NEW YORK STATE OF OPPORTUNITY. Department of Health

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 16 OHIP / ADM-02

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: July 1, 2016

SUBJECT: Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services

SUGGESTED DISTRIBUTION:	Medicaid Staff Temporary Assistance Staff Staff Development Coordinators Fair Hearing Staff
CONTACT PERSON:	Local District Liaison: Upstate - (518) 473-6397 New York City - (212) 417-4500
ATTACHMENTS:	Attachment – Immediate Need for Personal Care Services/Consumer Directed Personal Assistance Services: Informational Notice and Attestation Form (OHIP-0103)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR §505.14(b)(7) & (8) and §505.28(k) & (l)	SSL §366-a(12), §364-j(31) §365-a(2)(e)(iii) PHL §4403-f		

I. PURPOSE

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP ADM) is to advise local departments of social services (LDSS) of the requirements to provide expedited Medicaid eligibility determinations for Medicaid applicants who have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS). The directive also advises local districts of expedited procedures for determining PCS or CDPAS eligibility for Medicaid applicants and recipients with an immediate need for either service. The directive defines an applicant/recipient (A/R) with an immediate need for PCS or CDPAS, outlines the requirements that need to be met in order for local districts to perform an expedited eligibility determination and details the time frame for the assessment for PCS or CDPAS.

II. BACKGROUND

Social Services Law Section 366-a(12) requires the Department to develop expedited procedures for social services districts' determinations of Medicaid eligibility for applicants with an immediate need for PCS or CDPAS. The statute requires that the final Medicaid eligibility determination be made within seven days of the date of a complete Medicaid application. For Medicaid applicants with immediate needs for PCS or CDPAS who are determined eligible for Medicaid and PCS or CDPAS, such services are required to be provided pending the individual's enrollment in a managed care plan or managed long-term care plan. For individuals who are either exempt or excluded from enrollment in a managed care or managed long-term care plan, personal care services are provided under the Personal Care Services Program. Department regulations at 18 NYCRR Sections 505.14(b) and 505.28 were amended to set forth the requirements for an expedited determination of Medicaid eligibility for Medicaid applicants with an immediate need for PCS or CDPAS and expedited procedures for PCS or CDPAS assessments for Medicaid applicants and recipients with immediate needs for either service.

These new regulations do not establish a new "immediate needs" program. As noted above, they instead require expedited Medicaid eligibility determinations and expedited PCS and CDPAS assessment determinations for Medicaid applicants and recipients with immediate needs for either service.

III. PROGRAM IMPLICATIONS

A. Medicaid Applicants

Pursuant to the provisions of the newly adopted regulations, districts are required to perform expedited Medicaid eligibility determinations for Medicaid applicants who have an immediate need for PCS or CDPAS [18 NYCRR Sections 505.14(b)(7), for PCS, and 505.28(k), for CDPAS]. A Medicaid applicant with an immediate need for PCS or CDPAS may be either an individual not currently authorized for any type of Medicaid coverage, or an individual authorized only for community-based coverage that does not include coverage for long-term care services such as personal care services. These

individuals must provide the district with a physician's order for PCS or CDPA **and** a signed attestation, on a form required by the Department, attesting that: they have an immediate need for PCS or CDPAS; they have no informal caregivers; they are not receiving needed assistance from a home care services agency; they have no third party insurance or Medicare benefits available to pay for needed assistance; and adaptive or specialized equipment or supplies are not in use to meet, or cannot meet, their need for assistance.

As soon as possible, but no later than four calendar days after receipt of a Medicaid application or request for an increase in Medicaid coverage to include community-based long-term care, together with the physician's order and signed attestation of immediate need, the district is required to determine whether the Medicaid applicant has submitted a complete Medicaid application. The four-day period starts the day after receipt of the three documents (application/request, physician's order, and signed attestation form). A complete Medicaid application means a signed Medicaid application and all documentation necessary for the district to determine the applicant's Medicaid eligibility. If the applicant has not submitted a complete Medicaid application, the district must notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide the documentation.

Once a complete Medicaid application is received, the district must determine Medicaid eligibility within seven calendar days and send notification to the applicant. The seven-day period starts the day after all documentation is received.

For purposes of the eligibility determination, an applicant who would otherwise be required to document his or her accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts. After the determination of Medicaid eligibility, if the district has information inconsistent with the information attested to by the applicant, and the inconsistency is material to the individual's Medicaid eligibility, the district will request documentation adequate to verify resources.

Concurrent with the determination of Medicaid eligibility for a Medicaid applicant with an immediate need for PCS or CDPAS, the district must determine whether the applicant would be eligible for PCS or CDPAS, if determined financially and otherwise eligible for Medicaid [505.14(b)(7)(iv); 505.28(k)(4)]. As soon as possible but no later than twelve calendar days after receipt of a complete Medicaid application, the district must obtain or complete a social assessment and nursing assessment and determine whether the Medicaid applicant, if determined eligible for Medicaid, would be eligible for PCS or CDPAS and, if so, the amount and duration of services that would be authorized. To perform the PCS or CDPAS assessment, the district must follow the applicable regulatory requirements in Section 505.14, for PCS, or 505.28, for CDPAS, except that no referral to the local professional director ("LPD") is required in 24-hour cases or in any other case in which the regulations otherwise require such referrals to the LPD. In no event shall PCS or CDPAS be authorized unless the Medicaid applicant is determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

B. Medicaid Recipients

Department regulations at 18 NYCRR Section 505.14(b)(8), for PCS, and 505.28(l), for CDPAS, also provide for expedited procedures for Medicaid recipients with an immediate need for PCS or CDPAS. A Medicaid recipient with an immediate need for PCS or CDPAS includes an individual who is exempt or excluded from enrollment in a managed long term care plan or managed care entity, or an individual who is not exempt or excluded from enrollment in such a plan or provider but who has not yet been enrolled.

The Medicaid recipient could be an individual who was formerly a Medicaid applicant in immediate need of PCS or CDPAS and who was determined, pursuant to the expedited Medicaid eligibility determination and PCS or CDPAS assessment procedures outlined above, to be eligible for Medicaid as well as PCS or CDPAS. The district must promptly notify such recipients of the amount and duration of PCS or CDPAS to be authorized and issue an authorization for, and arrange for the provision of such services, which must be provided as expeditiously as possible. For recipients who are not exempt or excluded from enrollment in a managed care entity, the district would authorize services to be provided until the recipient is enrolled in such an entity.

The Medicaid recipient could also be any other Medicaid recipient who is eligible for Medicaid coverage of community-based long-term care services and who seeks an expedited PCS or CDPAS assessment because the recipient believes he or she is in immediate need of such services. Such individuals must present a physician's order for services and a signed attestation on the Department required form that they have an immediate need for PCS or CDPAS. The local district is required, as soon as possible but no later than twelve calendar days after receipt of the physician's order and the signed attestation form, to assess the recipient's eligibility for PCS or CDPAS and determine whether the recipient is eligible for services and, if so, the amount and duration of services to be authorized. To perform the PCS or CDPAS assessment, the district must follow the applicable regulatory requirements in Section 505.14, for PCS, or 505.28, for CDPAS, except that no referral to the local professional director ("LPD") is required in 24-hour cases or in any other case in which the regulations otherwise require such referrals to the LPD. If the recipient is determined to be eligible for PCS or CDPAS, the district must promptly notify the recipient of the amount and duration of PCS or CDPAS to be authorized and issue an authorization for, and arrange for the provision of such services, which must be provided as expeditiously as possible. For recipients who are not exempt or excluded from enrollment in a managed care entity, the district would authorize services to be provided until the person is enrolled in such an entity. Recipients who are determined to be ineligible for PCS or CDPAS must also be notified of the denial of services and of their right to request a fair hearing to review the denial.

Nursing assessments may be performed by additional registered professional nurses. Nursing assessments may be performed by a certified home health agency nurse; a nurse employed by a voluntary or proprietary agency under contract with the district for the provision of services; as well as a nurse employed by, or under contract with, the district.

IV. REQUIRED ACTION

A. Attestation of Immediate Need and Information Regarding Expedited Procedures to be Provided to Medicaid Applicants

Written information regarding the expedited Medicaid eligibility determination process and expedited PCS or CDPAS assessment process must be provided to Medicaid applicants. A new informational notice entitled "Immediate Need for Personal Care Services/Consumer Directed Personal Assistance Services: Informational Notice and Attestation Form" (OHIP-0103) (see the Attachment to this directive), is to be used for this notification and includes the required attestation of immediate need form. The OHIP-0103 must be provided with the Access NY Health Insurance Application (DOH-4220) and also when Access NY Supplement A (DOH-4495A or DOH-5178A, for local districts using the Asset Verification System) is required to be completed for a Medicaid recipient requesting Medicaid coverage of community-based long-term care. The Department will include information about immediate need for PCS or CDPAS on its website along with information about the procedures and forms for requesting these services. Individuals completing the combined Temporary Assistance and Medicaid application (LDSS-2921) are instructed to complete the Access NY Health Insurance Application (DOH-4220) if they are in need of PCS or CDPAS services.

The informational notice entitled "Immediate Need for Personal Care Services/Consumer Directed Personal Assistance Services: Informational Notice and Attestation Form" (OHIP-0103) includes the A/R's attestation that there is an immediate need for Personal Care Services or Consumer Directed Personal Assistance Services and that:

- no voluntary informal caregivers are available, able and willing to provide or continue to provide needed assistance to the applicant;
- no home care services agency is providing needed assistance to the applicant;
- 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; and
- third party insurance or Medicare benefits are not available to pay for needed assistance.

The attestation of immediate need must be signed by either the Medicaid A/R, the A/R's spouse or a legal representative of the A/R.

For NY State of Health Medicaid recipients who are not enrolled in managed care, if NY State of Health is notified of the need for immediate PCS or CDPAS, the individual's Medicaid coverage will be transitioned to the district for a PCS or CDPAS assessment when a physician's order for services and signed attestation of immediate need form (OHIP-0103) are received. Notifications of the need for immediate PCS or CDPAS, and

required documents, can come through various entities such as: the local district; the Department of Health; the NYSOH call center; and Medicaid providers. The Department has established a DOH mailbox at hxfacility@health.ny.gov as a central location for these contacts. Local districts and providers have been instructed to contact the Department through the mailbox to initiate a referral from NY State of Health to the district. When a referral is required, DOH staff will obtain information from NY State of Health that is necessary for the district to open a Medicaid case for the individual. This information will be sent to the Medicaid Director at the district. As soon as possible after the district receives a physician's order for services and a signed attestation of immediate need form (OHIP-0103), but no later than twelve calendar days after receipt of these documents, the district must determine whether the recipient is eligible for PCS or CDPAS and, if so, the amount and duration of services to be authorized. The district must otherwise follow the procedures governing expedited PCS or CDPAS eligibility determinations for Medicaid recipients with an immediate need for PCS or CDPAS that are set forth at page 8 of Section IV.D of this directive.

B. Expedited Medicaid Eligibility Determination Procedures for Medicaid Applicants with an Immediate Need for Personal Care Services/Consumer Directed Personal Assistance Services

When an applicant with an immediate need for PCS or CDPAS submits a signed Access NY Health Insurance Application (DOH-4220), or Access NY Supplement A (DOH-4495A or DOH-5178A, as applicable) for recipients not currently authorized for Medicaid coverage of community-based long-term care services, together with a signed attestation of immediate need form (OHIP-0103) and a physician's order, the applicant meets the criteria for an expedited eligibility determination for Medicaid coverage of PCS or CDPAS and an expedited assessment for PCS or CDPAS, as appropriate.

For Medicaid applicants with an immediate need for PCS or CDPAS, the district must first determine the Medicaid category of the individual. For individuals who otherwise meet the categorical criteria for the Modified Adjusted Gross Income (MAGI) category of assistance, the district shall compare gross income, as reported on the application and supported by any documentation submitted, to 138% of the federal poverty level for the appropriate household size. If the applicant's gross income is at or below the applicable income amount, the only resource information that is required in order to determine Medicaid eligibility is the equity value of the individual's home. As notified in GIS 14 MA/16, "Long Term Care Eligibility Rules and Estate Recovery Provisions for MAGI Individuals," the home equity limit and exceptions apply to MAGI individuals in determining eligibility for long-term care services. To expedite the eligibility determination process, MAGI individuals with an immediate need for PCS or CDPAS may attest to the value of their home equity.

For applicants in the SSI-related category of assistance (age 65 and older, certified blind and certified disabled), resource documentation is required to determine Medicaid eligibility for long-term care services. For purposes of expediting the eligibility determination process, an SSI-related applicant with an immediate need for PCS or CDPAS may attest to the current value of any real property (including the equity value of the homestead) and the current value of any bank accounts. All other resource

documentation requirements for Medicaid coverage of long-term care services remain the same.

Married applicants with a community spouse who is not applying for or in receipt of services through a managed long term care plan, waiver services under section 1915(c) of the Social Security Act, or nursing home care, and who may qualify for services through a managed long term care plan, shall have eligibility determined under the spousal impoverishment provisions pending the outcome of the assessment for managed long term care and enrollment into a managed long term care plan. If an assessment subsequently determines the individual ineligible for managed long term care, the district must re-determine the individual's Medicaid eligibility and send a timely notice of any change in eligibility.

Based on the applicant's category, the district must determine if the application and documentation submitted with the application, includes all the information and documentation necessary for a complete eligibility determination. As soon as possible, but no later than four calendar days after the receipt of the application and accompanying documentation, the district must notify the applicant of any additional documentation that the applicant must provide and the date by which the applicant must provide the documentation.

Note: If within this four-day period, the district receives information through a collateral source such as the Resource File Integration (RFI) System or Asset Verification System (AVS), that requires documentation of information in order to resolve a discrepancy, including bank account information, such documentation must be included with the request for further documentation sent to the applicant. If, in this situation, the documentation request has already been sent, a second request for information/documentation must be immediately sent.

Once a complete Medicaid application is submitted, including all information and documentation necessary for a complete eligibility determination, the local district must make a Medicaid eligibility determination and send the appropriate eligibility notice as soon as possible, but no later than seven calendar days after receipt of the complete application. The seven-day period starts the day after receipt of the complete application.

For SSI-related applicants who are determined to be eligible for Medicaid, districts should use Resource Verification Indicator code "2" (documented current resources) with the appropriate coverage code (Provisional Coverage, Outpatient Coverage with Community-Based Long-Term Care or Community Coverage with Community-Based Long Term Care). At renewal, such individuals who continue to reside in the community, can attest to the current value of resources.

If after an eligibility determination is made, the local district has information that is inconsistent with the attested information and the inconsistency is relevant to the individual's Medicaid eligibility, the local district shall request documentation to verify the inconsistency in question. If upon further review of the provided information, the individual is determined to be ineligible for Medicaid or the individual does not provide

the requested documentation within the required time period, proper notice regarding the individual's ineligibility must be sent with 10-day notice of the change. The district may pursue any Medicaid incorrectly paid back to the date of the expedited eligibility determination. This includes situations where following an assessment for managed long term care, a married individual is determined to not qualify for managed long term services and the change from spousal impoverishment budgeting to SSI-related budgeting no longer qualifies the individual for Medicaid. Timely notice must be provided to the individual. If the individual remains eligible for Medicaid but with a spenddown liability, such coverage change is to be made prospectively following 10-day notification of the change (the first day of the month following the 10-day notice period). In this situation, when pursuing a recovery for Medicaid incorrectly paid back to the date of the expedited eligibility determination, the recovery amount is limited to the amount of the individual's spenddown liability.

Upon submission of a Medicaid application by an individual with an immediate need for personal care, a referral for a PCS/CDPAS assessment is to be made immediately. The usual district procedures are followed to refer the individual for a PCS/CDPAS assessment.

C. <u>Expedited PCS or CDPAS Eligibility Determination for Medicaid Applicants with an Immediate Need for PCS or CDPAS</u>

Concurrent with the determination of Medicaid eligibility for a Medicaid applicant with an immediate need for PCS or CDPAS, as described above, the district must determine whether the applicant would be eligible for PCS or CDPAS, if determined financially and otherwise eligible for Medicaid [505.14(b)(7)(iv); 505.28(k)(4)]. **The district must not wait until the results of the Medicaid eligibility determination before assessing the applicant's eligibility for PCS or CDPAS, as appropriate.**

As soon as possible after receipt of a complete Medicaid application but no later than twelve calendar days after receipt of a complete Medicaid application, the district must obtain or complete a social assessment and nursing assessment and determine whether the Medicaid applicant, if determined eligible for Medicaid, would be eligible for PCS or CDPAS and, if so, the amount and duration of services that would be authorized. To perform the PCS or CDPAS assessment, the district must follow the applicable regulatory requirements in Section 505.14, for PCS, or 505.28, for CDPAS, except that no referral to the local professional director ("LPD") is required in 24-hour cases or in any other case in which the regulations otherwise require such referrals to the LPD.

In no event shall PCS or CDPAS be authorized unless the Medicaid applicant is determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

D. Expedited PCS or CDPAS Eligibility Determinations for Medicaid Recipients with an Immediate Need for PCS or CDPAS

Department regulations at 18 NYCRR Section 505.14(b)(8), for PCS, and 505.28(l), for CDPAS, also provide for expedited procedures for Medicaid recipients with an immediate need for PCS or CDPAS. A Medicaid recipient with an immediate need for PCS or CDPAS includes an individual who is exempt or excluded from enrollment in a managed long term care plan or managed care entity or an individual who is not exempt or excluded from enrollment in such a plan or entity but who has not yet been enrolled.

The Medicaid recipient could be an individual who was formerly a Medicaid applicant in immediate need of PCS or CDPAS and who was determined, pursuant to the expedited Medicaid eligibility determination and PCS or CDPAS assessment procedures outlined above, to be eligible for Medicaid as well as PCS or CDPAS. If the former Medicaid applicant is determined to be eligible for Medicaid as well as PCS or CDPAS, the district must promptly notify these individuals of the amount and duration of PCS or CDPAS to be authorized and issue an authorization for, and arrange for the provision of, such services, which must be provided as expeditiously as possible. For recipients who are not exempt or excluded from enrollment in a managed care entity, the district would authorize services to be provided until the recipient is enrolled in such an entity.

The Medicaid recipient could also be any other Medicaid recipient who is eligible for Medicaid coverage of community-based long-term care services and who seeks an expedited PCS or CDPAS assessment because the recipient believes he or she is in immediate need of such services. This includes NY State of Health Medicaid recipients who are not enrolled in managed care. (See discussion at pages 4-5 of Section IV.A. of this directive) Such individuals must present a physician's order for services and a signed attestation on the Department required form (OHIP-0103) that they have an immediate need for PCS or CDPAS. The local district is required, as soon as possible but no later than twelve calendar days after receipt of the physician's order and the signed attestation form, to assess the recipient's eligibility for PCS or CDPAS and determine whether the recipient is eligible for services and, if so, the amount and duration of services to be authorized. To perform the PCS or CDPAS assessment, the district must follow the applicable regulatory requirements in Section 505.14, for PCS, or 505.28, for CDPAS, except that no referral to the local professional director ("LPD") is required in 24-hour cases or in any other case in which the regulations otherwise require such referrals to the LPD. If the recipient is determined to be eligible for PCS or CDPAS, the district must promptly notify the recipient of the amount and duration of PCS or CDPAS to be authorized and issue an authorization for, and arrange for the provision of such services, which must be provided as expeditiously as possible. For recipients who are not exempt or excluded from enrollment in a managed care entity, the district would authorize services to be provided until the person is enrolled in such an entity. Recipients who are determined to be ineligible for PCS or CDPAS must also be notified of the denial of services and of their right to request a fair hearing to review the denial.

Nursing assessments may be performed by additional registered professional nurses. Nursing assessments may be performed by a certified home health agency nurse; a nurse employed by a voluntary or proprietary agency under contract with the district for

the provision of services; as well as a nurse employed by, or under contract with, the district.

V. SYSTEMS IMPLICATIONS

There are no systems implications associated with this directive.

VI. EFFECTIVE DATE

The provisions of this Administrative Directive are effective July 6, 2016.

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs