Medicaid Matters New York

October 20, 2023

Amir Bassiri
Deputy Commissioner and State Medicaid Director
NYS DOH Office of Health Insurance Programs
One Commerce Plaza
Albany, NY 12210

RE: Delay and slow the roll-out of expansion of NY Independent Assessor Program

Dear Deputy Commissioner Bassiri:

Advocates for Medicaid consumers urge delay of the recently announced expansion of the New York Independent Assessor Program (NYIAP) to roll out beginning January 2024. We continue to have many of the same concerns expressed in a meeting with you on January 17, 2023, as well as other meetings with Department of Health staff. We are disappointed that commitments made by DOH at that meeting have not been met: first, to provide consumer advocates and others an opportunity for input before any expansion, and second, to provide more transparency about the impact of the program on consumers.

We question whether NYIAP has capacity to add the reassessments as scheduled in 2024 to its existing workload. We estimate routine reassessments for MLTC and MAP alone will add 26,000 more two-part assessments (CHA and CA) per month to the current average of 12,000 two-part initial assessments per month. This tripled demand does not count the routine reassessments for mainstream/HARP members or LDSS FFS consumers, for which DOH has never disclosed how many receive PCS or CDPAP. Nor does this estimate include non-routine assessments across all plans and LDSS.

To protect consumers, we request that the State delay the planned expansion, start with routine reassessments before adding non-routine assessments, provide data concerning Maximus capacity and how NYIAP is impacting timely access to services, and meet with stakeholders for input on policies and procedures before embarking on this expansion that threatens to disrupt access to long term care.

We make the following recommendations regarding the proposed expansion:

1. Postpone this expansion entirely, and then start with routine reassessments only before rolling it out for non-routine reassessments.

We are concerned that Maximus lacks the capacity to handle the calls and to conduct timely assessments, some of which must be expedited. In addition, the roll-out as scheduled, does not leave enough time for Local Departments of Social Services (LDSSs) and plans to operationalize procedures, train their staff, amend member handbooks and plan websites, allow for HRA and other LDSSs to issue procedures, and for word to get out to the large support system of health care and social services providers who help consumers. DOH has not yet issued guidance for this transition to LDSSs and plans.

Phase in routine reassessments for a full year before adding non-routine reassessments. Non-routine reassessments are requested for those experiencing a deterioration in medical condition or who need increased hours of home care to be discharged safely from a hospital or rehab facility. Given the urgency of these situations, the roll-out of non-routine assessments should be delayed for at least a year while NYIAP rolls out the process of handling routine assessments. The year in which routine assessments are rolled out should be used to monitor capacity and delays, test the new procedures, gauge demand, identify and address any systems issues, and educate consumers and their social and medical supports, before expanding to non-routine requests. MCO members and LDSS consumers that go through routine reassessments with NYIAP over a year will become familiar with the NYIAP procedures and then be more prepared to call NYIAP when they need a sudden or unexpected change in the plan of care the following year.

2. Clearly communicate new policies regarding NYIAP to consumers, plans and other stakeholders.

The roll-out schedule is confusing. DOH should send letters to all plan members and LDSS consumers detailing the new procedures and clearly explaining when the changes will be made in that consumer's region. We request the opportunity to provide input on such a letter. Members must be told how to request a non-routine reassessment, and how their routine reassessments are changing.

The DOH NYIAP webpage still has blank FAQ and consumer information sections even though NYIAP began more than seventeen months ago.[1] Maximus' "consumer facing" website does not clearly explain the different pathways to accessing services for different populations.[2]
It is also essential to inform health care providers about this change via a Medicaid Update, as they assist their patients in requesting non-routine reassessments. This represents a significant change from past procedures. Information must be disseminated to the large network of health care and social service providers who help seniors and people with disabilities request changes in their plans of care, which are often needed under emergency circumstances. There is not enough time to publicize all of these changes to all networks by the January 2024 start date, especially given that ADMs and other policies have not yet been issued.

3. Improve training for call center staff.

Throughout NYIAP's existence, advocates have reported to DOH numerous instances of misinformation provided by NYIAP call center staff, including insisting that a designated representative or family member provide their Social Security number simply to assist in scheduling an assessment. Also, mainstream Medicaid managed care and HARP members (who DOH recently reported make 42% of all NYIAP requests), are often assumed to be seeking a transfer to MLTC, even though they are entitled to obtain PCS or CDPAP services from their mainstream plans. It is crucial that current call center staff receive additional training to minimize misinformation, and that the additional call center staff who will inevitably be needed to manage the increased volume of NYIAP calls be trained to fully understand the different rules for this diverse population.

[1] https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/index.htm, last accessed 10/17/23; https://www.health.ny.gov/health_care/medicaid/redesign/nyia/consumers/index.htm; last accessed 10/17/23.
[2] https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care; last accessed 10/17/23.

4. Publish data regarding the actual time to begin care, as well as the comparison between assessment results pre- and post-NYIAP, on denials, variances and call volume.

Throughout the time that NYIAP has existed, advocates have made repeated requests to DOH for data that shows how long it is taking for individuals to get through the assessment process and begin receiving care. We have also requested data regarding the overall scoring of acuity in the assessments. These requests are based on extensive anecdotal information regarding long delays in accessing care in the increasingly complex system, as well as individuals whose assessments significantly downplay their needs. We have been repeatedly told that this information is not available, and have been provided only minimal data on a monthly basis. We have shared with DOH numerous concerns about how these problems are leading to delayed and denied care and asked for data to help understand the impact of the program on access to care. It is even more important that data on timing of assessments and provision of care be made available before this significant expansion takes place. Such data should include at a minimum:

- **Percent of consumers determined eligible to enroll in MLTC who actually enroll and how long it takes after the NYIAP outcome notice**. DOH issues monthly data on total MLTC enrollment, which increases monthly, but this data does not break down the number who transitioned from a mainstream plan or local district (such as Immediate Need). Therefore, it does not reflect the number of successful post-NYIAP enrollments, nor how long they take.

- **Percent of mainstream and HARP plan members who go through the NYIAP process who are authorized for services by their plans, and length of time after NYIAP Outcome Notice is issued.** DOH has shared data showing that over 40% of all callers to NYIAP are from mainstream and HARP plans, showing a high demand. We would like to know how many access PCS or CDPAP from their plan. For those determined to be medically unstable, we would like to know whether these plans are authorizing private duty nursing services or simply denying PCS or CDPAP. For those determined to have no ADL needs, we would like to know whether plans are assessing and authorizing up to eight hours per week of Level I PCS (Housekeeping) services.

- **Percent of consumers who are determined not eligible to enroll in MLTC because they do not need 120+ days of CB-LTC or, because they are excluded from MLTC, make their way to their district and receive services.** They should be authorized for up to eight hours per week of Housekeeping services, but HRA data shows the number receiving this service has fallen from 510 in July 2022, to 310 in July 2023.[3] We are not aware of public data for other local districts.

- **Data regarding denials.** DOH has only provided the number of outcomes determining that the consumer is "not medically stable," but not the number or percent of consumers denied enrollment in MLTC plans because they do not need 120 days of community-based long term care (CB-LTC). We believe this outcome affects many more people – mostly dual eligibles – than denial for medical instability. At an earlier meeting, DOH orally reported that about 10-11% of requests are denied, but never provided data detailing the basis of denials, how many denials were for mainstream or HARP members vs. those seeking MLTC, or other details.

[3] HRA Monthly Fact Sheet, August 2023, page 2, available at https://www.nyc.gov/assets/hra/downloads/pdf/facts/hra_facts/2023/hra_facts_2023_08.pdf; monthly fact sheets available at https://www.nyc.gov/site/hra/about/facts.page#caseloads.

- **Data regarding variances**. DOH now gives the number of clinical variance requests received in a month but does not break this figure down to show the number received from MLTC plans, mainstream plans, and local districts. Nor is the number of factual variance requests provided, nor the outcome of the variance requests.

- **Data regarding capacity and performance**. We further repeat our past requests for data reflecting existing capacity and performance, including but not limited to call volume and wait times, number of regular two-part assessments conducted within 14 days, 21 days, 28 or more days, with separate data for (1) in-person and telehealth assessments, (2) Immediate Need and other expedited assessments, and (3) DSS and mainstream or HARP members. We ask for the number of consumers requesting assessments in languages other than English and the number of assessments conducted in those languages.

5. **Update policies and procedures and issue guidance to minimize disruption of services**

The current roll-out unnecessarily burdens consumers by putting the onus on them to contact NYIAP for the routine reassessment. This is a departure from longstanding practice, where the plan or LDSS nurse directly contacts the consumer to schedule the reassessment. NYIAP should stand in the shoes of the plan and LDSS nurses who formerly made these calls and contact the consumer directly. Plans and LDSS should be prohibited from discontinuing services for failure to schedule a reassessment.

NYIAP nurse assessors conducting reassessments must be required to review the prior CHAs, plans of care, and case management records that provide a baseline. Otherwise, a nurse who is unfamiliar with a consumer will be basing the assessment on an incomplete snapshot, when the consumer may have been receiving PCS or CDPAP for many years.

DOH must provide written guidance and training to the plans and LDSS regarding the Independent Review Panel. First, any consumer who receives or was ordered to receive more than 12 hours per day through a fair hearing, a court decision, or an external appeal decision is not required to have their case sent to the IRP (18 NYCRR 505.14(b)(4)(xi) and (b)(4)(vi). Also, guidance should remind plans and LDSS that pending review of the IRP's recommendation, the LDSS or MCO may authorize and implement services based on a temporary plan of care which provides for more than 12 hours of personal care services per day on average (505.14(b)(4)(vi). Guidance should remind plans and LDSS that the IRP recommendation is not binding.

DOH written guidance and training is needed to remind plans and LDSS of the required timelines in which they must review prior authorizations and concurrent reviews under standard and expedited timeframes has not changed even with the additional steps required under NYIAP.

Consumers, often in the hospital or nursing home, should not be burdened with making multiple requests for a non-routine assessment to their plan or LDSS and NYIAP. Rather, when the consumer contacts their plan or LDSS, the plan or LDSS should use a warm transfer procedure to contact NYIAP while the consumer is still on the phone. This procedure already exists for initial expedited MCO and immediate need requests. Further non-routine assessments should be conducted in person (18 NYCRR §505.14(b)(2)(i)(c). NYIAP must conduct non-routine reassessments where the consumer is located, including hospitals and rehabilitation facilities.

Advocates are prepared to provide additional recommendations to minimize the disruption of services as NYIAP expands. However, even if the above recommendations were adopted, under the current timeline set out by DOH, there is insufficient time for proper implementation.

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We welcome the opportunity to further discuss our concerns and suggestions to bring clarity to policies governing NYIAP and to provide clear communication to consumers and their families. The NYIAP implementation process suffered from a lack of full engagement by stakeholders, which we would like to rectify going forward.

Thank you for your time and consideration. We look forward to hearing from you on the scheduling of a meeting.

Sincerely,

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The Legal Aid Society

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cc: Dr. James V. McDonald, Commissioner NYS Department of Health
Adam Herbst, Deputy Commissioner, Office of Aging and Long Term Care
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