Immediate Needs for Personal Care Services and Consumer Directed Personal Assistance

Effective date: 7/6/16

SUMMARY OF EXPRESS TERMS

The proposed regulations amend the Department's personal care services regulations by adding paragraphs (7) and (8) to 18 NYCRR § 505.14(b). They also amend the Department's consumer directed personal assistance program regulations by adding subdivisions (k) and (l) to 18 NYCRR § 505.28.

New paragraph 505.14(b)(7) sets forth expedited procedures for social services districts' determinations of Medicaid eligibility and personal care services eligibility for Medicaid applicants with an immediate need for personal care services.

Clause 505.14(b)(7)(i)(a) defines the term "*Medicaid applicant with an immediate need for personal care services*." The term includes two groups of individuals who seek Medicaid coverage: those who are not currently authorized for any type of Medicaid coverage; and those who are currently authorized for Medicaid coverage but only for community-based coverage not including coverage for long-term care services such as personal care services. These individuals must provide the social services district with a physician's order for personal care services and a signed attestation, on a form required by the Department, that they have an immediate need for personal care services and that they have no informal caregivers, are not receiving personal care services from a home care services agency, have no adaptive or specialized equipment or supplies to meet their needs, and have no third party insurance or Medicare benefits available to pay for needed assistance.

Clause 505.14(b)(7)(i)(b) defines the term "*complete Medicaid application*." This term means a signed Medicaid application and all documentation necessary for the district to determine the applicant's Medicaid eligibility. 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 commissioner or district has information indicating an inconsistency with the information to which the applicant had attested prior to being determined eligible for Medicaid, and the inconsistency is material to the individual's Medicaid eligibility, the district shall request documentation adequate to verify the resources.

Subparagraph 505.14(b)(7)(ii) requires the social services district to determine whether the Medicaid applicant has submitted a complete Medicaid application and, if not, notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide such documentation. When the applicant submits the Medicaid application together with the physician's order and signed attestation of immediate need, the district must provide the notice as soon as possible and no later than four calendar days after receipt of the Medicaid application, physician's order, and signed attestation. When the applicant submits the Medicaid application and subsequently submits the physician's order, the signed attestation, or both such documents, the district must provide the notice as soon as possible and no later than four calendar days after receipt of both the physician's order and the signed attestation.

Subparagraph 505.14(b)(7)(iii) requires the social services district to determine whether a Medicaid applicant with an immediate need for personal care services is eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and notify the

applicant of such determination. The district must make this determination and notify the applicant as soon as possible but no later than seven calendar days after receipt of a complete Medicaid application.

Subparagraph 505.14(b)(7)(iv) provides that, concurrently with determining the Medicaid eligibility of an applicant with an immediate need for personal care services, the social services district would determine whether the applicant, if found eligible for Medicaid, would be eligible for personal care services. As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for personal care services, but no later than twelve calendar days after receipt of the complete Medicaid application, the social services district would obtain or complete a social assessment, nursing assessment and an assessment of other services, and determine whether the Medicaid applicant, if determined eligible for Medicaid, would be eligible for personal care services and, if so, the amount and duration of services that would be authorized. Personal care services would not be authorized to be provided unless the individual is determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

Subparagraph 505.14(b)(7)(v) requires social services districts to provide Medicaid applicants with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility determination and personal care services assessment procedures set forth in paragraph 505.14(b)(7) as the Department may require.

The proposed regulations also add paragraph (8) to Section 505.14(b), which sets forth expedited personal care services assessment procedures for Medicaid recipients with an immediate need for personal care services.

Subparagraph 505.14(b)(8)(i) defines the term "*Medicaid recipient with an immediate need for personal care services*."

Under subclauses 505.14(b)(8)(i)(a)(1) and (2), a "*Medicaid recipient with an immediate need for personal care services*" means an individual who is exempt or excluded from enrollment in a managed long term care plan or managed care provider or an individual who is not exempt or excluded from enrollment in such a plan or provider but who has not yet been enrolled.

In addition, a "*Medicaid recipient with an immediate need for personal care services*" means an individual who also meets the criteria in either subclause (i)(b)(1) of Section 505.14(b)(8) or subclause (i)(b)(2) of Section 505.14(b)(8).

Under subclause (i)(b)(1) of Section 505.14(b)(8), a "*Medicaid recipient with an immediate need for personal care services*" means a recipient who was a "Medicaid applicant with an immediate need for personal care services" pursuant to paragraph 505.14(b)(7) and who was determined, pursuant to such paragraph, to be eligible for Medicaid and personal care services. Under subparagraph 505.14(b)(8)(ii), social services districts would be required to notify such a "Medicaid recipient with an immediate need for personal care services" promptly of the amount and duration of personal care services to be authorized 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.

Under subclause (i)(b)(2) of Section 505.14(b)(8), a "*Medicaid recipient with an immediate need for personal care services*" means a Medicaid recipient who has been

determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who provides to the social services district a physician's order for personal care services and a signed attestation of immediate need on a form required by the Department. Under clause 505.14(b)(8)(iii)(a), social services districts would be required, as soon as possible after receipt of the physician's order and signed attestation of immediate need from such a recipient but no later than twelve calendar days after receipt of such documentation, to assess the recipient's eligibility for personal care services and determine whether the recipient is eligible for services and, if so, the amount and duration of services to be authorized. 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.

Subparagraph 505.14(b)(8)(iv) requires social services districts to provide Medicaid applicants with the required attestation of immediate need form and such other information regarding the expedited personal care services assessment procedures set forth in paragraph 505.14(b)(8) as the Department may require.

The proposed regulations make similar revisions to the Department's regulations governing the consumer directed personal assistance program at 18 NYCRR § 505.28. New subdivision 505.28(k) sets forth expedited procedures for social services districts' determinations of Medicaid eligibility for applicants with an immediate need for consumer directed personal assistance. These expedited procedures are similar to those set forth in proposed new 505.14(b)(7) for Medicaid applicants with an immediate need for personal care services. In addition, new subdivision 505.28(l) sets forth expedited consumer directed assistance assessment procedures for Medicaid recipients with an immediate need for consumer directed personal

assistance. These expedited assessment procedures are similar to those set forth at proposed new 505.14(b)(8) for Medicaid recipients with an immediate need for personal care services.

Section 505.14(b)(3) and Section 505.28(d)(3) would be amended to permit nursing assessments to be performed by additional registered professional nurses, those under contract with a social services district.

Pursuant to the authority vested in the Commissioner of Health by Social Services Law Sections 363-a(2), 365-a(2)(e) and 365-f and Public Health Law Section 201(1)(v), Sections 505.14 and 505.28 of Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) are amended, to be effective on July 6, 2016, to read as follows:

Subparagraph (b)(3)(iii) of section 505.14 is amended to read as follows:

(iii) The nursing assessment shall be completed by a nurse from the certified home health agency, [or] a nurse employed by, or under contract with, the local social services department, or a nurse employed by a voluntary or proprietary agency under contract with the local social services department.

Clause (b)(3)(iii)(a) of section 505.14 is amended to read as follows:

(a) A nurse employed by, or under contract with, the local social services department or by a voluntary or proprietary agency under contract with the local social services department shall have the following minimum qualifications:

Subparagraph (b)(5)(iv) of section 505.14 is repealed and subparagraphs (b)(5)(v) through (b)(5)(x) of section 505.14 are relettered as subparagraphs (b)(5)(iv) through (b)(5)(ix), respectively.

Clause (c) of such relettered 505.14(b)(5)(ix) is amended to read as follows:

(c) When the change in the patient's services needs results from a change in his/her medical condition, the local social services department shall obtain a new physician's order and a new nursing assessment and shall complete a new social assessment. [If the patient's medical

condition continues to require the provision of personal care services, and the nursing assessment can not be obtained within five working days of the request from the local social services department, the local department may make changes in the authorization in accordance with the procedures specified in subparagraph (b)(5)(iv) of this section.]

Paragraphs (7) and (8) are added to subdivision 505.14(b) to read as follows:

(7) This paragraph sets forth expedited procedures for social services districts' determinations of medical assistance ("Medicaid") eligibility and personal care services eligibility for Medicaid applicants with an immediate need for personal care services.

(i) The following definitions apply to this paragraph:

(a) A *Medicaid applicant with an immediate need for personal care services* means an individual seeking Medicaid coverage who:

(1) (i) is not currently authorized for Medicaid coverage; or

(ii) is currently authorized for Medicaid coverage only for community-based coverage without long-term care services; and

(2) provides to the social services district:

(i) a physician's order for personal care services; and

(ii) a signed attestation on a form required by the Department that the applicant has an immediate need for personal care services ("attestation of immediate need") and that:

(A) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the applicant;

(B) no home care services agency is providing needed assistance to the applicant;

(C) 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

(D) third party insurance or Medicare benefits are not available to pay for needed assistance.

(b) A *complete Medicaid application* means a signed Medicaid application and all documentation necessary for the social services district to determine the applicant's Medicaid eligibility. For purposes of this paragraph, an applicant who would otherwise be required to document 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 commissioner or the district has information indicating an inconsistency between the value or dollar amount of such resources and the value or dollar amount to which the applicant had attested prior to being determined eligible for Medicaid, and

the inconsistency is material to the individual's Medicaid eligibility, the district must request documentation adequate to verify such resources.

(ii) The social services district must determine whether the applicant has submitted a complete Medicaid application. 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 such documentation.

(a) When the applicant submits the Medicaid application together with the physician's order and the signed attestation of immediate need, the district must provide such notice as soon as possible and no later than four calendar days after receipt of these documents.

(b) When the applicant submits the Medicaid application and subsequently submits the physician's order, the signed attestation of immediate need, or both such documents, the district must provide such notice as soon as possible and no later than four calendar days after receipt of both the physician's order and the signed attestation of immediate need.

(iii) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for personal care services, but no later than seven calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must determine whether the applicant is eligible for Medicaid, including

Medicaid coverage of community-based long-term care services, and notify the applicant of such determination.

(iv) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for personal care services, but no later than twelve calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must:

(a) obtain or complete a social assessment, nursing assessment, and an assessment of other services pursuant to subparagraphs (3)(ii) through (3)(iv) of this subdivision; and

(b) determine whether the applicant, if determined eligible for Medicaid, would be eligible for personal care services and, if so, the amount and duration of the personal care services that would be authorized should the applicant be determined eligible for Medicaid; provided, however, that personal care services shall be authorized only for applicants who are determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services. In no event shall personal care services be authorized for a Medicaid applicant unless the applicant has been determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

(v) Social services districts must provide Medicaid applicants with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility determination and personal care services assessment procedures set forth in this paragraph as the Department may require.

(8) This paragraph sets forth expedited personal care services assessment procedures for medical assistance ("Medicaid") recipients with an immediate need for personal care services.

(i) A *Medicaid recipient with an immediate need for personal care services* means an individual seeking personal care services who:

(a)(1) is exempt or excluded from enrollment in a managed long term care plan operating pursuant to Section 4403-f of the Public Health Law or a managed care provider operating pursuant to Section 364-j of the Social Services Law; or

(2) is not exempt or excluded from enrollment in a plan or provider described in subclause (a)(1) but is not yet enrolled in any such plan or provider; and

(b)(1) was a Medicaid applicant with an immediate need for personal care services pursuant to paragraph (7) of this subdivision who was determined, pursuant to such paragraph, to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who was also determined pursuant to such paragraph to be eligible for personal care services; or

(2) is a Medicaid recipient who has been determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who provides to the social services district:

(i) a physician's order for personal care services; and

(ii) a signed attestation on a form required by the Department that the recipient has an immediate need for personal care services ("attestation of immediate need") and that:

(A) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the recipient;

(B) no home care services agency is providing needed assistance to the recipient;

(C) 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 recipient's need for assistance; and

(D) third party insurance or Medicare benefits are not available to pay for needed assistance.

(ii) With regard to a Medicaid recipient with an immediate need for personal care services who is described in subclause (i)(b)(1) of this paragraph, the social services district must promptly notify the recipient of the amount and duration of

personal care services to be authorized and issue an authorization for, and arrange for the provision of, such personal care services, which must be provided as expeditiously as possible. With respect to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or managed care provider, the district must authorize personal care services to be provided until such recipients are enrolled in such a plan or provider.

(iii)(a) With regard to a Medicaid recipient with an immediate need for personal care services who is described in subclause (i)(b)(2) of this paragraph, the social services district, as soon as possible after receipt of the physician's order and signed attestation of immediate need, but no later than twelve calendar days after receipt of such documentation, must:

(1) obtain or complete a social assessment, nursing assessment, and an assessment of other services pursuant to subparagraphs (3)(ii) through (3)(iv) of this subdivision; and

(2) determine whether the recipient is eligible for personal care services and, if so, the amount and duration of the personal care services to be authorized.

(b) The social services district must promptly notify the recipient of the amount and duration of personal care services to be authorized and issue an authorization for, and arrange for the provision of, such personal care services, which must be provided as expeditiously as possible. With respect to those recipients who are neither exempt nor excluded from

enrollment in a managed long term care plan or managed care provider, the district must authorize personal care services to be provided until such recipients are enrolled in such a plan or provider.

(iv) Social services districts must provide Medicaid recipients with the required attestation of immediate need form and such other information regarding the expedited personal care services assessment procedures set forth in this paragraph as the Department may require.

Subparagraphs (g)(3)(x) and (g)(3)(xvii) of section 505.14 are amended to read as follows:

(x) assuring that the patient is provided written notification of personal care services initially authorized, reauthorized, denied, increased, reduced, discontinued, or suspended and his or her right to a fair hearing, as specified in Part 358 of this Title and subparagraph [(b)(5)(v)] (b)(5)(iv) of this section;

(xvii) promptly initiating and complying with the procedures specified in subparagraph [(b)(5)(x)] (b)(5)(ix) of this section when the patient's social circumstances, mental status or medical condition unexpectedly change during the authorization period;

Subparagraph (h)(3)(iii) of section 505.14 is amended to read as follows:

(iii) If the services are provided by or under arrangements with an individual provider of personal care services, or an individual nurse under contract with the social services district for the performance of nursing assessments, payment is made directly to the

individual provider of service or such nurse at a rate approved by the department and the Director of the Budget. The social services district is responsible for establishing policies for the withholding of all applicable income taxes and payment of the employer's share of FICA, workers' compensation, unemployment insurance and any other benefits included in the contract with the provider.

Subparagraph (d)(3)(i) of section 505.28 is amended to read as follows:

(i) The nursing assessment must be completed by a registered professional nurse who is employed by, or under contract with, the social services district or by a licensed or certified home care services agency or voluntary or proprietary agency under contract with the district.

Subdivisions (k) and (l) are added to section 505.28 to read as follows:

(k) This subdivision sets forth expedited procedures for social services districts' determinations of medical assistance ("Medicaid") eligibility and consumer directed personal assistance eligibility for Medicaid applicants with an immediate need for consumer directed personal assistance.

(1) The following definitions apply to this subdivision:

(i) A *Medicaid applicant with an immediate need for consumer directed personal assistance* means an individual seeking Medicaid coverage who:

(a)(1) is not currently authorized for Medicaid coverage; or

(2) is currently authorized for Medicaid coverage only for community-based coverage without long-term care services; and

(b) provides to the social services district:

(1) a physician's order for consumer directed personal assistance; and

(2) a signed attestation on a form required by the Department that the applicant has an immediate need for consumer directed personal assistance ("attestation of immediate need") and that:

(i) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the applicant;

(ii) no home care services agency is providing needed assistance to the applicant;

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

(iv) third party insurance or Medicare benefits are not available to pay for needed assistance.

(ii) A *complete Medicaid application* means a signed Medicaid application and all documentation necessary for the social services district to determine the applicant's Medicaid eligibility. For purposes of this subdivision, an applicant who would otherwise be required to document 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 commissioner or the district has information indicating an inconsistency between the value or dollar amount of such resources and the value or dollar amount to which the applicant had attested prior to being determined eligible for Medicaid, and the inconsistency is material to the individual's Medicaid eligibility, the district must request documentation adequate to verify such resources.

(2) The social services district must determine whether the applicant has submitted a complete Medicaid application. 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 such documentation.

(i) When the applicant submits the Medicaid application together with the physician's order and the signed attestation of immediate need, the district must provide such notice as soon as possible and no later than four calendar days after receipt of these documents.

(ii) When the applicant submits the Medicaid application and subsequently submits the physician's order, the signed attestation of immediate need, or both such documents, the district must provide such notice as soon as possible and no later than four calendar days after receipt of both the physician's order and the signed attestation of immediate need.

(3) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for consumer directed personal assistance, but no later than seven calendar days after receipt of a complete Medicaid application from such an applicant, the social services district must determine whether the applicant is eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and notify the applicant of such determination.

(4) As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for consumer directed personal assistance, but no later than twelve calendar

days after receipt of a complete Medicaid application from such an applicant, the social services district must:

(i) obtain or complete a social assessment and a nursing assessment pursuant to paragraphs (d)(2) and (d)(3) of this subdivision; and

(ii) determine whether the applicant, if determined eligible for Medicaid, would be eligible for consumer directed personal assistance and, if so, the amount and duration of the consumer directed personal assistance that would be authorized should the applicant be determined eligible for Medicaid; provided, however, that consumer directed personal assistance shall be authorized only for applicants who are determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services. In no event shall consumer directed personal assistance be authorized for a Medicaid applicant unless the applicant has been determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

(5) Social services districts must provide Medicaid applicants with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility determination and consumer directed personal assistance assessment procedures set forth in this subdivision as the Department may require.

(l) This subdivision sets forth expedited consumer directed personal assistance assessment procedures for medical assistance ("Medicaid") recipients with an immediate need for consumer directed personal assistance.

(1) A *Medicaid recipient with an immediate need for consumer directed personal assistance* means an individual seeking consumer directed personal assistance who:

(i)(a) is exempt or excluded from enrollment in a managed long term care plan operating pursuant to Section 4403-f of the Public Health Law or a managed care provider operating pursuant to Section 364-j of the Social Services Law; or

(b) is not exempt or excluded from enrollment in a plan or provider described in clause (i)(a) but is not yet enrolled in any such plan or provider; and

(ii)(a) was a Medicaid applicant with an immediate need for consumer directed personal assistance pursuant to subdivision (k) of this section who was determined, pursuant to such subdivision, to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who was also determined pursuant to such subdivision to be eligible for consumer directed personal assistance; or

(b) is a Medicaid recipient who has been determined to be eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and who provides to the social services district:

(1) a physician's order for consumer directed personal assistance; and

(2) a signed attestation on a form required by the Department that the recipient has an immediate need for consumer directed personal assistance ("attestation of immediate need") and that:

(i) no voluntary informal caregivers are available, able, and willing to provide or continue to provide needed assistance to the recipient;

(ii) no home care services agency is providing needed assistance to the recipient;

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

(iv) third party insurance or Medicare benefits are not available to pay for needed assistance.

(2) With regard to a Medicaid recipient with an immediate need for consumer directed personal assistance who is described in clause (1)(ii)(a) of this subdivision, the social services district must promptly notify the recipient of the amount and duration of consumer directed personal assistance to be authorized and issue an authorization for, and arrange for the provision of, such consumer

directed personal assistance, which must be provided as expeditiously as possible. With respect to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or managed care provider, the district must authorize consumer directed personal assistance to be provided until such recipients are enrolled in such a plan or provider.

(3)(i) With regard to a Medicaid recipient with an immediate need for consumer directed personal assistance who is described in clause (1)(ii)(b) of this subdivision, the social services district, as soon as possible after receipt of the physician's order and signed attestation of immediate need, but no later than twelve calendar days after receipt of such documentation, must:

(a) obtain or complete a social assessment and a nursing assessment pursuant to paragraphs (d)(2) and (d)(3) of this subdivision; and

(b) determine whether the recipient is eligible for consumer directed personal assistance and, if so, the amount and duration of consumer directed personal assistance to be authorized.

(ii) The social services district must promptly notify the recipient of the amount and duration of consumer directed personal assistance to be authorized and issue an authorization for, and arrange for the provision of, such consumer directed personal assistance, which must be provided as expeditiously as possible. With regard to those recipients who are neither exempt nor excluded from enrollment in a managed long term care plan or

managed care provider, the district must authorize consumer directed personal assistance to be provided until such recipients are enrolled in such a plan or provider.

(4) Social services districts must provide Medicaid recipients with the required attestation of immediate need form and such other information regarding the expedited consumer directed personal assistance assessment procedures set forth in this subdivision as the Department may require.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Social Services Law ("SSL") § 363-a(2) and Public Health Law § 201(1)(v) empower the Department to adopt regulations implementing the State's Medical Assistance ("Medicaid") program. Under SSL § 366-a(12), the Department must develop expedited procedures for social services districts' determinations of Medicaid eligibility for applicants with immediate needs for personal care services ("PCS") or consumer directed personal assistance ("CDPA"). Under SSL § 364-j(31), the Department must provide PCS and CDPA, as appropriate, to Medicaid recipients with immediate needs for such services pending approval by managed care providers under SSL § 364-j or managed long term care ("MLTC") plans under Public Health Law § 4403-f. Under SSL § 365-a(2)(e)(iii), the Department must provide assistance, consistent with SSL § 364-j(31), to Medicaid PCS recipients who are transitioning to receive care from MLTC plans.

Legislative Objectives:

The Legislature's objective in enacting the statutory authority was two-fold: to expedite Medicaid eligibility determinations for Medicaid applicants with immediate needs for PCS or CDPA, and, for those Medicaid applicants with immediate needs for either service who are determined eligible for Medicaid, to require the provision of PCS and CDPA, as appropriate, pending the individuals' enrollment in a managed care provider or MLTC plan. The proposed regulations are consistent with the Legislature's objectives.

Needs and Benefits:

The purpose of the proposed regulations is to implement the Legislature's recent amendments to the SSL with regard to Medicaid applicants and recipients with immediate needs for PCS or CDPA.

The Legislature added new SSL § 366-a(12), as follows:

> The commissioner shall develop expedited procedures for determining medical assistance eligibility for any medical assistance applicant with an immediate need for personal care or consumer directed personal assistance services . . . Such procedures shall require that a final eligibility determination be made within seven days of the date of a complete medical assistance application.
>
> See Ch. 57, pt. B, § 36-c.

The Legislature also added SSL § 364-j(31)(a) as follows:

> The commissioner shall require managed care providers . . . managed long term care plans . . . and other appropriate long-term service programs to adopt expedited procedures for approving personal care services for a medical assistance recipient who requires immediate personal care or consumer directed personal assistance services . . . and provide such care or services as appropriate, pending approval by such provider or program.
>
> See Ch. 57, pt. B, § 36-b.

In addition, the Legislature amended SSL § 365-a(2)(e)(iii) as follows:

> The commissioner shall provide assistance to persons receiving personal care services under this paragraph who are transitioning to receiving care from a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law, consistent with subdivision thirty-one of section three hundred sixty-four-j of this title.
>
> See Ch. 57, pt. B, § 36-a.

The proposed regulations would reflect the Legislature's mandate in SSL § 366-a(12) for expedited Medicaid eligibility determinations for Medicaid applicants who have immediate needs for PCS or CDPA. It would also reflect the Legislature's mandate in SSL §§ 364-j(31)(a) and 365-a(2)(e)(iii) that PCA and CDPA be provided to Medicaid recipients in immediate need of such services prior to enrollment in a managed care entity.

Costs to Regulated Parties:

Regulated parties are social services districts that determine whether Medicaid applicants are eligible for Medicaid and whether Medicaid recipients are eligible for PCS or CDPA. Social services districts may incur administrative costs to comply with the expedited assessment procedures set forth in the proposed regulations. Districts would not incur any additional expense for the cost of PCS or CDPA provided to Medicaid recipients in immediate need of such services.

Costs to State Government:

The Department estimates that the proposed regulations could increase the State share of Medicaid costs by approximately $328,000 annually.

This cost estimate assumes that social services districts would annually authorize PCS or CDPA on a fee-for-service basis for an additional 88 newly eligible Medicaid recipients who the districts determine to be in immediate need of such services. This figure derives from Medicaid fee-for-service data for State Fiscal Years 2012-13 and 2013-14, which indicate that approximately 175 new Medicaid recipients were authorized annually for PCS and CDPA. The average monthly per-person cost of such services was $1,886.00. The Department assumed that, under the proposed regulations, fifty percent of the approximately 175 newly eligible Medicaid recipients (i.e. 88 recipients) would be found to be in "immediate need" of PCS or CDPA. The estimated annual Medicaid State share cost of providing PCS and CDPA to these 88 newly eligible Medicaid recipients would be approximately $996,000.00.

The Department estimates that this potential annual Medicaid State share cost of $996,000.00 would be reduced to the extent that Medicaid recipients in nursing or other facilities would be found to be in "immediate need" of PCS or CDPA and could be discharged home more

quickly and with less costly PCS or CDPA. Based on Department historical data, approximately 7,980 nursing facility or adult home residents received PCS or CDPA upon discharge. The average monthly per person cost of care in such facilities was $3,879.00 whereas the average monthly cost of PCS or CDPA was $537.00, an average monthly savings of $3,342.00. For every 400 persons (roughly five percent of 7,980) who may be discharged one month more quickly from institutional settings to receive PCS or CDPA at home, the estimated annual gross federal and State Medicaid cost savings could be $1.3 million (400 x $3,342). The estimated Medicaid State share savings would be half of this total, or $668,400.00. When subtracted from the annual estimated Medicaid State share costs of $996,000.00, this results in an estimated net increase in Medicaid State share costs of $328,000.00.

Costs to Local Government:

Social services districts may incur administrative costs to comply with the expedited assessment procedures set forth in the proposed regulations. Districts would not incur any additional expense for the cost of PCS or CDPA provided to Medicaid recipients in immediate need of such services. State law limits the amount that districts must pay for Medicaid services provided to district recipients.

Costs to the Department of Health:

There will be no additional costs to the Department.

Local Government Mandates:

The proposed regulations require that social services districts perform expedited Medicaid eligibility determinations of Medicaid applicants with an immediate need for PCS or CDPA. The revised proposed regulations also provide for expedited PCS or CDPA assessments of Medicaid applicants, and these assessments would be conducted concurrently with expedited

Medicaid eligibility determinations. Districts would also have to perform expedited PCS or CDPA assessments for Medicaid recipients who have an immediate need for either service.

Paperwork:

The proposed regulations do not impose any reporting requirements on social services districts.

Duplication:

The proposed regulations do not duplicate any existing federal, state or local regulations.

Alternatives:

There are no significant alternatives to the proposed regulations.

Federal Standards:

The proposed regulations do not exceed any minimum federal standards.

Compliance Schedule:

Social services districts should be able to comply with the regulations when they become effective.

Contact Person:

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

The proposed regulations affect social services districts. There are 62 counties in New York State, but only 58 social services districts. The City of New York comprises five counties but is one social services district.

Compliance Requirements:

Pursuant to proposed new §§ 505.14(b)(7) and 505.28(k), social services districts would be required to perform expedited Medicaid eligibility determinations for Medicaid applicants who have an immediate need for personal care services ("PCS") or consumer directed personal assistance ("CDPA"). Medicaid applicants with an immediate need for PCS or CDPA include those who are not currently authorized for any type of Medicaid coverage as well as those who are currently authorized for Medicaid but only for community-based Medicaid coverage without coverage for long-term care services.

The social services district must determine whether the Medicaid applicant has submitted a complete Medicaid application and, if not, notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide such documentation. When the applicant submits the Medicaid application together with the physician's order and signed attestation of immediate need, the district must provide the notice as soon as possible and no later than four calendar days after receipt of such documentation. When the applicant submits the Medicaid application and subsequently submits the physician's order, the signed attestation, or both such documents, the district must provide the notice as soon

as possible and no later than four calendar days after receipt of the physician's order and the signed attestation of immediate need.

The proposed regulations also provide for concurrent Medicaid eligibility determinations and PCS or CDPA assessments of Medicaid applicants with an immediate need for PCS or CDPA. As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for PCS or CDPA, but no later than seven calendar days after receipt of a complete Medicaid application, the district must determine whether the applicant is eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and notify the applicant of that determination. At the same time, the district must conduct a PCS or CDPA assessment of a Medicaid applicant with an immediate need for PCS or CDPA.

Specifically, as soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for PCS or CDPA, but no later than twelve calendar days after receipt of a complete Medicaid application, the district must assess the Medicaid applicant and determine whether the applicant would be eligible for PCS or CDPA, if determined eligible for Medicaid. No PCS or CDPA would be authorized, however, unless the applicant is determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services.

Notice to the individual of the PCS or CDPA for which the individual is authorized would be sent promptly after the individual has been determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services. Authorized PCS or CDPA must be provided to these Medicaid recipients as expeditiously as possible. If the recipient is subject to enrollment in a managed long term care plan or managed care provider, the district

would be required to authorize the services and arrange for their provision until the recipient is enrolled in such managed long term care plan or provider.

Pursuant to new Sections 505.14(b)(8) and 505.28(l), the proposed regulations also provide for expedited PCS or CDPA assessments of Medicaid recipients with immediate needs for PCS or CDPA who are also eligible for Medicaid coverage of community-based long-term care services. Medicaid recipients with immediate needs for PCS or CDPA may be exempt or excluded from enrollment in a managed long term care plan or a managed care provider or not so exempt or excluded but not yet enrolled in any such plan or provider. As soon as possible after receiving a physician's order for PCS or CDPA and a signed attestation of immediate need, but no later than twelve calendar days after receipt of such documentation, the social services district must conduct a PCS or CDPA assessment and determine whether the recipient is eligible for PCS or CDPA. The district must promptly notify the recipient of the district's PCS or CDPA eligibility determination. For those who are eligible for PCS or CDPA, the district must arrange for the provision of services, which must be provided as expeditiously as possible. If the recipient is subject to enrollment in a managed long term care plan or managed care provider, the district would be required to authorize the services and arrange for their provision until the recipient is enrolled in such managed long term care plan or provider.

Social services districts would be required to provide Medicaid applicants and recipients with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility and expedited PCS and CDPA assessment procedures as the Department may require.

Professional Services:

Social services would need to have contracts with sufficient number of Medicaid-enrolled providers to furnish authorized PCS or CDPA to Medicaid recipients with immediate needs for such services. The proposed regulations would not otherwise require social services to obtain new or additional professional services.

Compliance Costs:

The proposed regulations would not impose capital costs on social services districts. Social services districts may incur administrative costs to comply with the proposed regulations. These administrative costs would be associated with districts' performance of expedited Medicaid eligibility determinations and PCS or CDPA assessments of Medicaid applicants with immediate needs for PCS or CDPA as well expedited PCS or CDPA assessments of Medicaid recipients with immediate needs for such services.

Economic and Technological Feasibility:

There are no additional economic costs or technology requirements associated with the proposed regulations.

Minimizing Adverse Impact:

The proposed regulations should not have an adverse economic impact on social services districts. Each social services district's share of the cost of total Medicaid expenditures for PCS and CDPA is limited to the district's Medicaid "cap" amount established pursuant to State law. The proposed regulations would not require social services districts to incur any additional Medicaid expenditures for PCS or CDPA in excess of their Medicaid cap amounts. In addition, the revised proposed regulations would permit districts to contract with additional registered professional nurses for the conduct of nursing assessments.

Small Business and Local Government Participation:

The Department shared the proposed regulations with social services districts prior to publication.

Cure Period:

Chapter 524 of the Laws of 2011 requires agencies to include a "cure period" or other opportunity for ameliorative action to prevent the imposition of penalties on the party or parties subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one was not included. This regulation creates no new penalty or sanction. Hence, a cure period is not necessary.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 or fewer persons per square mile.

The following 43 counties have populations of less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following nine counties have certain townships with population densities of 150 or fewer persons per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Reporting, Record Keeping and Other Compliance Requirements and Professional Services:

Pursuant to proposed new §§ 505.14(b)(7) and 505.28(k), rural social services districts would be required to perform expedited Medicaid eligibility determinations for Medicaid applicants who have an immediate need for personal care services ("PCS") or consumer directed personal assistance ("CDPA"). Medicaid applicants with an immediate need for PCS or CDPA include those who are not currently authorized for any type of Medicaid coverage as well as those who are currently authorized for Medicaid but only for community-based Medicaid coverage without coverage for long-term care services.

Rural social services district must determine whether the Medicaid applicant has submitted a complete Medicaid application and, if not, notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide such documentation. When the applicant submits the Medicaid application together with the physician's order and signed attestation of immediate need, the district must provide the notice as soon as possible and no later than four calendar days after receipt of such documentation. When the applicant submits the Medicaid application and subsequently submits the physician's

order, the signed attestation, or both such documents, the district must provide the notice as soon as possible and no later than four calendar days after receipt of the physician's order and signed attestation of immediate need.

The proposed regulations also provide for concurrent Medicaid eligibility determinations and PCS or CDPA assessments of Medicaid applicants with an immediate need for PCS or CDPA. As soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for PCS or CDPA, but no later than seven calendar days after receipt of a complete Medicaid application, the rural district must determine whether the applicant is eligible for Medicaid, including Medicaid coverage of community-based long-term care services, and notify the applicant of that determination. At the same time, the rural district must conduct a PCS or CDPA assessment of a Medicaid applicant with an immediate need for PCS or CDPA.

Specifically, as soon as possible after receipt of a complete Medicaid application from a Medicaid applicant with an immediate need for PCS or CDPA, but no later than twelve calendar days after receipt of a complete Medicaid application, the rural district must assess the Medicaid applicant and determine whether the applicant would be eligible for PCS or CDPA, if determined eligible for Medicaid. No PCS or CDPA would be authorized, however, unless the applicant is determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services. Notice to the individual of the PCS or CDPA for which the individual is authorized would be sent promptly after the individual has been determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services. Authorized services must be provided to these Medicaid recipients as expeditiously as possible. If the recipient is subject to enrollment in a managed long term care plan or managed care

provider, the rural district would be required to authorize the services and arrange for their provision until the recipient is enrolled in such managed long term care plan or provider.

Pursuant to new Sections 505.14(b)(8) and 505.28(l), the regulations also provide for expedited PCS or CDPA assessments of Medicaid recipients with immediate needs for PCS or CDPA who are also eligible for Medicaid coverage of community-based long-term care services. Medicaid recipients with immediate needs for PCS or CDPA may be exempt or excluded from enrollment in a managed long term care plan or a managed care provider or not so exempt or excluded but not yet enrolled in any such plan or provider. As soon as possible after receiving a physician's order for PCS or CDPA and a signed attestation of immediate need, but no later than twelve calendar days after receipt of such documentation, the rural social services district must conduct a PCS or CDPA assessment and determine whether the recipient is eligible for PCS or CDPA. The district must promptly notify the recipient of the district's PCS or CDPA eligibility determination. For those who are eligible for PCS or CDPA, the district must arrange for the provision of services, which must be provided as expeditiously as possible. If the recipient is subject to enrollment in a managed long term care plan or managed care provider, the district would be required to authorize the services and arrange for their provision until the recipient is enrolled in such managed long term care plan or provider.

Rural social services districts would be required to provide Medicaid applicants and recipients with the required attestation of immediate need form and such other information regarding the expedited Medicaid eligibility and expedited PCS and CDPA assessment procedures as the Department may require.

Costs:

Rural social services districts would not incur initial capital costs to comply with the proposed regulations. Districts may incur administrative costs to comply with the proposed regulations. These administrative costs would be associated with districts' performance of expedited Medicaid eligibility determinations and PCA or CDPA assessments of Medicaid applicants with immediate needs for PCS or CDPA as well expedited PCS or CDPA assessments of Medicaid recipients with immediate needs for such services.

Minimizing Adverse Impact:

The proposed regulations should not have an adverse economic impact on rural social services districts. Each social services district's share of the cost of total Medicaid expenditures for PCS and CDPA is limited to the district's Medicaid "cap" amount established pursuant to State law. The proposed regulations would not require rural social services districts to incur any additional Medicaid expenditures for PCS or CDPA in excess of their Medicaid cap amounts. The revised proposed regulations would also permit districts to contract with additional registered professional nurses for the conduct of nursing assessments.

Rural Area Participation:

The Department shared the proposed regulations with rural social services districts prior to publication.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

No Job Impact Statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed regulations, that they would not have a substantial adverse impact on jobs and employment opportunities.

ASSESSMENT OF PUBLIC COMMENT

The Department received comments from The Legal Aid Society; New York Legal Assistance Group; Empire Justice Center; Aytan Y. Bellin, Esq.; the Human Resources Administration of the City of New York; and Suffolk County Department of Social Services.

1. Comment: Comments were received regarding the attestation form to be submitted by Medicaid applicants or recipients who assert they have an immediate need for personal care services ("PCS") or consumer directed personal assistance ("CDPA"). One commentator asked that the Department design and issue the required attestation form. Another commentator stated that it hoped the Department would issue a "model" attestation form but suggested that applicants and recipients should not be required to use the model attestation form as long as the form they submit conveys the same information as the model form requires.

Response: The Department has revised the regulations in response to the first comment. As revised, the regulations require "a signed attestation on a form required by the Department." The Department will issue the attestation form and require its use. The Department considered, but did not adopt, the second comment. Permitting variants from the required form could result in unnecessary disputes regarding whether the applicant is a "Medicaid applicant with an immediate need for personal care services" for whom an expedited Medicaid eligibility determination is required. It is also a routine, common, and not unreasonable practice to require the use of a specific form.

2. Comment: A commentator suggested that Medicaid applicants should be able to obtain an expedited Medicaid eligibility determination if they attest to an immediate need for PCS or CDPA after they have applied for Medicaid.

Response: The Department has revised the regulations in response to the comment. As published on March 2, 2016, the proposed regulations contemplate that an applicant would submit the Medicaid application together with the physician's order and signed attestation of immediate need. As revised, the regulations also address Medicaid applicants who submit the physician's order and the signed attestation of immediate need after applying for Medicaid and before the Medicaid eligibility determination has been made.

3. Comment: The proposed regulations permit Medicaid applicants who are otherwise required to document accumulated resources to attest to the current value of real property and the current dollar amount of any bank accounts. They also provide that, after the determination of Medicaid eligibility, if the commissioner or the district has information indicating an inconsistency between the value or dollar amount of such resources and the value or dollar amount to which the applicant had attested prior to being determined eligible for Medicaid, and the inconsistency is material to the individual's Medicaid eligibility, the district shall request documentation adequate to verify the resources. A commentator asked that the Department clarify what action the district is expected to take in these cases.

Response: The Department has not revised the regulations in response to the comment. The Department will address the comments in a forthcoming administrative directive.

4. Comment: Commentators asked that the Department clarify the regulations to assure that Medicaid applicants who are eligible for a Modified Adjusted Gross Income ("MAGI") eligibility category do not need to provide any information regarding their resources since there is no resource test in MAGI-budgeting.

Response: The Department has not revised the regulations in response to the comments. The proposed regulations clearly provide that applicants "who would otherwise be

required to document accumulated resources" may attest to the value of certain resources. By definition, this would not apply to Medicaid applicants in MAGI categories. Although the Department has not revised the regulations, the Department will provide guidance on this topic in its forthcoming directive.

5. Comment: Several commentators stated that the Department should allow spousal impoverishment budgeting to be applied to a married Medicaid applicant in immediate need of PCS or CDPA who would be eligible for enrollment in a managed long term care ("MLTC") plan even though the applicant is not yet enrolled in such a plan. They cite to a May 2015 State Medicaid Director letter issued by the federal Centers for Medicare & Medicaid Services ("CMS") interpreting Section 2404 of the Affordable Care Act. This provision temporarily revises the definition of "institutionalized spouse" to include individuals who are eligible for home and community based services under a Social Security Act § 1115 waiver, such as the MLTC program. According to the CMS guidance, spousal impoverishment budgeting is available to these individuals even if they are not actually receiving the home and community based services for which they are eligible.

Response: The Department has not revised the regulations in response to the comments. It is nonetheless considering this comment and may provide guidance in a forthcoming directive.

6. Comment: A commentator asked whether a "Medicaid applicant with an immediate need for personal care services" includes a Medicaid applicant with an immediate need for Level I personal care services.

Response: The Department has not revised the regulations in response to the comment. It is anticipated that most Medicaid applicants who assert an immediate need for PCS

would be seeking Medicaid coverage for Level II "personal care functions," such as bathing, toileting, transferring and other Level II functions set forth in the Department's regulations rather than assistance only with Level I "nutritional and environmental support functions," such as shopping and simple meal preparation. Nonetheless, the Legislature has provided in Social Services Law ("SSL") § 366-a(12) that the expedited procedures for determining Medicaid eligibility apply to applicants with an immediate need for "personal care services." If the Legislature had intended to limit the expedited eligibility procedures only to those with an immediate need for Level II personal care services, it would presumably have so stated.

7. Comment: Commentators asked that the Department revise the regulations to require social services districts to accept and process Medicaid applications for coverage of community-based long term care services from hospital patients or nursing home residents who have applied for Medicaid coverage of hospital or nursing home care and who assert an immediate need for PCS or CDPA to return home. They also commented that Medicaid recipients who are hospitalized or in nursing homes and who assert an immediate need for PCS or CDPA to return home be permitted to apply for an expedited Medicaid eligibility determination for community-based coverage with long term care services.

Response: The Department has not revised the regulations in response to the comments. It is beyond the scope of these regulations to require districts to process applications for Medicaid coverage of community-based long term care services, such as PCS or CDPA, from Medicaid applicants who have applications pending for Medicaid coverage of hospital or nursing home care. With regard to Medicaid recipients in hospitals or nursing homes, the regulations do not prevent them from applying for Medicaid coverage of community-based long term care services and districts would be expected to accept and process these applications.

8. Comment: A few commentators renewed their previous suggestions that the Department abbreviate the PCS or CDPA assessment process for Medicaid applicants or recipients with an immediate need for such services. They again suggested alternatives, such as having the Department revert to a policy permitting physicians to recommend the number of hours of services that should be authorized and permitting districts to authorize services based only on the physician's order and the individual's attestation of immediate need or based only on the physician's order and the social assessment.

Response: The Department has revised the regulations in response to the comments. As revised, the regulations eliminate the requirement for referral to the district's local professional director. This would expedite the PCS and CDPA assessment process. It would apply only to districts' determinations of PCS and CDPA eligibility for Medicaid applicants or recipients with an immediate need for such services.

9. Comment: Several commentators stated that the proposed regulations must include a deadline by which a social services district must assure that PCS or CDPA are provided to Medicaid recipients whom the districts determine eligible for services. One commentator urged that the regulations require that the "outer limit" for authorizing and providing services should be "somewhere in the range of one to three calendar days," citing Insurance Law § 4914, governing expedited appeals of adverse health decisions.

Response: The Department has not revised the regulations in response to the comments. The Legislature has mandated the adoption of expedited procedures for approving PCS or CDPA for Medicaid recipients with an immediate need for such services. The regulations comport with this requirement while also mandating that services be furnished to eligible recipients "as expeditiously as possible." The commentator's analogy to the 72 hour

time period set forth in Insurance Law § 4914 is inapt, as that is a clinical paper review only, relating neither to the individualized assessments necessary for determining the appropriateness of PCS or CDPA nor to the provision of the services themselves.

10. Comment: Commentators noted that the proposed regulations provide that, for Medicaid recipients who are neither exempt nor excluded from enrollment in a managed care entity, the district's authorization of PCS or CDPA is to continue until the recipient is enrolled in a plan. They suggested that the district's authorization of PCS or CDPA should continue even after the recipient has been enrolled in a plan and until the plan initiates services. Commentators also stated that the applicable transition of care policy should also apply to recipients who are in receipt of PCS or CDPA on a fee-for-service basis and who are enrolled in a plan.

Response: The Department has not revised the regulations in response to the comments. Payment for PCS or CDPA on a fee-for-service basis cannot continue after the recipient is enrolled in a managed care entity. This would result in duplicative Medicaid payments. Plans are required to provide PCS and CDPA as authorized by the district upon the recipient's enrollment in the plan. Further, plans are required to provide the district-authorized amount of PCS or CDPA for the applicable transition of care period. Any plan changes to such district-authorized PCS and CDPA after the applicable transition of care period are also subject to all applicable timely and adequate notice requirements.

11. Comment: Commentators stated that Medicaid applicants and recipients who are in immediate need of PCS or CDPA should receive priority in scheduling of any fair hearings they may request. Some stated that an expedited hearing right is required by SSL § 133, which provides that a social services district shall inform the person in writing of a right to an expedited hearing when "emergency needs assistance or care is denied."

Response: The Department has not revised the regulations in response to the comments. Regulations at 18 NYCRR § 358-3.2 already provide that priority in "scheduling of your hearing and determination" will be provided when "your circumstances warrant priority in scheduling" and the hearing is being scheduled because, among other reasons, there is an "urgent need for medical care, services or supplies" or personal care services are denied or are inadequate. With regard to SSL § 133, the Legislature has clarified that this statute does not apply to Medicaid. The Medicaid funded PCS and CDPA that would be authorized pursuant to the regulations is provided only pursuant to Title 11 of Article 5 of the SSL and not pursuant to SSL § 133.

12. Comment: Commentators stated that the proposed regulations did not contain provisions for notifying Medicaid applicants of the availability of expedited Medicaid eligibility determinations and expedited PCS or CDPA assessments for applicants in immediate need of such services.

Response: The Department has revised the regulations in response to the comments. The Department will also provide notice via its website and revisions to the Medicaid application.