NYLAG
New York Legal Assistance Group

To: NYS DOH – NYIA
From: NYLAG
Date: May 4, 2022
Re: Questions about MLTC Policy 22-01 and 22 OHIP/ADM-01 ["the ADM"]

We write to express continuing concerns about NYIA capacity and the readiness of LDSSs, plans and Maximus to commence NYIA on May 16th, and to pose questions about the ADM and MLTC Policy 22-01. We were disappointed that these issuances did not make public the many new notices and forms that will be used for the NYIA. The comments we already made on the excerpts of the notices included on the PowerPoints, and many other questions, remain outstanding. We limit these comments to those NYIA activities commencing on May 16th. Given the many policies and procedures that are still not developed, and the continuing capacity questions, this rollout should be further postponed.

1. **We request that the Department of Health establish and publicize a new complaint email and phone number for consumers seeking assistance with the NYIA program**. The MLTC TAC unit and Managed Care complaint lines are only available to those enrolled in those plans or seeking to enroll in MLTC plans. There is no complaint number for those applying for services to their LDSS.
2. **CAPACITY** – Some recent examples of delays in CFEEC scheduling are listed below. There should be a solid track record of ability to schedule assessments in 14 days statewide before rolling this out, and this is just not the case.

Date of call to NYMC	County	Scheduled CFEEC	No. of days	Reported to TAC?
4/21/22	NYC (Staten Island)	May 11th	19	Yes email from Beverly Koster 4/21
4/5/22	Erie	5/4/22 – but nurse no show (in-person)	29	Yes email from Nichole McDonald
3/29/22	NYC (Brooklyn)	5/4/22 – but nurse no show (in-person); rescheduled for 5/25/22 after call that took 1 hr 20 min	35 1st time but canceled 57 days 2nd	Yes email from Nichole McDonald 5/4/22
3/28/22	Erie	5/11/22	44	Yes email from Nichole McDonald

3. **Mainstream Managed Care Plans - Absence of guidance –** Neither the ADM nor the MLTC Policy apply to mainstream plans. A directive is needed to clarify the procedure for mainstream members to request PCS/CDPAP services and whether the NYIA or the MCO issues notice of denial of eligibility for PCS/CDPAP. Given the lack of any guidance for mainstream plans at this late date, **we urge that the NYIA for mainstream plans be delayed.**

    a. The directive for Mainstream plans should clarify that the consumer or the plan may call the NYIA helpline to initiate a request. The 1/14/22 MMCO presentation slide 16 states, "NOTE Consumer must be on the call with the plan to begin the process of scheduling." This is a burdensome requirement and unnecessary.

    b. If the CA determines the consumer's medical condition is not stable, and is otherwise not eligible, it seems notice is issued by NYIA. However, this may violate 42 CFR 438.210, which requires the plan to give adverse notice.

    c. If NYIA, rather than the plan, issues the adverse outcome 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 consumers to request Evidence Packets and other case information to prepare for a hearing. The volume of hearings will significantly increase from the existing number of CFEEC appeals, even more so if and when the 3-ADL minimum needs criteria go into effect.

    d. NYMC nurses have traditionally only evaluated based on the MLTC eligibility standard – the need for ADL assistance for 120 days. This 120-day requirement is solely for MLTC, not for LDSS or mainstream plan services. We wish to confirm that NYIA nurses are trained to apply these different standards for different consumers.

    e. Since private duty nursing services ("PDN") are in the mainstream benefit package, a denial notice finding the medical condition unstable for PCS or CDPAP should apprise the consumer of potential eligibility for PDN and the plan should be required to follow up with an assessment for this service.

4. **Requesting and Scheduling the NYIA CA and IPP**

    a. For LDSS cases, we are glad to see that the ADM at page 6 seems to abandon the requirement from the Powerpoints that the consumer must first call the LDSS and then do a 3-way call to request the NYIA. The ADM confirms that consumers may call the NYIA directly, whether referred by the LDSS, a plan, a discharge planner, or we presume any other entity.

    b. **Policies do not clarify that NYIA must permit a consumer's Power of Attorney or Designated Rep to speak on consumer's behalf in scheduling assessments, etc.** The NYIA should be able to access whether a designated representative is on file with the DSS. The guidance gives no procedure for that. If the NYIA says it has no record of designated

representative, will there instructions for how to designate someone, including a fax number or email address to send a power of attorney, or designation of representative form?

Even with no formal designation, a family member, friend, social worker, care manager, or attorney should be allowed to schedule the appointments.

c. DOH should clarify that NYIA may not require a current photo ID to do the assessment. NYMC has repeatedly refused to do CFEEC assessments if a photo ID has expired. Many consumers who have difficulty traveling have not been able to renew a photo ID, and should not be denied services as a result.

5. **CHA and IPP should be scheduled and conducted while Medicaid application is pending**. The final regulation requires only that "a members eligibility for medical assistance … must be established *before services are authorized or reauthorized*." 18 NYCRR §505.14(b)(4)(i)(emphasis added). This regulation codified past DOH policy, which allowed a CFEEC to be scheduled and conducted for a consumer whose Medicaid application was pending, which minimized enrollment delays. See DOH FAQs 9/29/2014, https://www.health.ny.gov/health_care/medicaid/redesign/2014-09-29_cfeec_faqs.htm.

> Q13. Will the CFEEC apply to consumers with pending Medicaid? Is there going to be a process in place while a Medicaid application is being processed?
>
> A13. Currently, CFEEC will complete the UAS and provide education to a consumer with a pending Medicaid application.

Now, MLTC Policy 22-01 states a rule that is stricter than the regulation cited above and prior DOH CFEEC policy: "The NYIA will only conduct the initial assessment process for individuals with active Medicaid." This rule must be modified to conform to the regulation, under basic principles of administrative law. We understand that a consumer may not enroll in the MLTC plan until Medicaid is approved, but we fail to understand why DOH prohibits the NYIA from conducting the initial CHA and CA until Medicaid is active, in a departure from past CFEEC policy. This will cause even more enrollment delays – and is stricter than the regulation.

Also, the ADM is internally inconsistent on this point. Page 5 says, "The LDSS can assess the individual's Medicaid eligibility for appropriate coverage concurrently with NYIA's assessment process to reduce the time to service authorization once if the individual is determined to be financially eligible for Medicaid coverage of these services and, where applicable, MLTC enrollment." This sentence is circular and does not make sense; NYIA's assessment process can run concurrently with LDSS' assessment of Medicaid eligibility only if '"…the individual is determined to be financially eligible for Medicaid coverage of these services and, where applicable, MLTC enrollment." Moreover, at page 6 the ADM says, "Once the NYIA CSR confirms the individual has active Medicaid, the CSR will schedule both a CHA and a clinical appointment." This suggests that the processes cannot run concurrently.

The MLTC Policy and ADM should both be amended to conform to the regulation and past policy, and permit the NYIA to conduct the CHA and CA while the Medicaid application is pending, to minimize delays.

a. **Spend-down cases -** In addition, the Policy and ADM should clarify that individuals do not have to meet their spend downs before having CHA or IPP conducted or before services are initiated. We frequently hear about consumers receiving misinformation about the impact of their spend down on their ability to enroll in MLTC or start services.

6. **Choice of Telehealth or In-person CHA and IPP assessments** - The ADM advises that an applicant can participate in the IPP via telehealth or exam. Will the in person exams be conducted in the applicant's home if the applicant does not have access to video for a telehealth visit, or the individual prefers an in-person assessment?

7. **Questions on 14 day timeframe to schedule CHA and IPP:**

   a. **Does the 14 days include 2-3 days to send Outcome Notice?** We asked this on 2/2/22 and this is still not clear. The ADM at page 6 states, "If these appointments cannot be completed in this timeframe, the CSR must note the reason in the call record." What consequence is there to Maximus for failing to schedule and complete these within 14 days, besides a notation in the call record?

   b. **What recourse is there for the consumer for delays?**

   c. **Assuming NYIA will use the automatic callback system** that NYMC recently instituted for calls to the CFEEC hotline, the 14-day time limit should run from the consumer's initial call, not from the callback. Please confirm whether this is the case.

5. **The lack of any procedures for the consumer to submit documents about their medical condition to NYIA, and for these documents to be made part of the record transmitted to the LDSS or plan for consideration in the plan of care, compel delay in implementing NYIA.**

   a. In the commentary published with the final 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." (Final PCS/CDPAP regulations posted 8/31/21, https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/Personal%20Care%20Services%20and%20Consumer%20Directed%20Personal%20Assistance%20Program.pdf, pp. 187-88). However, the ADM and MLTC policy fail to specify exactly how a consumer may submit medical records to the NYIA and its assessors.

   b. **Where assessments are conducted by telehealth, it is particularly unclear how a consumer may submit records** to be considered by the assessor. The ADM at page 6 says, regarding the CHA, "The individual will be advised to have

relevant medical records available, including a list of current prescriptions." However, it does not specify how the consumer can submit medical records if the assessments are conducted by telehealth.

c. **The policies must be amended to require NYIA and its assessors to accept any documents submitted by or on behalf of the consumer, whether the assessment is in-person or by telehealth.**

d. **Though use of the M11q and DOH-4359 are discontinued for purposes of initiating a request for PCS/CDPAP, the LDSS or mainstream plan should be instructed to submit these documents, if received, to NYIA** for consideration in the CHA and IPP. ADM p. 7. Given the lack of any consumer-facing information on this huge change in decades-old procedures, inevitably consumers will submit forms signed by their physicians to the LDSS on and after May 16, 2022, unaware of the new rules. The M11q and DOH-4359 contain information about a consumer's medical condition that they have the right to have considered by NYIA. We do appreciate that the ADM directs LDSS to accept the M11q and DOH-4359 in lieu of the new Practitioner's Statement of Need (DOH-5779) for Immediate need cases after July 1, 2022, but the same directive should apply prior to July 1, 2022 as well.

e. **NYIA must be required to transmit to the Plan or LDSS any documents submitted by the consumer**.

8. **NYIA Notice to Consumer of Next Steps if Found Eligible** -The last paragraph of the ADM Part c.i. on page 6 is vague and confusing.

> "Upon completion of both the CHA and the clinical appointment, the individual will receive a Notice providing direction on next steps, including whether the individual may be eligible for MLTC plan enrollment (in which case they should contact NYIA) and how to contact the LDSS to complete the care planning and service authorization process. All individuals assessed after being referred by the LDSS or approaching the NYIA on their own who are not enrolled in an MMCO will be advised to contact their LDSS or the NYIA for next steps."

The ADM and MLTC policy should require the NYIA to screen which consumers are subject to mandatory MLTC enrollment, so would be referred to NYIA for MLTC enrollment, and which consumers are excluded from MLTC enrollment (e.g. enrolled in hospice, OPWDD, TBI or NHTDW waivers), or exempt (ages 18-21 or age 21+ Medicaid-only), and referred to the LDSS. As written, consumers who are excluded from MLTC population may be referred back to NYIA and waste time trying to enroll in an MLTC from which they are excluded. Additionally, those enrolled in Mainstream plans should be referred back to the proper department within that plan for a service authorization to be entered. The ADM at bottom of page 7 is more clear about "exempt" consumers having a choice of MLTC or FFS, but the earlier part of the ADM is less clear, suggesting that the outcome notice will be unclear. We request a copy of this notice to review.

9. **NYIA Referrals of Consumers back to LDSS – We Question Whether Systems are in Place for May 16th.** The ADM says NYIA notice will tell the consumer "…how to contact the LDSS to complete the care planning and service authorization process." What phone numbers will NYIA be giving to contact the LDSS? If they are merely the phone numbers on the DOH website, this will send consumers on a wild goose chase in many counties. The number listed for HRA in this directory on the DOH website: https://www.health.ny.gov/health_care/medicaid/ldss.htm is the HRA Info-Line, which is for all HRA programs, not just Medicaid. There is a separate Medicaid Info-line, but that is also not sufficient for this purpose because it is not housed within the Home Care Services Program at HRA. To our knowledge, there is no public facing number for the Home Care Services Program. The same may be true in other counties. The NYIA should not move forward without DOH confirmation that there is a public facing number to handle consumer referrals back to the LDSS in each county. The list of these numbers should be posted on the DOH website and also on NY Medicaid Choice website (which we notice has no mention of NYIA starting).

10. **LDSS Must Proceed to Develop Plan of Care without being Contacted by the Consumer–** the same paragraph on page 6 of the ADM quoted in the foregoing paragraph says that upon completion of the CHA and IPP, the NYIA notice will tell the consumer "how to contact the LDSS to complete the care planning and service authorization process." ADM p. 6. As we have said before, the consumer has already applied for PCS/CDPAP. The notice should simply tell them to expect to be contacted by their LDSS. They should not have to contact the LDSS to initiate the care planning process. The DSS will be apprised of completion of the CHA and PO through NYIA's two daily outcome reports, described on page 8 of the ADM. The LDSS should be required to obtain these reports on a daily basis from the NYIA portal and proceed to the next step of completing the evaluation and plan of care, regardless of whether the consumer contacts the LDSS. Moreover, since the LDSS must complete a plan of care within 7 business days of receipt of the CHA and PO (ADM p. 9), it will only sabotage the DSS from meeting this timeframe if they have to wait to hear from the consumer.

11. **Independent Review Panel –**

    a. MLTC Policy 22-01 at page 5 says, "The MLTC plan should submit the IRP review request once the applicant has agreed to the proposed plan of care and the MLTC Plan has submitted the enrollment to NYMC." This sentence implies that the MLTC plan may submit the IRP review request even before the consumer is enrolled, which we support, so that services can commence immediately upon enrollment. However, the requirement that the applicant "agree" to the proposed plan of care is unnecessary, will cause further delays, and potentially violates consumer appeal rights. If the MLTC plan's plan of care is for 24-hour live-in, for example, but the consumer requested 24-hour 2x12 split shift, they should not be required to "agree" to the plan of care in order for the plan to submit for IRP review. This could be interpreted as requiring them to waive their appeal rights, which is improper.

b. **No deadline is specified in the ADM or MLTC policy for the plan/LDSS to refer case for the IRP** even though the Feb. 16th Powerpoint said that the MMCO must refer the plan of care to NYIA for IRP review within **1 business day** of developing the proposed plan of care (Slide 47). We had criticized that policy because the 1-day 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. However, DOH took a step backward in omitting any deadline whatsoever in the formal policies.

c. **No deadline is specified in the ADM or MLTC policy for IRP to be completed**, even though the Feb. 16th PowerPoint says the "Lead physician must be available to complete IRP over next 6 calendar days." 2/16/22 PowerPoint slide 55. We understand this is the NYIA's deadline, not the plan's or LDSS', but still the ADM and MLTC policy set forth the consumer rights as well in this process, and they have the right to adherence by all parties to these deadlines which should be spelled out.

d. **Right of consumer to submit documentation for consideration by IRP** - MLTC Policy says, "The MLTC plan may submit any documentation they wish to support the proposed POC." P. 5. This statement gives the plan discretion not to submit any documentation submitted by the consumer in support of their request. The plan must be required to submit any such documentation from the consumer.

e. Clarify Plan/LDSS Must authorize > 12 Hours/day if ordered by an External Appeal, despite lack of an IMR/IRP. (renewing request sent on Jan. 6, 2022)

The regulations, and the ADM at page 9, state that the requirement to perform an IRP review does not apply to service authorizations pursuant to a fair hearing or other order by a court of competent jurisdiction. See 18 NYCRR §505.14(4)(vi) and 505.28 (e)(4). We are disappointed that the MLTC Policy 22-01 did not clarify that the IRP is also not required for service authorizations pursuant to an External Appeal filed under Title II of Article 49 of the NYS Insurance Law. When we raised this issue at the Jan. 4, 2022 meeting with MMNY, as we had previously, DOH said it would look into this issue. If this is not clarified, and a plan refused to authorize more than 12 hours/day because there was no IRP, even though its decision was reversed on External Appeal, the policy would conflict with the NYS Insurance Law.

11. Notice and Hearing rights –

a. **No deadline is stated for NYIA to send an adverse outcome notice to consumer.** The 1/26/22 DOH presentation for MMCO's said the NYIA-issued Options Notice must be sent within 2-3 business days after assessments finalized (slides 25, 31). This requirement should be in the official policies. As said above, the time to send that notice should be included within the 14-day limit to conduct the CHA and IPP.

b. **The Department of Health must clarify which agency must give adverse notice and be present at a fair hearing** for a denial of PCA/CDPAP eligibility. The ADM states at p. 7 that NYIA will issue the outcome notice, but at p. 11 the ADM states that the LDSS will be responsible for the defending the decision at the fair hearing. The ADM at page 9 says, "if the LDSS determines that the individual does not have a need for PCS/CDPAS, the LDSS would be responsible for providing appropriate notice, including agency conference and fair hearing language." If NYIA has found the consumer medically stable to receive PCS/LDSS, and if not self-directing, having someone to direct care, it is unclear in what circumstance the LDSS could find no need for services. It would defeat the concept if an Independent Assessor for the DSS or Plan could find a consumer ineligible that NYIA found eligible.

c. While the ADM says both the appellant and the LDSS can **call the NYIA as a witness at the fair hearing**, it only explains how the LDSS does this, not how the consumer can. ADM page 11.

d. **Evidence Packet -** Whether the hearing is requested against NYIA, plan, or LDSS, guidance and all adverse notices must specify how consumer can request the evidence packet**.** The ADM and MLTC Policy do not have this information.

- Evidence packet must include a copy of all NYIA assessments as well as any plan or LDSS documents, and any documents submitted by the consumer to the NYIA, Plan, or LDSS.
- If DSS or plan requested a variance, the evidence packet should receive both the original CHA and the second one, along with the variance request submitted by the LDSS or MLTC. We disagree with policy that the 2nd CHA "replaces" the original CHA where a variance was requested. This is relevant information that should continue to be part of the consumer's case record.

e. **Fair hearing liaisons from NYIA** must be provided to advocates, consumers, and providers. What coordination has taken place with OTDA to ensure that that NYIA can receive fair hearing communications from OTDA?

f. **Concern about OTDA delays in scheduling Fair hearings –** DOH should be aware that OTDA has severe backlogs in scheduling hearings, which will particularly impact denials issued as a result of the May 16th NYIA roll-out, because denials of PCS/CDPAP or MLTC enrollment are not eligible for Aid Continuing,

g. **Clarify ALJ can order > 12 hours/day if found Medically Necessary, even without IMR review –** renewing our request sent on Jan. 6, 2022.

Section 18 NYCRR 505.14(b)(4)(vi) could be interpreted as prohibiting an ALJ or DFS in an External Review from ordering > 12 hours because no IMR was done. This needs to be clarified.

At the meeting with Medicaid Matters on Jan. 4, 2022, Brett Friedman expressed DOH's intent that an ALJ can approve over 12/hours without an IRP/IMR, and we

are disappointed this has not been made clear in the 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.

12. Variance request

a. Deadline for LDSS to submit a CHA Variance Form – ADM at p. 12 only says DSS must submit "with due expediency upon discovery of a mistake or clinical disagreement." The Powerpoint dated Feb. 16, 2022 at slide 44 gives a 5-day deadline for MCO/LDSS to submit the variance form. This deadline – while not short enough in our view -- should have been included in the ADM and MLTC policy directives. Additionally, the Powerpoint slide said the 5 days runs from the date the MCO reviewed the CHA/PO. We believe the time limit 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.

b. Like the powerpoints, neither the ADM nor the MLTC Policy give any deadline for the NYIA to return the Variance request to the MMCO or LDSS if it is not complete, for the NYIA to forward the Variance request, if complete, to its QA dept, for the NYIA QA nurse (QAN) to request further documentation, or for the QA nurse to make a recommendation to the NYIA Clinical QA Dept leadership. The only deadline in the PowerPoint, but not in the ADM or MLTC policy, is that the Clinical QA Dept leadership must review the QA Nurse's recommendation in 2 business days and either approve it or request QA nurse to review/revise. Feb. 16, 2022 slides 28-30, 39.

c. 10 days for the MCO or LDSS to provide additional information to support the need for a repeat assessment is excessive. Certainly once expedited and Immediate Need applications begin July 1st, this time period must be reduced.

Thank you.

Sincerely,

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