NEW YORK STATE OF OPPORTUNITY. Department of Health

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TRANSMITTAL: 22 OHIP/ADM-01

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: April 20, 2022

SUBJECT: New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS)

SUGGESTED DISTRIBUTION:	Director of Social Services Medicaid Staff Home Care Staff Fair Hearing Staff
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ATTACHMENTS:	None

FILING REFERENCES

Previous Ref. ADMs/INFs	Releases Cancelled	Dept. Regs. Law	Soc. Serv. & Other	Manual Ref	Misc.
12 ADM 01	None	18 NYCRR 505.14	365– a	None	None
16 ADM 02		18 NYCRR 505.28	365– f		

I. PURPOSE

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP ADM) is to provide Local Departments of Social Services (LDSS) with information and guidance regarding changes in the initial assessment process for how Personal Care Services (PCS) and Consumer Directed Personal Care Services (CDPAS) are assessed for adults (18 and over) after May 16, 2022.

The New York Independent Assessor (NYIA) will conduct all initial Community Health Assessments (CHA) in the Uniform Assessment System-New York (UAS-NY) for individuals seeking PCS and/or CDPAS under the Medicaid State Plan, delivered through the Local Department of Social Services (LDSS), or through Medicaid Managed Care Organizations (MMCOs). The CHA will also be used by NYIA to determine Managed Long Term Care (MLTC) Plan eligibility. This ADM should be read with 12 ADM 01 and 16 ADM 02 in mind, and where they differ, this ADM supersedes previous guidance.

For the purposes of this ADM, Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC) together will be referred to as Medicaid Managed Care Organization(s), or MMCO(s). MMCOs and Plans may be used interchangeably. CDPAS and the Consumer Directed Personal Assistance Program (CDPAP) are used interchangeably, as well, for purposes of this directive.

II. BACKGROUND

Chapter 56 of the Laws of 2020 added a new subdivision 10 to Social Services Law §365-a, which requires "the department of health to establish or procure the services of an independent assessor or assessors. . . to take over from local departments of social services, Medicaid Managed Care providers, and Medicaid managed long term care plans performance of assessments and reassessments required for determining individuals' needs for personal care services, including as provided through the consumer directed personal assistance program, and other services or programs available pursuant to the state's medical assistance program as determined by such commissioner for the purpose of improving efficiency, quality, and reliability in assessment and to determine individuals' eligibility for Medicaid managed long term care plans." See Chapter 56 of the Laws of 2020, §11, pp. 268-269.

Subsequently, the Department of Health (Department) promulgated regulations to effectuate this and other statutory and technical amendments. These regulations were published as adopted on September 8, 2021, but included a 60-day Notice period and as such, the regulation went into effect on or after November 8, 2021. The Department sent a letter to all MMCOs and LDSSs on November 1, 2021 outlining which provisions took effect November 8, 2021 and which provisions would take effect at a later date (see DOH Letter and DOH Communication 9/8/2021 summarizing the significant changes). These amended regulations can be found at 18 NYCRR 505.14 and 18 NYCRR 505.28.

21 OHIP/ADM-04 was issued on December 13, 2021, to outline guidelines and instructions for those regulatory changes that went into effect on November 8, 2021. This ADM outlines guidelines and instructions for those provisions going into effect on or after May 16, 2022 for the New York Independent Assessor (NYIA), independent practitioner panel (IPP), and independent review panel (IRP).

DEFINITIONS

New York Independent Assessor (NYIA) – Through a contract with MAXIMUS Health Services, Inc. (MAXIMUS) the NYIA has been created to conduct independent assessments, provide independent practitioner orders, and perform independent reviews of high needs cases for PCS and CDPAS. The NYIA will also take over the work currently done by the Conflict Free Evaluation and Enrollment Center (CFEEC) to assess individuals for MLTC plan eligibility.

Community Health Assessment (CHA) – The assessment used in New York State (NYS) to determine the need for community based long term services and supports (CBLTSS) including: PCS and CDPAS; home health aide services; home care including nursing, physical, speech and occupational therapy; and adult day health care. In the context of this ADM, the CHA is referenced in connection with its use in assessing needs for PCS and/or CDPAS and MLTC eligibility. This assessment is contained in the UAS-NY and is part of the InterRAI suite of assessments. It has been in continuous use in NYS since 2011 and is not changing based on the revised statute or regulation. The NYIA will continue to use this tool for the independent assessments.

Independent Practitioner Panel (IPP) – The regulations replace the requirement for a physician's order to authorize PCS and/or CDPAS with a requirement that these services are ordered by a qualified, independent practitioner, and expand the list of ordering practitioners to include Medical Doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Assistants (PA) contracted to work for the Independent Practitioner Panel (IPP) under the NYIA.

Clinical Appointment – The IPP clinician will conduct a medical exam, review the CHA and any supporting documents, and issue a Practitioner Order (PO) for PCS and/or CDPAS.

Practitioner Order (PO) – The Practitioner Order (PO) is the order form, which is required to authorize PCS and/or CDPAS, that must be completed by the IPP clinician after conducting the medical exam, reviewing the CHA in the UAS-NY and determining if the individual is self-directing, or has an appropriate self-directing other, and can safely receive PCS and/or CDPAS at home based on their medical stability. The PO replaces the currently used Physician's Order forms (DOH-4359 and HCSP-M11Q) which are obtained prior to an assessment.

Practitioner Statement of Need – The Practitioner Statement of Need (DOH-5779) is the form used by individuals 18 and over to help substantiate a need for services when the individual is seeking to obtain PCS and/or CDPAS on an immediate need basis. This form replaces the use of the Physician's Order form (DOH-4359 or HCSP-M11Q) for individuals 18 and over for immediate needs. The Practitioner Statement of Need form must be included in the materials submitted to the LDSS for a request based on immediate need of services for adults (18 and over).

Customer Service Representative (CSR) – When a consumer initiates a call to the NYIA Helpline requesting a CHA, the NYIA call center representative (CSR) screens the caller to determine if an appointment should be scheduled. The CSR will proceed with scheduling a CHA and a clinical appointment upon verifying the consumer's identity, contact information, preferred assessment modality (telehealth or face-to-face) and, if needed, the location of an in-person visit.

Operations Support Unit (OSU) – The interface between the NYIA and LDSS or Plans when referring a specific case for action such as an expedited or request based on immediate need, or a disputed assessment.

Independent Review Panel (IRP) – An independent panel of clinicians under the NYIA that will provide a secondary medical review for high needs cases and issue a recommendation to the LDSS or MMCO regarding whether the proposed plan of care is reasonable and appropriate to maintain the individual's health and safety at home.

High Needs Cases – For the purposes of the Independent Review Panel, high needs cases are defined as needing, for the first time, more than 12 hours of care per day, on average.

Plan of Care (POC) – A person-centered plan of care developed in consultation with the individual and their representative(s), if any, that reflects the individual's needs, preferences, and goals in receiving services to maximize independence and community integration and incorporates social and cultural considerations for the provision of care.

Telehealth – Synchronous live interactive video teleconference.

III. PROGRAM IMPLICATIONS

Scope

On or after May 16, 2022, anyone seeking PCS and/or CDPAS for the first time or seeking initial MLTC plan eligibility must be referred to the NYIA for their CHA and Clinical Appointment. Beginning May 16, 2022, the NYIA will conduct all initial assessments for adults (18 and over), including fee for service (FFS) Medicaid recipients and MMC/HARP/SNP enrollees. The CHA and Clinical Appointment completed by the NYIA will assess for PCS and/or CDPAS service needs and, where applicable, MLTC plan eligibility. The LDSS (or MMCO) will no longer conduct a separate CHA to authorize these services.

Individuals who initiated the process for PCS/CDPAS through the LDSS prior to May 16, 2022 can be assessed under the process in place prior to May 16, 2022. For example, if an individual called the LDSS for an assessment on May 12, 2022 and was scheduled to have an assessment conducted by the LDSS on May 20, 2022, that individual should still be assessed by the LDSS.

State plan services including PCS and/or CDPAS authorized by an LDSS or MMCO for 1915(c) waiver participants in the Nursing Home Transition and Diversion (NHTD), Traumatic Brain Injury (TBI) and the Office for People with Developmental Disabilities (OPWDD)'s Comprehensive Waiver, will require a NYIA CHA pursuant to the revised regulations. For the NHTD and TBI waivers, these services are approved by the LDSS or MMCO and will be reflected in the waiver participant's service plan coordinated with the Regional Resource Development Center (RRDC). Assessments necessary to confirm level of care and assess other waiver services will not be completed by the NYIA.

Until further notice, the LDSS will continue to perform:

- pediatric CHAs to authorize PCS/CDPAS for children aged 0-17 years;
- routine annual reassessments for authorizing PCS and/or CDPAS for all ages; and
- non-routine reassessments as necessary including return from institutionalization assessments, significant change in condition assessments and assessments at the individual's request for all ages.

The regulations allow DOH to pend full implementation of the NYIA until all aspects can be operationalized. Separate ADMs that detail a) the NYIA reassessment process for adults (18 and over) and b) the NYIA assessment process for the pediatric population will be issued prior to their implementation.

A. Independent Assessment Process

18 NYCRR Section 505.14(b)(1) and the opening paragraph of section 505.28(d) provide an overview of the assessment process, which consists of an independent community health assessment (CHA), a clinical appointment which includes an independent medical examination and practitioner order (PO), an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required, an additional independent medical review for high needs cases. The paragraph further provides for how portions of the process may be conducted through telehealth modalities.

B. Eligibility

The NYIA will only conduct the initial assessment process for individuals with active Medicaid. If the NYIA Customer Service Representative (CSR) cannot verify the individual's Medicaid enrollment, or if the enrollment is not current, the CSR will refer the individual to the LDSS to apply for, or request an increase in, Medicaid to include coverage of community based long term care services before returning to the NYIA for the CHA and clinical appointment. The only exception to this rule will be individuals that the LDSS refers to the NYIA for assessment based on Immediate Need for services using the NYIA Expedited/Immediate Need Assessment Request Form. This process is described in section III.F below.

To be authorized for PCS and/or CDPAS, as well as other community based long term services and support (CBLTSS), individuals must have Medicaid with:

- coverage of all covered care and services or
- community coverage with community-based long-term care, or
- either of the above coverage types with a spenddown.

Individuals who are authorized for Medicaid through the New York State of Health (NYSOH – New York's Health Insurance Exchange) must have their coverage transferred to the LDSS in order to receive these services through the LDSS or an MLTC plan. The NYIA CSR will verify the individual's Medicaid coverage and inform them if their coverage needs to be redetermined for eligibility to receive PCS and/or CDPAS. If the individual's Medicaid coverage needs to be redetermined, the CSR will refer the individual to their LDSS for further action to obtain a determination of eligibility for Medicaid coverage of PCS and/or CDPAS. 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.

18 NYCRR §505.14(b)(4)(i) states that "an individual's eligibility for medical assistance and services, including the individual's financial eligibility and eligibility for personal care services" must be established before services are authorized or reauthorized. Even in the case where an individual seeks PCS and/or CDPAS based on an immediate need, services may not be authorized and commenced unless this coverage is in place.

C. Community Health Assessment (CHA) in UAS-NY

i. Initial Assessment Referral and Scheduling

Starting May 16, 2022, the LDSS must refer individuals with active Medicaid eligibility who are seeking an initial assessment for PCS or CDPAS to NYIA. As stated above, 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.

To refer to NYIA, the LDSS must provide the individual with the number to call the NYIA Helpline (855-222-8350). Individuals seeking eligibility for PCS and/or CDPAS for the first time can be referred to the NYIA by many different entities, including the LDSS, a current service provider, a managed care plan, or a facility discharge planner. Individuals may also call the NYIA directly at 1-855-222-8350.

Note, this directive does not apply to immediate need requests, which will be phased in on July 1, 2022. See Section III.G for additional instructions.

Once the NYIA CSR confirms the individual has active Medicaid, the CSR will schedule both a CHA and a clinical appointment for the individual. The individual will be advised to have relevant medical records available, including a list of current prescriptions. The CSR will offer individuals the option of a telehealth or in-person CHA and clinical appointment. If the individual chooses to have either their assessment or their medical exam performed via telehealth, the CSR will explain the process, ensure that the individual has appropriate equipment and WiFi or Cellular Data to facilitate the evaluations, and make sure that someone can be present to assist the assessor and/or clinician in capturing the necessary information to complete the telehealth appointment.

The CHA and clinical appointment will be scheduled to be completed within 14 calendar days of contact with the NYIA. If these appointments cannot be completed in this timeframe, the CSR must note the reason in the call record. The individual will receive reminder calls from the NYIA CSR and the Nurse Assessor in advance of the appointments. The LDSS should advise individuals under their care to be on the lookout for calls from unfamiliar phone numbers regarding their assessment; however, the caller ID should read “NY Independent Assessor.”

The CHA will assess the individual’s need for services, as well as eligibility for MLTC plan enrollment, if applicable. 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.

ii. CHA and PO Expiration

Currently the CHA conducted by the CFEEC is valid for 75 days for the purposes of determining MLTC eligibility. A CHA and PO conducted by the NYIA are valid for 12 months for both PCS/CDPAS service authorization and MLTC eligibility purposes, unless another CHA and PO are required due to a significant change in condition or at the individual’s request. LDSS staff may access the CHA and related practitioner order (PO) through the UAS-NY. These documents should be used to develop a Plan of Care (POC) and authorize services.

During the transition period between the old process and NYIA implementation, a CFEEC CHA conducted after May 16, 2022 will be valid for 12 months for both PCS/CDPAS service authorization and MLTC eligibility purposes, barring a new CHA conducted due to a change in condition, return from institutionalization or at the individual’s request. The LDSS is encouraged to use this CFEEC CHA as it would a NYIA CHA for the initial assessment to develop a POC.

D. Clinical Appointment (CA) and Practitioner Order (PO)

The current practice of initiating PCS and/or CDPAS services with the HCSP-M11Q or the DOH-4359 is discontinued for adults seeking Medicaid State Plan PCS and/or CDPAS on and after May 16, 2022. This third-party physician's order has been used to start the assessment process at the LDSS. The new process is described below.

The revised regulations describe the new medical exam and practitioner order at 18 NYCRR §505.14(b)(2)(ii). Individuals are determined eligible for PCS and/or CDPAS based on an independent assessment and an order from a qualified, independent clinician who does not have a provider-patient relationship with the individual. The NYIA IPP will conduct the clinical appointment now required to obtain PCS and/or CDPAS and it will occur after the CHA has been conducted.

The IPP is comprised of qualified, independent clinicians including Medical Doctors (MDs), Doctors of Osteopathy (DOs), Nurse Practitioners (NPs) and Physician or Specialty Assistants (PAs). Any of these practitioners can, as of November 8, 2021, both fill out and sign the Practitioner Order form relied on by the LDSS to authorize PCS and/or CDPAS. The practitioner will conduct the medical exam and complete and sign the Practitioner Order. At the completion of the clinical appointment, the PO will be uploaded to the individual's case record in the UAS-NY.

During the clinical appointment the IPP clinician will:

- review the CHA; examine the individual, either in person or through a telehealth modality; and, if necessary, interview providers and others who may have insight into the individual's needs;
- ensure that the current diagnoses and medications are documented accurately and thoroughly;
- attest to the individual's need for assistance;
- determine whether the individual's medical condition is stable to receive PCS and/or CDPAS;
- indicate whether the individual is self-directing, or has identified an appropriate self-directing other; and
- indicate if they can complete the consumer's roles and responsibilities if they are authorized for and enroll in CDPAS.

The PO represents the clinical judgment of the practitioner. They will indicate whether there is a need for services and whether they believe that the individual is medically stable to receive PCS and/or CDPAS. If the IPP clinician determines the individual is not medically stable to receive PCS and/or CDPAS, then the NYIA will send notice to such individuals which will include conference and fair hearing language. The LDSS may not authorize services for individuals that the NYIA IPP has determined are not medically stable to receive PCS and/or CDPAS.

E. Initial Assessment

Individuals seeking services through FFS Medicaid authorized by the LDSS may be eligible for MLTC plan enrollment on a voluntary basis (MMC exempt population including Medicaid only adults over 21 years of age or dually eligible adults 18-21 years of age). The NYIA initial assessment will evaluate the individual's needs for both PCS and/or CDPAS and MLTC plan eligibility. Individuals who are eligible to join an MLTC plan on a voluntary basis will have the option to remain in FFS Medicaid to receive these services authorized by the LDSS.

The LDSS can learn of upcoming assessments of county residents in a weekly report of scheduled CHA and CA appointments prepared by NYIA and uploaded to MOVEit. This report, "Consumers Scheduled for Initial Assessments within the next 30 Days", will provide each LDSS with a list of FFS individuals who have an initial assessment (including CHA and CA appointments) scheduled within the next 30 calendar days.

The NYIA will also prepare outcome reports for the LDSS so they are aware of completed parts of the NYIA assessment process. One report, "Initial CHA Appointment Outcomes Report," provides each LDSS a list of FFS individuals for whom NYIA completed an Initial Community Health Assessment (CHA) Appointment. This report is run daily and uploaded to MOVEit.

Another report, "Initial PO Outcomes Report," will provide each LDSS with a list of FFS individuals for whom NYIA completed the Clinical Appointment and issued a Practitioner Order. This report is also run daily and uploaded to MOVEit.

Upon the completion of the CHA and clinical appointment, and where appropriate, NYIA will provide the LDSS contact information to individuals.

F. Authorization of PCS and/or CDPAS

i. Plan of Care and Service Authorization

While the NYIA is now responsible for performing the independent CHA and PO, the LDSS remains responsible for developing the individual's plan of care and authorizing PCS and/or CDPAS. In developing the plan of care and authorization of services, the LDSS must review the NYIA CHA and PO and determine that PCS and/or CDPAS are appropriate, medically necessary and can reasonably maintain the individual's health and safety in their home.

As part of this process, the LDSS continues to be responsible for a) reviewing other available services and supports to determine whether they meet the individuals needs and if they are cost effective, b) determining frequency of nursing supervision, c) determining the individual's preferences and social and cultural considerations for the receipt of care, d) heightened documentation requirements for 24-hour cases, and e) confirming the willingness and availability of any informal supports identified the in CHA. See 18 NYCRR §505.14(b)(2)(iii) and §505.28(d)(3). The LDSS remains ultimately responsible for the authorization of services and must record in the plan of care (POC) the level, amount, frequency and duration of services that the LDSS authorizes, and send notice of service authorization.

In evaluating the cost effectiveness of services, the LDSS must consider the availability of informal caregivers and the availability of other Medicaid and non-Medicaid services, programs, equipment or adaptive or assistive technologies that meet the individual's needs. Where these services and supports are available, the LDSS must authorize them, or discount them from the PCS and/or CDPAS authorization as applicable. See 18 NYCRR §505.14(b)(2)(iii)(b)(2) and 505.28(d)(3)(ii)(b). When determining the availability of voluntary informal supports, the LDSS must contact the caregiver identified by NYIA in the CHA, or one identified by the LDSS through care planning activities. The LDSS must then record in the POC the days and times the caregiver is willing to provide assistance.

Requirements for authorizing continuous PCS and/or CDPAS or live-in 24-hour PCS and/or CDPAS remain unchanged from prior directives, except for the requirement for additional medical review by the IRP in the first instance once the NYIA is implemented. This review replaces the role of the local medical director. (See "High Needs Review," below).

The care planning process must conclude and the LDSS must authorize services within seven (7) business days of receipt of the NYIA CHA and PO, unless an earlier decision is required under the Immediate Need process described below. For high-needs cases that are forwarded to the IRP, the seven (7) business-day timeframe for authorization is pended until receipt of the IRP recommendation.

If, based on the review of the CHA, PO and care planning activities, 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.

While the LDSS may not require as many contracted nurses as they did before the implementation of NYIA, they will need to plan for sufficient staff to conduct home visits, meet with the individual, and any representatives they choose, and develop a person centered POC. The regulations outline case management responsibilities at 505.14(b)(4)(g) and make clear that a professional staff member of the LDSS or contracted case management agency that satisfies the Department's requirements for this position may conduct these activities (See 18 NYCRR 505.16(e)(2)). It does not have to be done by a Registered Nurse. Nor is it required to be conducted concurrently with the assessment.

Changes in an individual's need for services unrelated to a significant change in condition (such as availability of informal supports) do not require CHA reassessment but must be documented in the POC and the LDSS must consider and make any authorization changes as appropriate. See 18 NYCRR §505.14(b)(4)(viii) and 505.28(f)(3).

ii. High Needs Review

After May 16, 2022, when the NYIA conducts an initial assessment, for those newly in receipt of a proposed plan of care that calls for more than 12 hours per day, on average, of PCS and/or CDPAS, the LDSS must refer the case to the NYIA's Independent Review Panel (IRP) for an additional independent medical review and must consider the recommendation of the IRP when finalizing the POC. See 18 NYCRR §505.14(b)(2)(v) and 505.28(d)(5). However, recipients who were authorized to receive more than 12 hours of services per day on average prior to and as of May 16, 2022, may continue to receive services without the need for IRP review upon reassessment.

Once NYIA begins conducting reassessments, unless the service recipient's authorization later falls below more than 12 hours on average, the recipient will not need to receive another IRP review to continue to have services reauthorized at more than 12 hours per day on average. If the recipient's authorization is ever reduced below 12 hours per day on average, the recipient may need another IRP review if the LDSS later proposes to authorize more than 12 hours per day on average.

Regulations define the high need threshold as more than 12 hours a day, on average, of PCS and/or CDPAS. To determine the average, the LDSS may add up the total number of hours it intends to authorize over the course of a week for which services are needed, and then divide by 7. Using this method, a high-needs case is any case where the LDSS would authorize more than 84 hours in a given week. Hours covered by voluntary informal assistance or other services or programs do not count towards the high needs threshold and should not be included in the calculation.

Note 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).

When the requirement to perform an IRP review is triggered, the LDSS must call the NYIA Operations Support Unit (OSU). NYIA will provide a designated, secure URL for the LDSS to submit the IRP Request Form and include in the referral to the IRP all records and documents used to develop the POC.

The IRP is comprised of a panel of at least two (2) clinicians, including a lead physician (MD or DO). It is charged with reviewing the most recent NYIA CHA and PO, the POC developed by the LDSS, and any additional documents or records that may be necessary to make a recommendation about whether the proposed POC is adequate and reasonable to ensure the individual's health and safety in the home or other appropriate community-based setting.

This additional medical review is expected to primarily be a review of the noted records, although the panel may determine that they need to speak to or evaluate the individual, either in person or through a telehealth modality, or speak to the individual's primary care practitioner and/or designated representative. The independent medical professional who conducted the IPP medical exam may not be on the independent review panel for that case. In addition, the IRP Recommendation must be signed by the lead physician.

The recommendation may suggest alternative services and supports or other changes to the POC but cannot specify the number of hours or the changes that must be made. The IRP Review Panel Report and Recommendation Form for High Needs Cases will be uploaded to the UAS-NY.

The LDSS is expected to review and consider the recommendation prior to finalizing the POC and authorizing services. NYIA's OSU will notify the LDSS of the availability of an IRP recommendation by phone or email and the LDSS will retrieve the IRP recommendation report from the UAS-NY by downloading the PDF. The recommendation should be considered before finalizing the POC, which should include any amendments with which the LDSS agrees. The LDSS should document why it is not making recommended changes in the case file if it decides to implement the previously proposed POC or makes some, but not all, recommended changes.

In the event the IRP review would impair the LDSS's ability to authorize services pursuant to an immediate needs review, the LDSS must authorize the proposed POC on a temporary basis to meet the 12 calendar day deadline, pending review of the IRP recommendation. See 18 NYCRR §505.14(b)(4)(vi) and 505.28(e)(4). Services of more than 12 hours per day on average may be provided under a temporary plan of care due to the immediate need. Upon receipt of the IRP recommendation, the LDSS will finalize the POC and issue an initial determination notice.

An IRP review is not required if:

- The individual is already in receipt of more than 12 hours a day, on average, of PCS/CDPAS as of May 16, 2022, unless they are subsequently authorized for fewer than 12 hours a day, on average, then later breach the high needs level again,
- an individual has had an IRP review and services are maintained at this higher level of care through subsequent proposed POCs regardless of whether proposed by the LDSS or an MMCO, or
- an individual's authorized hours are more than 12 per day, on average, and they are then raised to additional hours (e.g., from 16 hours to 24 hours).

See 18 NYCRR 505.14(b)(3)(xi)(b).

iii. Case Management Requirements

18 NYCRR §505.14 and §505.28 require LDSS to coordinate with the NYIA to minimize disruption to the individual. This includes informing the NYIA when initial assessments or practitioner orders are needed and maintaining updated enrollment records in the Uniform Assessment System (UAS-NY) so that Reassessment Notices go out automatically from the NYIA. If the NYIA requests the LDSS to confirm or update an individual's record in the UAS-NY, the LDSS must respond within one (1) business day and confirm or update the record within three (3) business days. See 18 NYCRR 505.14(b)(iv)(c) and 505.28(d)(4)(iii). In addition, the LDSS remains responsible for ensuring that the POC is completed, obtaining the individual's agreement and providing them with a copy, and serving as a resource for the individual in case they need further assistance or problem solving in meeting their demonstrated needs.

iv. Notice and Fair Hearing Processes

As indicated above, the LDSS remains responsible for developing the POC and authorizing services. Accordingly, the requirements for providing notice and fair hearing rights have not changed materially. The LDSS must continue to notice individuals of its decisions to deny or authorize services, even where those decisions are based in part on the CHA, PO, or IRP recommendation performed by the NYIA.

Likewise, the LDSS remains responsible for defending its decisions as the proper party to the fair hearing, including preparing materials to be presented at fair hearing ("evidence packet") and for providing these materials to the appellant or the appellant's authorized representative upon request. See 18 NYCRR Sections 358-4.2. Where appellant is challenging the LDSS's determination of PCS and/or CDPAS, these materials include, but are not necessarily limited to, the CHA, PO, IRP recommendation if applicable, plan of care, and any notices issued by the LDSS to the appellant with respect to the action in question.

Both the appellant and the LDSS may call NYIA as a witness to any case regarding the challenge of a determination of services where the LDSS relied on the CHA, PO, or IRP recommendation provided by NYIA. To arrange for the NYIA to appear as a witness, the LDSS must call the OSU to notify NYIA of the fair hearing request. Where the LDSS requests that NYIA provide materials or written testimony to be presented by the LDSS or entered into the record at the hearing, such materials shall also become part of the evidence packet.

v. Discrepancies in CHA or PO

The Department has defined processes to address any discrepancies the LDSS finds in the NYIA CHA or PO. See 18 NYCRR §§505.14(b)(2)(iv)(d) and 505.28(d)(4)(iv). The process, which is called the CHA Variance request process, can be initiated when the LDSS identifies either one of two concerns: a mistake or a clinical disagreement.

A. Mistake

If the LDSS identifies a material mistake in the CHA or PO that can be confirmed by the submission of evidence, the LDSS must submit the NYIA CHA Variance Form to the NYIA OSU through a secure URL along with the evidence that a mistake has occurred and that the mistake is material. A mistake is an error of fact or observation that occurred when the assessment was performed that is not subject to the assessor's clinical judgment. A mistake is material when it would affect the amount, type, or duration of services authorized. When identifying the mistake, the LDSS must provide evidence of the mistake to NYIA and indicate how the mistake is material.

When the LDSS submits a material mistake via the CHA Variance Form, NYIA will promptly issue a corrected assessment or schedule a new assessment. If NYIA decides to schedule a new assessment, it will complete the new CHA within 10 days of the date it receives the notice from the LDSS.

B. Clinical Disagreement

After reviewing the CHA, PO and the result of any social service district assessment or evaluation, if the LDSS has a material disagreement regarding the outcome of the independent assessment, the LDSS may use the same NYIA CHA Variance Form to submit a material disagreement. A disagreement occurs when the LDSS disputes a finding or conclusion in the CHA that is subject to the independent assessor's clinical judgment. A disagreement is material when it would affect the amount, type, or duration of services authorized. When submitting a disagreement to NYIA, the LDSS must provide the clinical rationale that forms the basis for the disagreement and indicate how the disagreement is material. Upon submission and confirmation of a material disagreement, NYIA will schedule and complete a new CHA within 10 days of the date it receives notice from the LDSS.

The LDSS is expected to submit a CHA Variance Form with due expediency upon discovery of a mistake or clinical disagreement. NYIA OSU staff will review the form and the evidence submitted in support of the contention that a mistake or clinical disagreement occurred. If NYIA cannot reach a decision on whether such variance occurred due to insufficient or incomplete information, OSU staff will reach out to the LDSS to obtain additional documentation.

The dispute record will be set to "disregard" if the information is not received by NYIA within 10 business days. The LDSS will be notified via secure email. Once the OSU staff verify that the application for the variance process is complete, it is referred to a Quality Assurance Nurse. Disputes requested by the LDSS will be updated via a weekly report to individual LDSS offices.

C. Requirement of the CHA Variance process

When submitting a CHA Variance request to the NYIA, the LDSS must also inform the individual that a new CHA may be conducted because of this request. The LDSS may explain the reason for the new CHA. If an individual refuses to have a new CHA conducted, the refusal to cooperate with a new assessment pursuant to a CHA Variance request does not constitute non-compliance with the assessment process and may not be used as a basis to deny, reduce or terminate services. If the individual refuses the new CHA, the LDSS must use the CHA on file in developing the plan of care and authorization.

G. Immediate Need

Effective July 1, 2022, the below guidance should be read in conjunction with 16 OHIP/ADM-02, except where 16 OHIP/ADM-02 references the need to perform a social and nursing assessment to determine the need for PCS/CDPAS. Authorization for expedited PCS and/or CDPAS will instead be made based on the LDSS review of the NYIA assessment, conducted as follows.

If an individual seeks PCS and/or CDPAS based on an immediate need for those services, they may be entitled to expedited Medicaid eligibility and services determinations. To be considered to have an immediate need, the individual must provide the LDSS with an "attestation of immediate need" for PCS and/or CDPAS (Attestation) along with a Practitioner Statement of Need (DOH-5779) from a practitioner who is familiar with the individual's condition. For individuals who are not yet eligible for Medicaid, they must also present a completed Medicaid application.

The previous directive (16 OHIP/ADM-02) required a Physician Order for Immediate Need processing. Because the Physician Order is being replaced with the *Practitioner* Order, which occurs *after* the CHA assessment, the Department has replaced the Physician Order with a Practitioner Statement of Need (DOH-5779). In order to streamline the immediate need process, the Practitioner Statement of Need requires less documentation on the part of the practitioner as compared with the Physician Order, and can be completed by a MD, DO, NP or PA. Note, if an individual provides the LDSS with a Physician Order when requesting immediate need processing, the LDSS should accept the Physician Order and not require the Practitioner Statement of Need. Regardless of whether the individual provides a Practitioner Statement of Need or Physician Order to substantiate their immediate need for services, this does not replace the need to obtain an independent Practitioner Order from the IPP.

No material changes have been made to the Attestation of Need (OHIP-0103), which has been updated to reflect the new Practitioner Statement of Need (DOH-5779) form. The Attestation form continues to require that the individual attest to the following: 1) their need for assistance, 2) that they have no willing and available informal supports, 3) that they are not currently served by a home care agency, 4) that adaptive or assistive devices are not and cannot meet their needs, 5) they do not have any third-party insurance or Medicare available to pay for needed assistance.

Where Medicaid eligibility for community based long term services has been established the submission of the Practitioner Statement of Need and Attestation of Need forms initiate the start of immediate need processing. Where Medicaid eligibility for community based long term services has not been established, the applicant must also submit a completed Medicaid application to trigger immediate need processing. Please refer to 16 OHIP/ADM-02 for previous guidance on this topic.

Upon receipt of both the signed Attestation and Practitioner Statement of Need forms, as well as the completed Medicaid application, where applicable, the LDSS must refer adult individuals to the NYIA immediately and without delay.

To refer Immediate Need cases to NYIA, the LDSS must use the Expedited/Immediate Need Form. This form should be submitted to NYIA through a dedicated URL. NYIA will outreach to the LDSS to provide them the dedicated URL directly, under separate cover. The LDSS should not submit the “Attestation of Immediate Need” or Practitioner Statement of Need forms to NYIA. The LDSS should also initiate a three-way call with the OSU, the LDSS and the individual. Individuals may not bypass the LDSS when requesting immediate need processing for PCS and/or CDPAS. See 18 NYCRR §505.14(b)(6) and (7) and §505.28(l).

Note that for children (under 18 years of age), the LDSS will follow the process outlined in 16 OHIP/ADM-02, in which a physician’s order form (HCSP-M11Q or DOH-4359) is required with the Attestation of Need. The LDSS will also continue to perform the assessments for this population.

As indicated in 16 OHIP/ADM-02, an individual with an immediate need for PCS or CDPAS may either be an individual not currently authorized for any type of Medicaid coverage, or a current Medicaid recipient authorized only for community-based coverage that does not include coverage for long-term care services such as PCS or CDPAS. It is the responsibility of the LDSS to, based on a complete Medicaid application, determine the individual’s eligibility for Medicaid, including Medicaid coverage of community based long term services. The reasons that an individual may need to be approved under the Immediate Need process have not changed from those in policies and procedures already in effect.

If an individual seeking PCS and/or CDPAS based on an Immediate Need self-refers to the NYIA or is directed to the NYIA by a discharge planner or other referral source, the CSR will direct the individual to call back with a representative of the LDSS. Once Immediate Need is verified through the LDSS by submission of the Expedited/Immediate Need Form, the CSR will schedule a CHA and clinical appointment to be completed within six (6) calendar days. If these appointments cannot be completed in this timeframe, the CSR must note the reason in the call record. All other aspects of the CHA and clinical appointment are the same as the initial assessment process described above.

The LDSS continues to have no more than 12 calendar days from receipt of the Attestation of Need and Practitioner Statement of Need, and when applicable a completed Medicaid application, to refer the individual to the NYIA for an Immediate Need CHA and clinical appointment, review the outcome, develop a POC and authorize PCS and/or CDPAS as needed. The LDSS shall provide such services to individuals not exempt or excluded from membership in an MMCO until they can be enrolled. The LDSS may not authorize any services unless the individual is determined to be eligible for Medicaid, including coverage of community based long term services. See 18 NYCRR §505.14(b)(4)(i) and 505.28(e)(1)(i).

IV. SYSTEMS IMPLICATIONS

The LDSS **must** enter an Enrollment Record into the individual's case file in the UAS-NY when the local district authorizes services for the individual.

The LDSS **must** enter a disenrollment in the UAS-NY when the individual is no longer receiving services with the LDSS (e.g. the person enrolls in a Medicaid Managed Care Plan, death, or moves out of state).

It will be imperative for LDSS to maintain accurate and timely records in the UAS-NY system and in eMedNY so that reassessment notices can be sent automatically by NYIA and that New York's enrollment broker (NYMC) can effectively complete their activities.

V. EFFECTIVE DATE

The provisions in this Administrative Directive are effective on and after May 16, 2022, except with respect to the NYIA Immediate Need assessment process in Section III.G, which is effective on and after July 1, 2022.

Amir Bassiri
Acting Medicaid Director
Office of Health Insurance Programs