been made by NYMC for these voluntary MLTC populations, such as whether they meet a Nursing Home Level of Care, or for the mandatory population, whether they are in hospice or in a waiver so are excluded from MLTC enrollment. It would streamline procedures and cause less confusion if NYMC does all eligibility screening. Also, it defeats the point of the conflict-free assessment if the plan, not NYMC, determines eligibility, as it allows a plan to "cherry pick" low-need enrollees and deny admission to those with high needs.

    d. Slide 16 – If NOT eligible to enroll in MLTC because you don't need one of the listed services for **more than 120 days** (PCS, CDPAP, PDN, HHA, ADHC,

PT/OT), the language says this doesn't mean consumer is not eligible for PCS/CDPAP. What, then, will notice say consumer is eligible for and what is their next step?

e. Slide 17 – Outcome notice says that consumer must require **Nursing Home Level of Care** and a listed service for more than 120 days to be eligible for MLTC. If slide 16 quoted part of the notice saying consumer didn't meet the 120-day requirement, what requirement does Slide 17 say consumer did not meet?

   The NHLOC requirement was eliminated for adult dual eligibles when MLTC became mandatory. If this language is intended to be used only for voluntary enrollees under age 21, the notice template must be clear to limit use of this language to that population. We recommend that different notice templates be used for that population, and for Immediate Need applicants, which will require different language than for adult dual eligibles seeking MLTC enrollment. Combining all of these populations into one notice template will be confusing and will likely result in mistakes.

f. Slide 17 –says the excerpted notice "language is included when a FFS individual does not meet the MLTC plan eligibility requirement. However this does NOT mean that they are ineligible for CBLTSS." This is unclear. Since the ADL minimum needs criteria haven't changed yet, when would an individual not be eligible for MLTC but still be eligible for PCS/CDPAP? Perhaps if the applicant was excluded from MLTC - because enrolled in hospice or a waiver program. If so, the notice should be specific about those exclusions. Otherwise, for most mandatory enrollment adult dual eligibles, the language makes no sense and is confusing. If the language is intended to mean those who meet the criteria only for Housekeeping Level I PCS/CDPAP but not for Level II PCS/CDPAP, then it should say so. If not, then what does this language mean?

2. **Slides 18-21 – Clinical Assessment Outcome/Notice that medical condition not stable enough for PCS/CDPAP -** The excerpts indicate that the notice will not include **specific findings** as to why this individual's **medical condition was determined to be 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. For instance, it should, at minimum, name the medical condition and specify what factors render consumer not stable enough for home care.

   a. Slide 19 - What is meaning of language in notice that says consumer is not stable for PCS/CDPAP but that you "may qualify" to receive LTSS through MLTC? Does that mean Private Duty Nursing? If so, it should say so. If not, notice should clarify what services they may qualify for. Since receipt of some PCS/CDPAP has long been a requirement for eligibility for MLTC, we fail to understand what is intended here. See, e.g., MLTC Policy 13.15.

   b. Slide 20 – MAINSTREAM plans – language of notice stating you are eligible for CBLTSS but CA shows not stable enough for PCS/CDPAP at home**.** Again, a

detailed explanation should be required of why it is determined condition is not stable enough for PCS/CDPAP at home, and should say what other services in the benefit package consumer is eligible for, such as PDN.

Does the Mainstream plan also issue an IAD denying PCS/CDPAP? Or is this NYIA notice the sole notice issued? As we said previously, the federal regulations assign the duty of denying a service request to the plan, and we question whether the State may delegate this to a third party like Maximus.

c. Slide 21 – This appears to be identical to slide 16 for FFS recipients seeking enrollment in MLTC, who are determined not to need CBLTC services for > 120 days? Why is the language different? Again, notice says this doesn't mean you're not eligible for CBLTC. But – with enrollment in MLTC mandatory for anyone seeking PCS/CDPAP, how else would an adult Dual Eligible receive these services?

3. **Slide 22 – What Happens Next** -

   a. FFS – tells consumer to call NYIA to learn about LTSS. What is NYMC script if it is determined consumer is not eligible for MLTC, or that health and safety can't be maintained at home with CBLTC? For adult dual eligible, nothing is available except housekeeping PCS/CDPAP.

   b. Mainstream – as we've said before, notice should not tell member to "call your plan" to tell them the assessments were done. Plan should be required to contact member to develop plan of care once NYIA notifies plan assessments are done. Consumer should just be told that plan will be developing a plan of care and will be in touch.

4. Slides 25, 31– **TIMING -** 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 statutory and regulatory deadlines to authorize services.

5. **Slides 27 – 29 - DOLLY SCENARIO 1- DUAL FFS seeking MLTC –**

   a. If NYIA determines eligible for MLTC, why does notice say "**you MAY qualify to receive LTSS through a MLTC plan**" rather than you ***do*** qualify to enroll in MLTC? Again, this defeats purpose of conflict free assessment, allowing plan to override NYIA and say not eligible – providing opportunity for cherry-picking.

   b. Slide 27 also says, "We can help you choose a plan or connect you with your LDSS if you choose not to join a Plan at this time." What is the point of referring consumer back to LDSS? MLTC enrollment is mandatory for adult dual eligibles determined eligible for MLTC. Only if consumer has an Immediate Need could LDSS do anything – and this option is not stated in the notice. The LDSS will simply refer the consumer back to NYMC/NYIA – causing more delays, and posing yet another obstacle that some consumers will not be able to surmount.

c. Slides 28-29 – If eligibility to enroll in MLTC is approved by NYIA, Outcome notice tells consumer to call NYIA for counseling. The Letter should explain the next step is for the consumer to contact an MLTC plan for enrollment, and include a list of local MLTC plans. The letter should say consumer MAY call NYIA for counseling, but consumer should have option to call plans directly. The extra step of calling NYIA should not be required, since it takes extra time and will cause further delays.

d. Slide [24 and] 29 – ICAN info – good this is included.

e. Slide 30 of LDSS PowerPoint – scenario is that Dolly is eligible for MLTC but decides not to enroll, then is referred back by NYIA to LDSS, stating that LDSS determines plan of care "as usual." Again, **this language is misleading.** If Dolly is a dually eligible adult and determined eligible for MLTC, she must enroll in MLTC, unless she is seeking Immediate Need services. Separate notices should be used for those who applied to the LDSS for Immediate Need and then were referred to NYIA, or for those who applied for Immediate Need directly to the NYIA. It is too confusing to refer ALL APPLICANTs back to the LDSS, as those who do not have an Immediate Need must enroll in an MLTC. The notice conflates the many types of applicants, using language not applicable to all types, and will cause confusion.

6. **Consumer should not be required to call their plan or LDSS to share the results of the Outcome notice and request further development of their plan or care.** This is burdensome and violates due process by imposing an extra requirement after consumer has already applied for or requested approval of the service. This requirement appears in:

   a. **SCENARIO 2 – Mainstream member requesting PCS** - Slides 31, 34, 36 – Favorable Outcome 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.

   b. In **LDSS PowerPoint, slide 33, 36, 39** – MOVEit report gives LDSS a list of FFS individuals who *may be contacting them* to develop their POC as the individual has completed the CHA and CA appointments.

   When NYIA has completed those assessments, both plans and LDSS receive notice through MOVEit of the outcome of the assessments, showing that eligibility was approved. (LDSS slides 36 - LDSS Initial CHA Apptment Outcome Report generated daily). Why is burden on CONSUMER to contact LDSS or mainstream plan? This is like asking the consumer to apply for services twice.

   The plan or LDSS should proceed with developing plan of care, including conducting any further assessment needed, upon receiving notice through MoveIt or otherwise from NYIA that assessment was completed (per slide 42 of MMCO slides and 36-39 LDSS slides) and then issue a notice. Policy must make clear this is plan's and LDSS responsibility.

File Process, Scheduling and Technology

1. Slide 39 – Weekly appointment schedule posted on NYIA site. How many times per week will the schedule be updated for any given week?

    a. **Expedited** assessments must be conducted in only 6 days, so a weekly posting wouldn't be frequent enough to capture the timing of these.

    b. Does the schedule also indicate whether an assessment was completed?

    c. How does an MCO/LDSS identify their members/recipients from the full schedule? Does each MCO/LDSS get its own file?

2. MOVEit – LDSS slides 42-46 –

    a. Is the same as the Data Exchange described in MMCO slide 58?

    b. Do all plans and LDSS now have MoveIt and/or the Data Exchange set up with designated personnel who have been trained, with readiness review conducted? If not, how many plans and how many LDSS? Are they expected to regularly check or is there an alert system in place as files are updated?

    c. On May 1, 2022, how will those not yet set up with trained personnel and procedures obtain status of the assessments? MMCO slide 58 says Data Exchange takes several weeks to set up – is this true for MOVE-it?

    d. Slide 44 - Variance report - Variance Reasons – what do the different reasons mean - "ID info," "Communication and Vision," "Status" – upheld or overturned. What do these terms mean?

3. **CONSENT** prompts – (MMCO slide 44, DSS slide 51) Plan or LDSS must certify that they verified consumer applied for Medicaid. This makes sense for LDSS, but not for MMC or MLTC.
    a. MMCO or LDSS is asked whether this person signed DOH 5032. DOH 5032 is not the only HIPPA release that should be accepted. Since 2013, NYS DOH policy has required MLTC plans to accept the OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA. See *MLTC Policy 13.24: Authorization for Release of Protected Health Information – Applicable to Partial MLTC, MAP, and PACE Plans.*
    b. A protocol is needed requiring plans to get this signature on form 5032 or the OCA 960. Otherwise the lack of a signature will cause delays in enrollment and in authorization of services.

    c. What are the accommodations for people who physically cannot sign the form? The dialog box asks only yes or no if the person signed. Accommodations must be provided.

4. Slide 56 MMCO – What are examples of a business need for which an MMCO would need to access case files for someone not a member?

5. **Removal of individual from UAS-NY Case List -** Slide 47 – 49 MMCO (slide 56 LDSS)– . As written here it appears that the plan or LDSS is required to remove every consumer from

case list who did not accept the offered Plan of Care. We understand that a plan or LDSS would be instructed to remove an individual from this list if individual did not enroll in the MLTC plan, or if the LDSS or Mainstream plan denied authorization of PCS/CDPAP services. In the latter instance, the LDSS or Plan is required to send Notice of the denial to the consumer with appeal rights. BUT – we are concerned that the requirement to remove the consumer from the UAS-NY case list does not clearly distinguish those consumers who appeal, and could even be misunderstood and applied by MMCO and LDSS in such a way as to deprive consumers of notice and appeal rights.

a. What are the implications of removing a consumer from the case list? Should a consumer who received a notice of denial, and appeals it, still be removed from the case list?

b. The language implies that a consumer must accept the plan of care in order to receive services, which is not true. A consumer can accept the plan of care to get services started, but still appeal for more. This language must be clarified to ensure MMCO/LDSS issues notices in these instances to ensure notice and appeal rights are protected.

c. **Terminology – usage of "disenrollment"** - Mainstream – slide 49 tells plan to "disenroll" member who is no longer receiving PCS/CDPAP services. If this is meant to describe removal from the UAS-NY Case List, terminology should not use term "disenrollment," since in the managed care world that means disenrollment from the plan, not from a particular service. Use of this term creates more confusion. Also, what exactly is meant by "no longer receiving?" Since the Voluntary Changes in Plan of Care guidance from 2020 is still in effect, cases where services are paused should not be disenrolled.

   A definition should be added to ensure that a consumer who is temporarily hospitalized or in a rehab facility, or on a vacation or other temporary absence, is not "disenrolled" within the meaning of the UAS-NY Case List.

d. LDSS slide 56 – LDSS must remove individual from UAS-NY case list if no longer receiving services from LDSS and enrolled in MLTC. Won't NYMC enter this transaction because they are enrolling the person in MLTC, whether through auto-assignment or on a voluntary basis?

6. ENROLLMENT REPORT – MMCO slide 54 – screenshot shows monthly profile by RUG category and group. What is the purpose of showing RUG categories and groups?

7. **MISSING DISENROLLMENT REPORT –** slide 55 - shows org enrolled someone already enrolled elsewhere, such as in a different MLTC plan. This suggests enrollment in multiple plans simultaneously is possible. Doesn't NYMC block 2nd enrollment if consumer already enrolled in another MLTC plan?

8. Slides 42 – 68 – **Process Review** – **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 LDSS' readiness to utilize these systems. Each plan and DSS must draft its own internal procedures, train staff on them, and make 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, and final guidance still not issued, it is simply unrealistic to ask LDSS's and MMCO's to launch this May 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.

TOPIC 3 - Feb. 16, 2022 Presentations - (slide numbers below refer to MMCO presentation unless notes specify "LDSS slide")

Physician's Order Form (PO)

1. **Slide 12 – Sample PO form. This appears to be a new form.** See above at page 1, for our request that DOH post all new forms, and provide opportunity for comment by consumer advocates.

2. Slide 13 – **Sample PO form** - this form should be revised as follows to prevent denials that would be wrongful on their face, and also to ensure a higher quality of information elicited:

    a. **Questions 4 and 8.** Question 4 asks if consumer is capable of making choices about ADLs and managing their care, but if answer is NO, Question 4 does not ask if consumer has someone else to make those choices and manage their POC. Whether consumer has a designee is not asked until Question 8, but this would not necessarily prevent a finding of ineligibility based on Question 4. At minimum, Question 4 should say that if answer is NO then go to Question 8 for whether they have a designee.

    b. **Question 11.** Practitioner should be directed to state specific reasons why consumer's medical condition is considered unstable and provide some space for practitioner to do so.

    c. **Question 10.** Practitioner is asked to paint an incomplete picture of patient.

        i. Question 10 asks MD to list ADLs requiring PCS, listing the ADLs in a parenthetical. This question would elicit more consistent responses if it listed each ADL with a "yes" or "no" rather than asking practitioner to write in each ADL in the blank. If practitioner doesn't write in an ADL in the blank, this could be misinterpreted as meaning consumer does not need assistance with any ADLs that are not affirmatively listed by the practitioner, when practitioner could have just picked 1 or 2 to write in. This leads to incomplete and inconsistent responses.

        ii. Question 10 should be revised to indicate if consumer has any skilled tasks, require the practitioner to list the tasks that are considered "skilled," state

whether the consumer can perform those tasks on their own,[1] and if not, whether an informal caregiver is available to perform such skilled tasks. The form does not otherwise elicit the extent to which a consumer needs help with skilled tasks, which is an important part of evaluation of need for PCS or CDPAP.

iii. Many of the terms used in the form are terms of art defined in state regs, such as "administration of medications," which are commonly misunderstood by physicians and other professionals. The regulatory definitions should be printed on the form in full.[2] Mistakes are often made because of misunderstanding of how these terms are defined, that hurt consumers, such as a plan claiming that a consumer cannot self-administer medication, when in fact they can with permitted assistance of a PCA. For this reason, the form must be completed to describe the specific tasks that are allegedly "skilled," and include the key definitions on the form.

iv. Also of note, the form does not indicate anywhere that consumer requested CDPAP, which would allow personal assistant to perform any skilled tasks. This information should be provided to the IPP, along with the CHA.

Variance Process

1. Slide 17 (both MMC and LDSS PPTS)– Again, we disagree that the Mainstream and MLTC plans & LDSS need only initiate development of plan of care when the enrollee contacts them, not when they receive notice through MOVE-it that the assessments were completed. Again this places an excessive burden on the consumer and will cause harmful delays to consumers in need of service. Plans and LDSS must be required to develop plan of care as soon as notified by the NYIA of IA/CA completion.

2. **TIMING –** many of the deadlines are NOT specified for this process:

    a. Slide 21 and Slide 44 - Slide 44 says the **5-day deadline for MCO/LDSS to submit the variance form** runs from the date the MCO *reviewed* the CHA/PO, but it should run from the date the NYIA posted completion of the assessments in the portal or otherwise notified the plan/LDSS of completion. Otherwise there is simply no deadline. Based on the information presented, the MCO/LDSS can

[1] For instance, a consumer may need to inject insulin to manage diabetes and be perfectly capable of doing so, but be unable to use the toilet on her own.

[2] The sample form in the slide deck asks about patient's ability to take medication, with 5 options that do not align neatly with the personal care regulation. The options range from can self-administer to needs administration. In between, the only options are "needs reminding, needs supervision, and needs help with preparation." However, 18 NYCRR 505.14 (a)(5)(ii)(a)(10) defines administration of medication as a multi-step process "prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly." To prevent wrongful denials based on a need for "skilled" medication administration, the form should elicit the exact functional ability and need of the consumer.

review the assessments whenever they want, and the 5-day deadline runs from the date they indicate they reviewed them.

b. Slide 28 – **No deadline is given for the NYIA to return Variance request to MMCO if it is not complete.**

c. Slide 28-29 – **No deadline is given for the NYIA to forward the Variance request, if complete, to its QA dept**. In the "Fred" Scenario, the NYIA OSU reviewed the variance submission on the same day, and assigned it to QAN the next business day (3 calendar days later). But it is unclear if these processing times are required or just used in the example. Presumably this time limit is in Maximus contract and should be included in the public guidance.

d. Slides 28,29 -- **No deadline is given for the NYIA QA nurse (QAN) to request further documentation.**

e. **MMCO/LDSS has 10 business days to submit further documentation requested**. 10 business days is **excessive** for plan/LLDSS to submit further documentation – **especially if Immediate Need case or Expedited request filed with MMCO**. Also, while variance review is canceled if no more information is submitted after 10 business days in response to the QA nurse's request, an MMCO/LDSS would not initiate a variance request unless it already had such information in its possession. Plan is given notice in the variance request form itself (slide 25) that such supporting documentation should be submitted with the variance request in the first place. It is therefore unclear why the MMCO/LDSS is given 10 business days to provide additional documents after initiating a variance request at all.

f. Slide 30, 39 – No deadline is given for the QAN (QA nurse), once the variance documentation is complete, to make a recommendation to Clinical QA Dept leadership.

Clinical QA Dept leadership. must review the QAN's recommendation in **2 business days** – which is to either approve recommendation or request QA nurse to review/revise.

No deadline specified for QAN to notify MMCO by secure email in MOVEit of final QA decision. (and slide 39 also on the existing file, "Involuntary Disenrollments, Plan Enrollment Denial and Dispute status").

- Fred scenario slides 41-42 gives no deadlines for QAN notification to MMCO and for NYIA OSU to call consumer and send letter re new assessment.

g. NYIA has **10 days to do new CHA assessment in response to variance request**. (slide 21). Slide 21 says the new assessment must be done "within 10 days of receipt of the form." But this does not seem possible given all of the steps that occur before the NYIA receives, processes and approves a recommendation for a new CHA. After the plan/LDSS submits the variance request, there is an unspecified time for NYIA to review it, but it appears to be at

least 3 days, plus 10 days for plan to submit requested additional documentation, and 2 days for final QA review). The time limit for the new CHA assessment should be shorter.

- Slide 32 – IA OSU contacts consumer to schedule in **4 calendar days** of the variance review. Unclear if this is from review by Clinical QA Dept. leadership, which has 2 days to review it.

h. **Faster deadlines must be given for Immediate Need or expedited MMCO requests** – and for assessments needed for member to be discharged from hospital or rehab facility.

3. **New CHA should not replace the old CHA in UAS-NY system- and at a minimum must be provided to consumer in any appeal** (slide 21). The slides don't indicate what happens to the original CHA that was disputed. We understand that the new CHA would be used by the plan/DSS to develop the plan of care, but the original CHA assessment must be retained and provided to the consumer in the event of an appeal or fair hearing, and must be part of the evidence packet for these appeals.

   a. **The Variance form and accompanying documents should also be part of the evidence packet** available to the consumer. Slide 23 lists documentation that must accompany the variance form – including statement on letterhead. All such documentation must be provided to consumer as part of any evidence packet on appeal.

   b. Slide 32 – UAS-NY will label a CHA as a "variance assessment," which is good, but the original one must be retained on file as well. In the sample screen given on slide 33 it appears that only the date of the original CHA remains in the system (with strike-out) not the actual CHA.

4. Guidance should state LDSS/MMCO may not request more than one variance.

5. **Notice to consumer of variance –** slide 22 – When MMCO notifies member that findings on the recent CHA do not align with what the plan is observing, and that a new CHA may be necessary, the notice should specify the facts or clinical findings that plan/LDSS claim do not align.

   a. Consumer is told "that they can decide not to have a new CHA conducted." Consumer has the right to weigh the delay caused by a repeat assessment with the possible benefit to the consumer of the repeat assessment. Consumer can not make this choice without being informed exactly what the discrepancy is.

   b. Slide 35 – NYIA gives notice of variance to consumer, explaining that MMCO/LDSS requested a new assessment and that you will be contacted for a new one. Is this written notice from NYIA? Fred scenario says consumer is called and does receive written notice.

      - Notice should specify what fact or finding was disputed.
      - Notice should specify right to refuse reassessment.

- Fred scenario slides 41-42 gives no deadlines for NYIA OSU to call consumer and send letter re new assessment.

6. **No new PO required with variance –** slide 21 -- While we do not want further delays, if a material change is made on the CHA, this should be given to the practitioner(s) that completed the PO to make any related changes.

Independent Review Panel (IRP)

1. **When IRP not required – grandfathered cases –** slides 47, 49 - We appreciate PPT confirms that IRP is only required in a new case where consumer does not already have > 12 hours/day on average. Slide 49 helpfully confirms that IRP referral is not needed if the increase is from 24-hour live-in to 24-hour split shift. These policies should also be clarified in future official guidance, as the regulation is not clear on this point. See 18 NYCRR 505.14(b)(4)(xi)(b)(stating, " *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")(emphasis added)..

2. **When IRP not required – Plan did not refer case for IRP because it determined consumer needed 12 hours** or less on average, and consumer appealed at Fair Hearing or External Appeal. At an MMNY meeting on Jan. 4, 2022, DOH confirmed its intent that an ALJ may reverse a plan/LDSS decision and order authorization above 12/hours without an IRP. We ask that this would be made clear in guidance, both for fair hearings and external appeals. Otherwise, ALJs or External Appeal reviewers could affirm a denial of an increase for lack of an IRP, if they interpret the regulation as requiring it as a condition of authorizing more than 12 hours/day.[3] Alternately, ALJs could remand the hearing to the plan/LDSS, which could launch an endless cycle of remands.

3. **Timing:**

    a. Slide 47 – States that the MMCO must submit plan of care to NYIA for IRP review in **1 business day of developing proposed plan of care**. The submission deadline should run from when the NYIA notified the MMCO that the IA/CA was completed and available, not from when the MMCO developed the plan of care. The MMCO should not be able to delay referral for the IRP by delaying development of the POC.

[3] 18 NYCRR 505.14(b)(4)(vi) provides in part, "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." This language doesn't make clear that a fair hearing or court may require the DSS or MMCO to authorize more than 12 hours if no referral was made for an IRP. Also, DOH confirmed to MMNY that guidance would clarify that External Appeals done by the NYS Dept. of Financial Services must also be complied with, regardless of whether an IRP was done.

b. Slide 71 - MMCO may submit IRP review form if it PLANS to enroll member, not just for new enrollees. This is helpful and should be made clear in official guidance. Since enrollment is only effective the 1st of the month, the MMCO's ability to submit the IRP review form in advance of enrollment will help to reduce delay of initiation of services after enrollment.

c. Slide 55 –**No deadline is specified for OSU to assign the IRP to the Lead Physician** upon receipt of IRP Request form.

d. Slide 55 – Lead physician must be available to complete IRP over next **6 calendar days. A faster timeline should be required for Immediate need or expedited requests** –as they are necessary for plan/LDSS to meet statutory and regulatory deadlines.

e. Slide 55 -56 – Lead physician reviews, selects 2nd practitioner, determines whether to evaluate consumer or if needs additional info from MMCO or consumer's physician(s). OSU coordinates these requests with MMCO. If consultation or documentation not received by **4th day** after Lead physician accepted the request for an IRP, NYIA will continue to review based on what is on file and make recommendation.

   i. Is this 4th day a calendar day or business day?

   ii. "NYIA" will continue to review based on what is on file – is that reviewer the Lead Physician and panel?

f. Slide 57 – Lead physician completes Panel Report – either agrees with recommended POC or suggests modifications.

g. Slide 65 – if MMCO/LDSS participate in UAS-NY Data Exchange, IRP info set in **nightly feed.** If does not participate in this Exchange, how is MMCO/LDSS alerted that IRP recommendation is on file in UAS-NY?

4. **Temporary Plan of Care** (slides 51-54)

   a. **Significant inconsistency with regulation – the slides indicate MMCO may authorize services for 12 hours or *less*, not *more* than 12 hours as the regulation provides.** 18 NYCRR 505.14(b)(4)(vi); 505.28(e)(4). The policy may not be more restrictive than the regulation. The whole point of this part of the regulations was to respond to consumer comments expressing concern about the delays in authorizing medically necessary care over 12 hours/day.

5. Consumer Notice after IRP Review - slide 51 - if IRP recommends fewer hours than plan proposed in POC or higher level of care (nursing home), and plan or LDSS agrees, says notice of reduction or discontinuance would include fair hearing language.

   a. Presumably the referenced notice is from the plan or LDSS. If this is incorrect, and the notice is from Maximus, model notices should be made available for stakeholders, including consumer advocates, to review.

b. For MMCO cases, the slide saying notice must have Fair Hearing language is incorrect, as plan IAD notice has info about requesting Plan Appeal, not a fair hearing.

c. The policy should specify that if, after the IRP review, the plan or LDSS determines to authorize fewer hours than it authorized in a Temporary plan of care, the IAD notice or LDSS notice should be a notice of reduction, not a denial, with Aid Continuing rights.

6. **IRP Report & Recommendation** --

   a. Slide 61 shows form only shows if reviewer spoke to consumer or their physician, not whether they ASKED to consult with them and if the consult wasn't/ could not be scheduled. Form should indicate any requests for consults the reviewer(s) made, and the status of these requests.

      Likewise, form should specify what documentation the IRP determined was needed and that was requested, and which documentation was and was not received.

   b. The purpose of the IRP review is to make a recommendation of whether the proposed plan of care is reasonable and appropriate to maintain the individual's health and safety at home. Slide 54, regulation. The purpose is not to second-guess the plan or LDSS on determining what services are medically necessary. The Plan, not the IRP is responsible for determining a person-centered service plan.

      In Scenario 2, however (slides 68-69), IRP recommendation to substitute more SADC hours and reduce hours of PCS "to address loneliness" does not fit within IRP mandate. Slide says change will "ensure safety during her long days alone in the home" but unclear that substitution of more SADC for PCS gives her more total coverage. If IRP mandate is to ensure health and safety, how can they ever recommend FEWER hours of coverage? Also, balance of different services in POC is supposed to be consumer's choice under person-centered planning.

7. **If Consumer rejects proposed plan of care -** (Scenario 2 slide 69)

   The scenario describes consumer's option of rejecting a plan's proposed plan of care and finding another MMCO that would offer more PCS hours. Telling the consumer about the option to change plans, instead of to appeal the amount of hours proposed, will cause further delays and stifles consumer choice. Even if consumer is within the 90-day grace period in lock-in rules, she must enroll in 2nd plan by the 18th of month to secure enrollment for the 1st of the next month. If the MMCO's final plan of care is offered mid-month, this will add yet another 4-6 weeks at least for consumer to enroll in a new plan, further delaying initiation of services.

8. **Evidence packet for plan appeal or fair hearing** - We hope that a future presentation and the final guidance will specify what documents must be provided. The NYIA poses a huge change in the important due process right to receive the consumer's file, in that much of the documentation will now be under NYIA's custody, rather than the plan or LDSS. In the comments above we have identified some documents that must be provided, including but not limited to:

a. all documents submitted to or reviewed by the IA or the CA,
b. the LDSS/MMCO Variance Request form and supporting documents, and any communications between the LDSS/MMCO and the NYIA concerning a variance request;
c. The original CA as well as the second CA that was completed if a variance request was approved;
d. all documents obtained and/or reviewed by the IRP,
e. all documents showing any additional documents or consults requested by the IRP.