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New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
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Re: Comments on Notice of Proposed Rulemaking – Amendment of 18 NYCRR §§ 505.14 and 505.28 (Immediate Need for Personal Care Services and Consumer Directed Personal Assistance)
I.D. No. HLT-43-15-00003-P

Dear Ms. Ceroalo:

Thank you for the opportunity to comment on the proposed regulations regarding Immediate Needs for Personal Care Services and Consumer Directed Personal Assistance that would amend 18 NYCRR §§ 505.14 and 505.28.

Empire Justice Center is a not-for-profit public interest law firm focusing on civil legal services for low-income individuals. In addition to policy analysis, litigation and direct client representation, we support legal services programs across the state with training and technical assistance, and act as an informational clearinghouse. We focus on a number of issues affecting low income individuals and families including access to health care and Medicaid. A significant portion of our health law work focuses on helping Medicaid recipients access and maintain community-based long-term care services. Beyond assisting individual clients, we also educate advocates and providers about changes in the Medicaid program that affect beneficiaries. In recent years we have focused particular attention on the statewide roll out of mandatory Managed Long-Term Care (MLTC).

The proposed regulations amending 18 NYCRR §§ 505.14 and 505.28.seek to implement New York Social Services Law (SSL) §§ 364-j(31)(a), 365-a(2)(e)(iii), and 366-a(12) which, together, require expedited Medicaid eligibility determinations for people with an immediate need for personal care services (PCS) or consumer directed personal assistance (CDPA), as well as the provision of such services pending enrollment in managed care. Although not referenced in the regulatory impact statement, the proposed regulations are also presumably responsive to the July 13, 2015 Order in Konstantinov v. Zucker, Supreme Court, New York County, requiring the

Department of Health (the Department) to issue regulations regarding the provision of immediate temporary PCS.

The Empire Justice Center makes the following comments on the proposed rulemaking. These comments aim to strengthen the proposed regulations so that low income Medicaid recipients will expeditiously receive the home care they need to live safely in their homes.

A. **Timing**

We are concerned that the time period from submitting a completed request for immediate need PCS/CDPA to receiving services is too long under the proposed regulations. As drafted, individuals who are already authorized for Medicaid coverage with long term care will wait 12 days to receive the services needed to maintain their health and safety in the community and those defined as a "Medicaid applicant with an immediate need for personal care services" will not receive needed services for up to 19 days. By allowing up to 12 to 19 days to initiate services, the proposed regulations fail to respond to the immediate need they purport to address.

Our clients who need PCS/CDPA cannot wait a week and a half or more to receive the services that the proposed regulations acknowledge are needed to maintain their health and safety in the community. In our experience, when these services are not provided immediately, our clients have had been injured from preventable falls in their homes, had avoidable emergency room visits, and been forced to await needed home care services at a nursing home.

We urge the Department of Health (the Department) to significantly shorten the proposed time frames so that the people the regulations intend to help will actually receive care that will promptly ameliorate the health or safety risks they face without such care. The following suggestions will help speed up the PCS/CDPA authorization process for people with an immediate need for such services:

1. **Individuals who received an expedited Medicaid eligibility determination under the proposed regulations:** The number of days it takes to conduct assessments for, authorize, and provide PCS/CDPA can easily be shortened by three days for those who have already gone through an expedited Medicaid eligibility determination because the LDSS already took three days during the eligibility process to determine that there is an immediate need for PCS/CDPA. See Proposed §§ 505.14(b)(7)(ii)(a); 505.28(k)(2)(i).

2. **Permit physician's to recommend the number of PCS/CDPA hours needed and allow LDSS's to authorize services based on the physicians order and attestation of need without requiring a social and nursing assessment.** Alternatively, allow the nursing assessment to take place after services have been authorized and initiated as is permitted under current

§ 505.14(b)(5)(iv). Since most people seeking immediate PCS/CDPA will be transitioned within a few months to MLTC, sooner if they go into MMC, there will be a second opportunity for a full assessment of needs.

3. **Forego the social assessment**. All applicants for immediate PCS/CDPA will have already attested to the availability of informal supports making the social assessment redundant except to the extent that it is need to ascertain the availability of adequate sleeping arrangements for live-in cases.

4. Individuals expressing a desire for CDPA should be referred, at the time of their application for immediate CDPA/expedited Medicaid, to a fiscal intermediary under contract with the LDSS to begin the process of enrolling their desired aides with that fiscal intermediary. If the aide enrollment process occurs concurrently with the Medicaid eligibility and/or immediate CDPA approval process, it will significantly reduce delays in obtaining services. Expedited procedure for prospective aides to qualify and register as aides with the fiscal intermediary under contract with the LDSS should also be established.

B. **Determining "Immediate Need" for Medicaid Applicants and Recipients**

1. We are pleased that the Department has eliminated the requirement that an individual either be in receipt of Protective Services for Adults (PSA) or have a determination that a PSA investigation of the applicant is necessary, which was suggested in previous proposed amendments to § 505.14.

2. **Expand the activities of daily living that are considered in determining whether an individual has an immediate need for PCS/CDPA.** (Proposed §§ 505.14(b)(7)(i)(a)(2); 505.14(b)(8)(i)(b)(2)(i); 505.28(k)(1)(i)(b); 505.28(l)(1)(ii)(b)(1).)

   The proposed regulations limit a finding of immediate PCS/CDPA to individuals with a physician-documented need for "toileting, transferring from bed to chair or wheelchair, turning or positioning in bed, walking, or feeding." Proposed Sections 505.14(b)(7)(i)(a)(2); 505.14(b)(8)(i)(b)(2)(i); 505.28(k)(1)(i)(b); 505.28(l)(1)(ii)(b)(1). While these activities of daily living are important, the proposal is insufficient because it:

   (a) Omits other key activities critical to maintaining health and safety in the home such as, assisting with medications, meal preparation, bathing, and assisting with medical supplies and equipment;

   (b) Uses a more restrictive standard than is used under current § 505.14(b)(iv) (which is proposed for repeal). The standard under that subsection is "needs Level I or Level II services immediately to protect his or her health or safety." 18 NYCRR § 505.14(b)(iv).

(c) Impermissibly narrows the requirements of the SSL provisions regarding immediate need PCS/CDPA. Those provisions do not limit the availability of expedited PCS/CDPA services and Medicaid determinations to people who need immediate assistance with specific ADLs, but instead speak to an immediate need for "personal care" or "consumer directed assistance" generally, regardless of the ADL at issue. See SSL § 364-j(31)(a) (requiring provisions of services to Medicaid recipients who need "immediate personal care or consumer directed personal assistance services pursuant to [SSL § 365-a(2)(e)] or [SSL § 365-f], respectively, or other long-term care"); SSL § 366-a(12) (requiring expedited Medicaid eligibility determination for applicants with an "immediate need for personal care or consumer directed personal assistance services pursuant to SSL § 365-a(2)(e)] or [SSL § 365-f], respectively.")

Rather than delineate which ADL needs can trigger an immediate need finding, the touchstone of an immediate need finding should remain whether assistance with any ADL is essential to maintaining health and safety at home.

3. **Attestation Regarding Availability of Other Means to Meet PCS/CDPA Needs.** (Proposed §§ 505.14(b)(7)(i)(a)(3); 505.14(b)(8)(i)(b)(2)(ii); 505.28(k)(1)(i)(c); 505.28(l)(1)(ii)(b)(2).)

   The attestation regarding the lack of other available means to meet an individual's need for PCS/CDPA should account for whether those other resources will continue to be available and whether they are sufficient to meet the needs identified in the physician's order.

   (a) **Voluntary and Informal Caregivers** (Proposed §§ 505.14(b)(7)(i)(a)(3)(i); 505.14(b)(8)(i)(b)(2)(ii)(A); 505.28(k)(1)(i)(c)(1); 505.28(l)(1)(ii)(b)(2)(i).): Individuals in need of personal care may rely on voluntary informal caregivers out of necessity, but the individual may not be comfortable with certain caregivers continuing to provide care or the caregiver may not be willing to provide ongoing services. In such cases, the Local Department of Social Services (LDSS) should not base a determination of immediate need on an attestation regarding current assistance provided by informal caregivers, but should instead seek an attestation regarding the ongoing availability of informal caregivers.

   (b) **Services Provided by Homecare Services Agency** (Proposed §§ 505.14(b)(7)(i)(a)(3)(ii); 505.14(b)(8)(i)(b)(2)(ii)(B); 505.28(k)(1)(i)(c)(2); 505.28(l)(1)(ii)(b)(2)(ii).): An attestation that an individual is receiving services form a home care services agency should not preclude a finding of immediate need if the individual or someone else is private paying for

those services, or Medicare or other third party insurance is paying for those services on a time limited basis.

The fact that an individual, family or friend is private paying a home care services agency to provide services while Medicaid PCS/CDPA is pending should not be part of the immediate need determination. Many family members private pay for their loved ones to receive personal care with the expectation that they will be reimbursed once eligibility for Medicaid and personal care is established. However, since most private pay home care is obtained from LHCSAs and other non-Medicaid providers there is no mechanism for reimbursement. Since immediate need PCS/CDPA will only be provided to individuals who have already been found eligible for Medicaid, the Medicaid program is responsible for paying for the care. Individuals and family should not be forced to deplete their income and resources when Medicaid is responsible for paying.

The homecare benefit available through Medicare and other insurance is extremely limited both in terms of the number of hours that is usually authorized and the duration of the benefit. Therefore, the availability of Medicare or other third party insurance to pay for assistance with the personal care should only be considered if that payment will continue and is adequate to meet the needs documented in the physician's order.

(c) **Adequacy of Services:** For each of the four items to which an individual must attest – availability of voluntary informal caregivers, services provided by a homecare agency, availability of adaptive or specialized equipment, availability of third party insurance – the immediate need determination should take into account whether the services being received fully meet the needs identified in the physician's order. If they do not, a finding of immediate need should be made.

We therefore urge the **following amendments** to proposed § 505.14(b)(7)(i)(a)(3) and the corresponding provisions of §§ 505.14(b)(8)(i)(b)(2)(ii); 505.28(k)(1)(i)(c); and 505.28(l)(1)(ii)(b)(2):

(i) no voluntary informal caregivers are available, able, and willing to provide **or continue to provide** assistance to the applicant with the personal care services functions **to the extent needed as** documented in the physician's order;

(ii) **payment is not available for a** ~~**no**~~ home care services agency ~~**is providing**~~ **to provide or to continue to provide** assistance to the applicant with the personal care services functions **to the extent needed as** documented in the physician's order;

(iii) adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers, or wheelchairs, are not in use to meet or cannot meet the applicant's need for

assistance with the personal care services function **to the extent needed as** documented in the physician's order.

(iv) third party insurance or Medicare benefits are not available to pay for assistance with the personal care services functions **to the extent needed as** documented in the physician's order.

4. **Availability of Immediate PCS/CDPA to Medicaid applicants and recipients in a nursing home or hospital.**

The proposed regulations should be revised to explicitly state that Medicaid applicants and recipients who are in a hospital or nursing home and would be eligible to be discharged to the community if PCS/CDPA services were in place must be considered to have an immediate need for PCS/CDPA if their health or safety in the community would be at risk if they were discharged without such services.

The proposed regulations require a physician's order regarding the need for assistance with ADLs for "maintaining the applicant's health and safety in the applicant's home." See, e.g., Proposed § 505.14(b)(7)(i)(a)(2) (emphasis added). This language could be misinterpreted as precluding a finding of immediate need if a person has not yet returned home from a nursing home or hospital because PCS/CDPA is not in place. Such an interpretation would be a change to current policy which permits expedited authorization for PCS to individuals, "whether located in the community or a nursing facility…" GIS 15 MA/011 (emphasis added). The new regulations should not be reducing access to immediate need PCS from the level at which it is currently available.

Moreover, failing to provide PCS/CDPA on an expedited basis to individuals seeking to transition home from a hospital or nursing home would be a violation of both the reasonable promptness provision of the Medicaid Act, 42 USC § 1396a(a)(8) and the Americans with Disabilities Act's integration mandate as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999). We have had a number of clients who have been discharged from hospitals to nursing homes and unnecessarily confined to nursing homes simply because PCS/CDPA has not been arranged to allow them to go home. Often this problem occurs because of delays in MLTC enrollment. But regardless of the reason, individuals should not be forced into or unnecessarily remain in institutional settings because of delays in accessing necessary homecare.

C. Expedited Seven Day Medicaid Determinations

1. **Resource** Attestation (Proposed §§ 505.14(b)(7)(i)(b); 505.28(k)(1)(ii)):
We strongly support the proposal that individuals with an immediate need for PCS/CDPA be permitted to attest to the value of their real property and bank accounts. However, we ask that the proposed rules regarding resource attestation be clarified in two respects:

(a) **Do not require attestation to or proof of resources by MAGI Medicaid eligible individuals.** The regulations must make clear that Medicaid applicants seeking immediate PCS/CDPA who are eligible for a MAGI eligibility category do not need to provide any information regarding resources since MAGI Medicaid has no resource test.

(b) **Resource inconsistencies should not delay the seven-day time frame for making a Medicaid determination.** The proposed regulations require the LDSS to request documentation to verify resources where there is a material inconsistency with "information subsequently obtained by the commissioner or the district from other sources." Proposed §§ 505.14(b)(7)(i)(b); 505.28(k)(1)(ii)). As drafted, it is unclear what is meant by "subsequently obtained." If that occurs within the seven-day processing time for an expedited Medicaid determination, we request that the regulations clarify that the request for additional documentation must not delay the Medicaid eligibility determination beyond seven days.

2. **Expedited 7-Day Medicaid Determination Should Include Spousal Impoverishment Protections.** Spousal impoverishment allowances should be taken into account in determining whether a married applicant (whose spouse is not applying for or receiving Medicaid) who will be mandated into or eligible for MLTC has excess income or resources. It has been the Department's policy to use spousal impoverishment protections only post-eligibility after enrollment in an MLTC plan. However, CMS has now issued guidance on the federal law extending spousal impoverishment protections to all waiver programs.[1] This federal guidance expressly states that for those who need home-and-community-based services [HCBS], which include PCS and CDPA offered through MLTC, "the statute does not require that they actually receive the HCBS for which they are eligible.…This means that a State would determine a married applicant's need for the relevant HCBS within the underlying Medicaid eligibility process in order to determine if spousal eligibility rules apply."[2] Under this CMS guidance, an applicant's indication on the Medicaid application that they need or receive long term care services should trigger a determination of the need for PCS or CDPA and also use of spousal impoverishment rules.

   The CMS policy directive remedies a severe barrier to married individuals seeking Medicaid home care services in MLTC plans. Those with "excess" assets or income under regular Medicaid rules, for whom eligibility would be denied or subject to complicated spend-down procedures, may be fully eligible using spousal impoverishment protections. In that regard, a married applicant

[1] CMS State Medicaid Director Letter No. 15-001, "Affordable Care Act's Amendments to the Spousal Impoverishment Statute," May 7, 2015, available at http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf.

[2] Id. at 3-4.

with excess assets should be provided 45 days to transfer any assets to the spouse as a Community Spouse Resource Allowance, and be granted eligibility in the meantime.

D. Individuals Who Need an Increase in PCS/CDPA

The proposed regulations should explicitly cover individuals with an immediate need for an increase in PCS/CDPA. The Department proposes eliminating the only current provisions of Section 505.14 that clearly do apply to individuals with an immediate need for an increase in PCS (current § 505.14(b)(5)(iv) and the second sentence of current § 505.14(b)(5)(x)(c)), yet the proposed regulations do not clearly lay out a replacement mechanism for this population to access immediate need PCS/CDPA.

The proposed regulations must set out procedures and time frames for individuals currently receiving PCS/CDPA to obtain an increase in PCS/CDPA when needed to maintain their health and safety in their home. This population would include individuals in the community as well as those who are in a hospital or nursing home temporarily and who need an increase in previously received PCS/CDPA in order to be safely discharged. Procedures and time frames should be consistent with those required of Medicaid Managed Care and Managed Long Term Care plans for concurrent review.

E. Transition to MLTC or MMC

Ensure a seamless transition to an MLTC or MMC. We urge the Department to ensure that any regulations and procedures that are adopted ensure a seamless transition from the receipt of immediate PCS/CDPA through the LDSS to the receipt of PCS/CDPA under managed care, avoiding gaps and disruptions in care.

1. **Immediate Need PCS/CDPA Must Continue Until Services Under MMC/MLTC Begin.** The proposed regulation requires the local district to authorize the provision of PCS/CDPA to people who are mandated into MMC or MLTC "until such recipients are enrolled in such a [managed care] plan or provider." Proposed §§ 505.14(8)(ii)(e); 505.28(l)(2(iv).[3] This is not sufficient. The LDSS must continue to provide the authorized services until services under the MMC or MLTC have started. We routinely work with people who have waited a month after the effective date of their enrolment in an MLTC plan before PCS/CDPA services began. One of these clients was injured and ended up needing hospital care followed by nursing home rehabilitation twice while waiting for PCS services from her MLTC plan to begin.

[3] There are two Proposed Sections 505.28(l)(2)(iv). The reference above is to the second one which should be Proposed § 505.28(l)(2)(v).

2. **The 90-Day Transition Period for Continuity of Services Should Apply.** The 90-day transition period should apply to people moving from immediate need PCS/CDPA authorized by the LDSS to receiving services from an MLTC or MMC. Under the transition rules, the MLTC or MMC must continue the same level of service with the same providers authorized at the LDSS. After the transition period, if the MLTC or MMC plan seeks to reduce services below the amount authorized through immediate need PCS/CDPA, the plan must provide advance written notice with aid continuing rights. This will ensure there is no disruption in services in the transition.

F. Notice & Communication

1. **Require Adequate Notice of the Availability of Immediate PCS/CDPAP.** Consistent with the court orders in Konstantinov v. Daines, written notice of the availability of immediate need PCS must be provided to all Medicaid applicants and recipients. The proposed regulations contain no provisions for notifying people of the availability of immediate need PCS and thus fail to satisfy the court's orders. While the July 13, 2015 Konstantinov Order vacated and stayed that portion of the original Konstantinov Order relating to the provision of immediate temporary PCS to Medicaid applicants, it did not stay the requirement that the department make Medicaid applicants and recipients aware of the availability of immediate PCS. Konstantinov v. Daines, Sup. Ct N.Y. Cty, No. 114152/07, Decision, Order and Judgement at 15 (July 20, 2010).

   The proposed regulations must be amended to require notice of the availability of temporary PCS/CDPAP. This notice must minimally be included on the Medicaid application itself; included on the New York State of Health Marketplace (Marketplace) electronic health care application; posted at the offices of LDSSs; mailed to MMC and MLTC members; and posted on the websites of LDSSs, the New York State Department of Health (DOH), MMCs and MLTCs.

   The notice must identify the availability of immediate need PCS/CDPA, clearly explain the availability and process for seeking an expedited Medicaid eligibility determination in order to access services, clearly explain the process for requesting and receiving these services for Medicaid applicants and recipients, and indicate applicable fair hearing rights, should the initial request for immediate PCS/CDPA be denied. The notice should be clear that an individual may request immediate PCS/CDPA at any time, including upon or after applying for Medicaid, after a favorable Medicaid eligibility determination and prior to receipt of PCS/CDPA through a managed care product, and where there is an immediate need for an increase in the amount of PCS/CDPA already authorized.

2. **Availability of Forms and Applications.** All forms, including the physician's order and attestation form, as well as applications that Medicaid recipients and applicants need to complete an application for immediate need for PCS/CDPA should be made available upon request and conspicuously posted on the Department of Health, Marketplace, LDSS and New York State Office for the Aging websites. Also, information about the procedures and forms must be publicized and made available through the New York Connects program counselors and websites.

3. **Expedited Means of Communication with Applicants.** Application materials for immediate need PCS/CDPA should include space for applicants to provide the best means an LDSS can use to quickly communicate with them, such as email and cell phone. For expedited Medicaid applications, using regular mail will not be practical and will prevent LDSS's from meeting the seven-day statutory deadline.

   LDSSs should be required to telephone and e-mail when communicating with the applicant or his or her representative, including when requesting additional information under Proposed §§ 505.14(b)(7)(ii)(b)(1); 505.28(k)(2)(ii)(a).

G. **Fair Hearings Must Be Expedited**

1. All individuals who are denied, in whole or in part, immediate need PCS/CDPA must be informed of their right to an expedited hearing. Moreover, individuals who are in receipt of immediate need PCS/CDPA and subsequently found not to require, or to require less, PCS/CDPA should automatically receive an expedited hearing under 18 NYCRR § 358-3.2(b)(9). A person who recently has been found to need immediate PCS/CDPA has been identified as having health needs that would be jeopardized absent home care. Such individuals should therefore be presumed to have an "urgent need for medical care, services or supplies," 18 NYCRR § 358-3.2(b)(9), justifying an expedited hearing.

2. Similarly, Medicaid applicants who are found to have an immediate need for PCS/CDPA but are determined under the expedited procedures to be ineligible for Medicaid should be provided with an expedited hearing. Having been found to need immediate PCS/CDPA, they too should be presumed to have an "urgent need for medical care, services or supplies," 18 NYCRR § 358-3.2(b)(9), justifying an expedited hearing.

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Thank you for your considering our comments on these important proposed regulations. We urge the Department to adopt our recommendations and promptly implement regulations that will ensure expedited access to PCS/CDPA.

Respectfully Submitted,

/s/
Amy E. Lowenstein
Senior Attorney