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 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 take certain action as soon as possible but no later than four calendar days after receipt of the Medicaid application, physician's order and signed attestation. Within this period, the district must determine whether the applicant submitted a "*complete Medicaid application."* When the district determines that the individual has not submitted a complete Medicaid application, the district must also within this time period notify the applicant of the additional documentation the applicant must provide; the date by which the applicant must provide such documentation; and that the district will determine the applicant's Medicaid eligibility within seven calendar days after receipt of the documentation.

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; refer the case to the local professional director if it involves the provision of continuous personal care services or live-in 24-hour personal care 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.

The proposed regulations also add paragraph (8) to Section 505.14(b), which sets forth expedited 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. 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.

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 immediate needs 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 upon publication of a Notice of Adoption in the New York State Register, 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 that the applicant has an immediate need for personal care services 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 shall request documentation adequate to verify such resources.

(ii) As soon as possible after receipt of the Medicaid application and the physician's order and signed attestation required pursuant to items (i)(a)(2)(i) and (ii), respectively, of this paragraph, but no later than four calendar days after receipt of such application, physician's order, and signed attestation, the social services district shall determine whether the applicant has submitted a complete Medicaid application and, if not, shall notify the applicant:

(a) of the additional documentation that the applicant must provide;

(b) of the date by which the applicant must provide such documentation; and

(c) that the district will determine the applicant's Medicaid eligibility within seven calendar days after receipt of such documentation.

(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 shall 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 shall:

(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;

(b) if the case involves the provision of continuous personal care services or live-in 24-hour personal care services, refer the case to the local professional director or designee for an independent medical review pursuant to paragraph (4) of this subdivision, except that the local professional director's or designee's final determination shall be made as soon as possible after receipt of the physician's order and the required assessments; and

(c) 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.

(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 that the recipient has an immediate need for personal care services or an increase in personal care services 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 shall 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 shall 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 shall 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, shall:

(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;

(2) if the case involves the provision of continuous personal care services or live-in 24-hour personal care services, refer the case to the local professional director or designee for an independent medical review pursuant to paragraph (4) of this subdivision, except that the local professional director's or

designee's final determination shall be made as soon as possible after receipt of the physician's order and the required assessments; and

(3) 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 shall 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 shall 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 shall authorize personal care services to be provided until such recipients are enrolled in such a plan or provider.

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)] <u>(b)(5)(iv)</u> of this section;

(xvii) promptly initiating and complying with the procedures specified in subparagraph [(b)(5)(x)] <u>(b)(5)(ix)</u> of this section when the patient's social

circumstances, mental status or medical condition unexpectedly changes 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 that the applicant has an immediate need for consumer directed personal assistance 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 shall request documentation adequate to verify such resources.

(2) As soon as possible after receipt of the Medicaid application and the physician's order and signed attestation required pursuant to subclauses (1)(i)(b)(1) and (2), respectively, of this subdivision, but no later than four calendar days after receipt of such application, physician's order, and signed attestation, the social services district shall determine whether the applicant has submitted a complete Medicaid application and, if not, shall notify the applicant:

(i) of the additional documentation that the applicant must provide;

(ii) of the date by which the applicant must provide such documentation; and

(iii) that the district will determine the applicant's Medicaid eligibility within seven calendar days after receipt of such documentation.

(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 shall 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 shall:

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

(ii) if the case involves the provision of continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance, refer the case to the local professional director or designee for an independent medical review pursuant to paragraph (d)(5) of this subdivision, except that the local professional director's or designee's final determination shall be made as soon as possible after receipt of the physician's order and the required assessments; and

(iii) 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.

(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 that the recipient has an immediate need for consumer directed personal assistance 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 shall 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 shall 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 shall 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, shall:

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

(b) if the case involves the provision of continuous consumer directed personal assistance or live-in 24-hour consumer directed personal assistance, refer the case to the local professional director or designee for an independent medical review pursuant to

paragraph (d)(5) of this subdivision, except that the local professional director's or designee's final determination shall be made as soon as possible after receipt of the physician's order and the required assessments; and

(c) 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 shall 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 shall 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 shall authorize consumer directed personal assistance to be provided until such recipients are enrolled in such a plan or provider.

REVISED 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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REVISED 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.

As soon as possible after receipt of the Medicaid application, physician's order and signed attestation of immediate need, but no later than four calendar days after receipt of such documentation, the social services district would be required to determine whether the Medicaid applicant has submitted a complete Medicaid application. If the applicant has not submitted a complete Medicaid application, the district must notify the applicant, within this four day period, of the additional documentation that the applicant must provide, the date by which the applicant must provide such documentation, and that the district will determine the applicant's Medicaid eligibility within seven calendar days after receipt of such documentation.

The revised 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.

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 and 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.

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.

REVISED 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.

As soon as possible after receipt of the Medicaid application, physician's order and signed attestation of immediate need, but no later than four calendar days after receipt of such documentation, rural districts would be required to determine whether the Medicaid applicant has submitted a complete Medicaid application. If the applicant has not submitted a complete Medicaid application, the district must notify the applicant, within this four day period, of the additional documentation that the applicant must provide, the date by which the applicant must

provide such documentation, and that the district will determine the applicant's Medicaid eligibility within seven calendar days after receipt of such documentation.

The revised 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.

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 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 and 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.

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 numerous sources. The following advocate groups commented: The Legal Aid Society, New York Legal Assistance Group, Empire Justice Center, and People Organized for Our Rights, Inc. Nina Keilin, Esq., commented, as did Aytan Bellin, Esq., of Bellin & Associates, LLC. Also commenting was the Elder Law and Special Needs Section of the New York State Bar Association and Assemblyman Richard Gottfried, Chair of the NYS Assembly Committee on Health. Two social services districts submitted written comments: the Human Resources Administration of the City of New York and Suffolk County Department of Social Services.

1. Comment: Under the proposed regulations, expedited Medicaid eligibility determinations and expedited personal care services ("PCS") or consumer directed personal assistance ("CDPA") assessments would be performed for Medicaid applicants and recipients with an immediate need for PCS or CDPA. The individual would provide the district with a physician's order for PCS or CDPA that documented the need for assistance with toileting, transferring, or certain other activities of daily living ("ADLs"). Most commentators stated that this list of ADLs was too restrictive, omitting ADLs that are important to maintaining health and safety. Commentators suggested that the current recommended physician's order form does not enable the physician to document whether the individual requires assistance with the ADLs listed in the proposed regulations and that a revised physician's order form should be issued.

Response: The Department has revised the proposed regulations in response to the comments. As revised, the Medicaid applicant or recipient who asserts an immediate need for PCS or CDPA would provide the district with a physician's order for PCS or CDPA. The

physician's order would not be required to document that the individual needs assistance with certain specified ADLs.

2. Comment: Under the proposed regulations, a Medicaid applicant or recipient asserting an immediate need for PCS or CDPA would attest to certain factors on a form required by the Department. The individual would generally have to attest that no voluntary informal caregivers are available, that no home care agency is providing assistance, that adaptive or specialized equipment or supplies are not in use, and that third party insurance or Medicare benefits are not available to pay for assistance. With respect to the availability of informal caregivers, a majority of commentators suggested that districts must consider whether such caregivers will continue to be available. With respect to whether the individual is already receiving home care services, a majority of commentators stated that this should be irrelevant to whether an immediate need exists.

Response: The Department has revised the proposed regulations in partial response to the comments and to clarify the Department's intent regarding the attestation of immediate need.

Although Medicaid applicants and recipients would still be required to attest to an immediate need for PCS or CDPA, the content of the attestation has been revised. With respect to one factor, whether home care services are being provided, the Department disagrees that this factor should not be considered. An individual who is receiving home care services provided by an agency is not in the same position as an individual to whom no assistance whatsoever is being provided.

Most significantly, it's apparent from the comments that the commentators misunderstood the purpose and effect of the attestation of immediate need. Commentators mistakenly inferred that social services districts would analyze or "look-behind" applicants' or

recipients' attestations and determine whether the individual does, or does not, have an immediate need for PCS or CDPA. This is not the Department's intent. Accordingly, the Department has revised the proposed regulations to clarify its intent. Medicaid applicants and recipients who submit a physician's order and a signed attestation that conforms to the proposed regulatory requirements would automatically meet the definition of a Medicaid applicant or recipient who is in immediate need of PCS or CDPA. As such, these individuals would receive expedited Medicaid eligibility determinations and expedited PCS or CDPA assessments. Social services districts would not determine whether, in fact, an "immediate need" exists but would treat each Medicaid applicant or recipient who submits the physician's order and the signed attestation as being in "immediate need."

3. Comment: The proposed regulations permitted Medicaid applicants who are otherwise required to document resources to attest to the current value of real property and the current dollar amount of any bank accounts. If there was a material inconsistency between the information to which the applicant attested and any information "subsequently obtained," the district was to request documentation to verify the resources. Commentators stated that the meaning of information "subsequently obtained" was unclear and that the request for such documentation should not delay the Medicaid eligibility determination.

Response: The Department has revised the proposed regulations to clarify the Department's intent. The revised proposed regulations clarify that the Medicaid eligibility determination is not to be delayed should the district request that the individual verify resources. They provide that, after the determination of Medicaid eligibility, if the commissioner or district has information indicating an inconsistency between the value or dollar amount of the resources and the value or dollar amount to which the applicant attested prior to being determined eligible

for Medicaid, and the inconsistency is material to Medicaid eligibility, the district shall request documentation to verify the resources.

4. Comment: The published version of the proposed regulations would require social services districts, as soon as possible after receipt of a Medicaid application, physician's order and attestation of immediate need, but not later than three calendar days after receipt of such documentation, to determine whether the applicant is a Medicaid applicant with an immediate need for PCS or CDPA and, if so, whether the applicant had submitted a complete Medicaid application. If the applicant had not submitted a complete Medicaid application, the district would have been required to notify the applicant, also within this three calendar day period, of the additional documentation that must be submitted, the date by which the applicant must provide the documentation and that the district would determine the applicant's Medicaid eligibility within seven calendar days after receipt of the documentation. Social services districts commented that, as with all calendar day time frames set forth in the proposed regulations, the three calendar days should be revised to three business days. They commented that this three calendar day requirement would be difficult to meet since applications could arrive late in the day or immediately before weekends or holidays. For example, if the Medicaid application were received on a Friday, this would afford a district only one business day to comply with this requirement.

Response: The Department has revised the proposed regulations in response to the comments. The revised proposed regulations still require districts to act as soon as possible after receipt of a Medicaid application, physician's order and signed attestation of immediate need, but would afford districts four calendar days to determine whether the applicant had submitted a complete Medicaid application and, if not, notify the applicant of the

documentation to be provided and the other factors. In cases of Medicaid applications being received on a Friday, this would afford districts an additional business day, until the following Tuesday, to accomplish these tasks.

5. Comment: As proposed, the regulations would have required districts to perform PCS and CDPA assessments, notify Medicaid recipients of the PCS or CDPA eligibility determination, and arrange for services for eligible persons, as expeditiously as possible and within twelve calendar days.

The majority of commentators urged the Department to require districts to expedite the PCS and CDPA assessment process to a greater extent. Most objected that twelve calendar days was too long and could mean that Medicaid applicants could wait as many as nineteen days to receive PCS or CDPA (up to seven calendar days for the determination of Medicaid eligibility and, for Medicaid applicants who are determined eligible for Medicaid, up to twelve additional calendar days for the determination of PCS or CDPA eligibility and, if eligible, the provision of services). Commentators suggested alternatives, such as that the Department revert to permitting physicians to recommend the number of hours of services that should be authorized and permit 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.

Social services districts, however, commented that the twelve calendar day time frame would be difficult to meet, particular in 24-hour cases requiring an independent medical review.

Response: The Department has revised the proposed regulations in response to the comments.

To address advocates' comments that the PCS and CDPA assessment process should be expedited, the proposed regulations provide for concurrent Medicaid eligibility

determinations and PCS or CDPA assessments. With respect to Medicaid applicants in immediate need of PCS or CDPA, the district would assess the Medicaid applicant to determine whether the applicant, if determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services, would be eligible for PCS or CDPA and, if so, the amount and duration of services that would be authorized if the applicant is found Medicaid eligible. The PCS or CDPA assessment would occur 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. No PCS or CDPA would be authorized, however, for any Medicaid applicant unless the applicant was determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services. Nor would notice be provided to the individual of the results of the PCS or CDPA assessment process unless the individual is determined eligible for Medicaid, including Medicaid coverage of community-based long-term care services. If the district finds the applicant eligible for Medicaid, including Medicaid coverage of community-based long-term care services, the district would promptly provide notice to the individual of the PCS or CDPA determination and arrange for the provision of services as expeditiously as possible. Although this proposed revision could result in districts conducting PCS and CDPA assessments of Medicaid applicants who are determined ineligible for Medicaid, it is intended to expedite the provision of PCS or CDPA to those Medicaid applicants in immediate need who are, in fact, found eligible for Medicaid as well as PCS or CDPA.

With respect to Medicaid recipients in immediate need of PCS or CDPA, the Department also revised the proposed regulations to address district comments that they need more than twelve calendar days to perform all the following functions set forth in the proposed

regulations: conduct PCS or CDPA assessments, notify the individual of the determination, and arrange for services for eligible individuals. As revised, the proposed regulations would provide that, within the twelve calendar days after receipt of the physician's order and signed attestation of immediate need, the district is to assess the individual and determine whether the individual is eligible for PCS or CDPA. If so, the district would then be required to promptly notify the individual of the amount and duration of services to be authorized and arrange for the provision of services, which must be provided as expeditiously as possible.

6. Comment: A commentator suggested that the proposed regulations should address PCS or CDPA recipients with an immediate need for an increase in PCS or CDPA, including institutionalized recipients who need an increase in their pre-institutional level of services to be discharged.

Response: The Department has not revised the proposed regulations in response to the comments and will address this concern in its implementation guidance to districts.

7. Comment: A social services district commented that the Department should eliminate all references to CDPA from the proposed regulations. Another commentator suggested that individuals with an immediate need for CDPA be referred as soon as possible to a fiscal intermediary to begin the process of enrolling the CDPA aide.

Response: The Department has not revised the proposed regulations in response to the district's comment. The Legislature directed the Department to establish expedited procedures for individuals with immediate needs for PCS as well as CDPA. It will consider the other comment when advising districts how best to implement the requirements.

8. Comment: Social services districts have commented that they are having difficulty obtaining nurse assessors.

Response: The Department has revised the proposed regulations to afford districts additional flexibility to obtain nurse assessors.