NEW YORK STATE | Department of Health | Office of Health Insurance Programs

To: **Medicaid Managed Care Plans**

From: **Office of Health Insurance Programs, Division of Health Plan Contracting and Oversight**

Re: **May 16, 2022 Implementation of New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS)**

Date: **April 28, 2022**

This guidance provides notification of changes to the initial assessment process for Medicaid Managed Care (MMC) members in mainstream (MMC) plans, to include HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs), seeking Personal Care Services (PCS), Consumer Directed Personal Assistance Services (CDPAS) or transfer to a Managed Long Term Care (MLTC) plan.

These changes are the result of various statutory, regulatory, and administrative reforms included in the enacted 2020-21 NYS Budget and regulatory amendments to 18 NYCRR §§ 505.14 and 505.28 finalized in the September 8, 2021, NYS Register with an effective date on or after November 8, 2021.

Beginning May 16, 2022, the NYIA will conduct all initial assessments for individuals seeking PCS and/or CDPAS, including Fee for Service (FFS) Medicaid members, MMC members and MLTC applicants. NYIA will complete the Community Health Assessment (CHA) to determine service needs and, where applicable, MLTC plan eligibility. For standard requests, the MMC plan will no longer conduct a separate CHA to authorize PCS and/or CDPAS.

Requests for PCS and/or CDPAS made on an expedited basis will continue to be made by the MMC plan until July 1, 2022.

MMC members voluntarily seeking a transfer into a MLTC plan will need a NYIA assessment to determine eligibility. If an MMC member began the initial assessment process prior to May 16, 2022, they will complete it with the MMC plan under the prior rules.

Services covered through New York's 1915(c) Waivers, including the Nursing Home Transition and Diversion (NHTD), Traumatic Brain Injury (TBI) and the Office for People with Developmental Disabilities (OPWDD) Comprehensive Waiver, will not require a NYIA CHA. However, PCS and/or CDPAS authorized for Waiver participants by an MMC plan, will require a NYIA CHA pursuant to the revised regulations.

MMC plans will continue to conduct reassessments for adults aged 18 and over, and initial assessments and reassessments for children aged 4-17, until further notice.

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 NYS to determine the need for long term services including PCS and CDPAS; home health aide services; home care including nursing, physical, speech and occupational therapy, and adult day health care. The CHA is referenced in connection with its use in assessing needs for PCS and CDPAS. 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 clinical 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 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.

Customer Service Representative (CSR) – When a consumer initiates a call to the 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 immediate need request, 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 MLTC plan 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.

ASSESSMENT PROCESS

NYIA Assessment

As of May 16, 2022, NYIA will conduct the initial assessment for MMC members seeking PCS, CDPAS and/or enrollment into a MLTC plan.

The NYIA will schedule both a CHA and a Clinical Appointment for the member and both will be completed within 14 days of contact with the NYIA. These documents are used by the MMC plan to develop a Plan of Care (POC) to address the members identified needs and authorize services. The MMC plan shall not conduct its own CHA but must use the NYIA CHA and Practitioner Order to inform the POC development for PCS and CDPAS.

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

The CHA conducted by the NYIA is valid for 12 months unless another CHA is required due to a significant change in condition or at the member's request.

B. Practitioner Order (PO) for PCS or CDPAS

The current practice of initiating PCS and/or CDPAS with the HCSP-M11Q or the DOH-4359 ends and is replaced by this new assessment process. The NYIA includes an Independent Practitioner Panel (IPP) to conduct the exam that is now required to obtain PCS and/or CDPAS. 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). At the completion of the Clinical Appointment, the clinician will complete the PO, which will be uploaded to the UAS-NY.

During the Clinical Appointment, an IPP clinician will:

- review the CHA, examine the member, either in person or through a telehealth modality, the member and, if necessary, consult with providers and others who may have insight into the member's needs;
- ensure that the current diagnoses and medications are documented accurately and thoroughly;
- attest to the member's need for assistance;
- indicate whether the member is self-directing, or has identified an appropriate self-directing other;
- indicate if the member can complete the consumer's roles and responsibilities if they are authorized for and enroll in CDPAS; and
- determine if the member's medical condition is stable to receive PCS and/or 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, then the MMC plan may not authorize PCS and/or CDPAS.

For members seeking services within the MMC plan, upon completion of both the CHA and the PO, the individual will receive a notice form NYIA indicating whether their health condition is stable to receive PCS and/or CDPAS in their home. If the NYIA determines the individual is not medically stable, then the notice from NYIA will include conference and fair hearing language. These members will also be instructed to contact their MMC plan for next steps. Next steps include the MMC plan reviewing the CHA and PO and determining whether other Community Based Long Term Services and Supports (CBLTSS) may address the member's assessed needs, and arranging for that care, if available.

For members seeking a voluntary transfer to an MLTC plan, the member will receive a notice from NYIA indicating their eligibility for MLTC enrollment and whether their health condition is stable to receive PCS and/or CDPAS in their home. If qualified for MLTC plan enrollment, the notice provided by NYIA will direct the member to contact the NYIA for information about available MLTC plans

Plan of Care (POC)

The MMC plan remains responsible for authorizing PCS and/or CDPAS and other CBLTSS that may address the member's demonstrated needs to maintain their health and safety in the community. The MMC plan must review the NYIA CHA and the PO in the UAS-NY, which contains the relevant information to inform the development of a POC. The POC should be updated and documented at least every twelve months if continuing to meet the member's needs; or more frequently if the member's condition changes, at the request of the member, or as otherwise appropriate. The MMC plan must develop and maintain a process to allow the member to request an updated POC if the member's circumstance necessitates a change.

The MMC plan remains responsible for:

a) reviewing other available services and supports to determine cost effectiveness;
b) determining frequency of nursing supervision;
c) determining the member's preferences and social and cultural considerations for the receipt of care;
d) heightened documentation requirements for 24-hour cases; and
e) the development of the POC, including the amount, duration, and frequency of services.

See 18 NYCRR §§ 505.14(b)(2)(iii) and 505.28(d)(3). The MMC plan 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 they authorize, and send notice of service authorization to the enrollee.

In evaluating the cost effectiveness of services, MMC plans 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, MMC plans 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, MMC plans must contact the caregiver identified by NYIA during the assessment process, or one identified

by the MMC plan through care planning activities. The MMC plan 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 remain unchanged from prior directives, except for the requirement for additional medical review by the NYIA IRP in the first instance once the NYIA is implemented. (See "High Needs Review," below).

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

For standard requests, the MMC plan must conclude the authorization of services within 14 calendar days of receipt of a request for services for a member who has a current NYIA CHA and PO on file, in accordance with the requirements of 42 CFR § 438.210(d). Similarly, expedited requests must be processed within 72 hours. The MMC plan may seek an extension for an additional 14 calendar days to these timeframes. Upon receipt of all necessary information, the MMC plan must authorize services and provide notice within three (3) business days, unless federal regulations require the authorization earlier. See PHL § 4903(2)(a).

High Needs Review – Independent Review Panel (IRP)

Prior to authorizing more than 12 hours of services per day on average, for a new recipient of PCS and/or CDPAS on or after May 16, 2022, the MMC plan 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). The MMC plan does not need to refer cases to the IRP if the amount of service in excess of 12 hours a day, on average, is ordered pursuant to a Fair Hearing decision, external review decision, or by any other 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 MMC plan must call the NYIA Operations Support Unit (OSU). NYIA will provide a designated, secure URL for the MMC plan to submit the IRP review request. The MMC plan must submit the request through the secure URL using the IRP Request Form and include all records and documents used to develop the POC other than the CHA and PO. The MMC plan should submit the package once the POC is developed and the number of hours can be calculated.

The regulations, as cited above, define the high needs threshold as more than 12 hours a day, on average of PCS and/or CDPAS. To determine the average, the MMC plan may add up the total number of hours they intend 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 MMC plan 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. The MMC plan may submit any documentation they wish to support the proposed POC.

The IRP is comprised of a panel of at least two clinicians, including a lead physician (MD or DO). It is charged with reviewing the most recent NYIA CHA and PO as well as the POC, 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 member's health and safety in the home. This additional medical review is expected to primarily be a review of the noted records, although the IRP may determine that they need to speak to or evaluate the member through a telehealth modality or speak to the member's primary care practitioner and/or designated representative. The independent medical professional who conducted the IPP exam may not participate in the IRP. The IRP recommendation must be signed by the lead physician. MMC plans will be notified of completed IRP reviews by a phone call from the OSU.

The IRP recommendation may suggest alternative services and supports or other changes to the POC but cannot specify the number or hours or the specific changes that must be made. The IRP report and recommendation form for high needs cases will be uploaded to the UAS-NY and must be considered by the MMC plan prior to finalizing the POC and authorizing services.

Timeframes for authorizing services are not pended for high-needs cases that are forwarded to the IRP. If the IRP process extends beyond required timeframes, the MMC plan must provide services in accordance with the proposed POC on a temporary basis, 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 POC. Upon receipt of the IRP recommendation, the MMC plan will finalize the POC and issue an initial determination notice.

The IRP review is not required if the member:

- is already in receipt of more than 12 hours a day, on average, of PCS and/or CDPAS as of the start date of the IRP,
- 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 current plan, new plan or LDSS, and
- has authorized hours above 12 previously and the hours are increased further, e.g., an increase from 16 to 24 hours.

See 18 NYCRR §505.14(b)(3)(xi)(b)

Care Management

18 NYCRR §§505.14 and 505.28 require the MMC plan to coordinate with the NYIA to minimize disruption to the member. This includes informing the NYIA when assessments or POs are needed and maintaining updated enrollment records in the UAS-NY so the reassessment notices go out automatically from the NYIA when reassessments are assumed by NYIA. If the NYIA requests the MMC plan to confirm or update the member's record in the UAS-NY, the MMC plan must respond within one business day and confirm or update the record within three business days. See 18 NYCRR §§505.14(b)(iv)(c) and 505.28(d)(4)(iii).

Fair Hearing

MMC plans remain responsible for developing the POC and authorizing services for members. Accordingly, the requirements for providing notice and fair hearing rights have not changed materially. The MMC plan must continue to notice members 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.

MMC plans remain responsible for defending their 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 358-4.2. Where appellant is challenging the MMC plan's determination of PCS and/or CDPAS, these materials include, but are not necessarily limited to, the CHA, PO, IRP recommendation if applicable, POC, and any notices issued by the MMC plan to the appellant with respect to the action in question.

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

Discrepancies in CHA or PO

The Department has defined processes to address any discrepancies the MMC plan 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 MMC plan identifies either one of two concerns: a mistake or a clinical disagreement.

A. Mistake

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

B. Clinical Disagreement

After reviewing the CHA and PO, if the MMC plan has a material disagreement regarding the outcome of the independent assessment, the MMC plan may use the same NYIA CHA Variance Form to submit a material disagreement. A disagreement occurs when the MMC plan 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 MMC plan 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 MMC plan.

The MMC plan 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, NYIA OSU staff will reach out to the MMC plan to obtain additional documentation. The dispute record will be automatically set to disregard if the information is not received by NYIA within 10 business days. The MMC plan will be notified via secure email. Once the NYIA OSU staff verify that the application for the variance process is complete, it is referred to a Quality Assurance Nurse. Results of disputes requested by the MMC plan will be updated via a weekly report.

C. Requirement of the CHA Variance process

When submitting a CHA Variance request to the NYIA OSU, the MMC plan must also inform the member that a new CHA may be conducted because of this request. The MMC plan may explain the reason for the new CHA. If the member 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 member refuses the new CHA, the MMC plan must use the CHA on file in developing the plan of care and authorization.

Penalties

DOH is authorized to impose monetary sanctions pursuant to NYS Public Health Law §12 on an MMC plan for failure to coordinate with the NYIA in accordance with 18 NYCRR §505.14(b)(iv)(a)-(c) or if the MMC plan engages in abusive behavior that affects the coordination of the assessment process. This includes any abuses with respect to the variance process intended to address mistakes or clinical disagreements.

DOH will monitor MMC plan participation in coordinating assessments through the NYIA and assess violations in light of its own performance and against its peers, its history, the impact of any violations and evidence of good faith effort and past responsiveness in determining whether to levy such sanctions.

Questions

Questions on this guidance can be sent to independent.assessor@health.ny.gov.