October 27, 2022

Dr. Mary T. Bassett, M.D., M.P.H
Commissioner
NYS Department of Health (DOH)
Corning Tower, Empire State Plaza
Albany, NY 12237

Amir Bassiri
Acting Medicaid Director
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Angela Profeta, PhD
Deputy Secretary for Health
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Albany, NY 12224

Dear Commissioner Bassett, Mr. Bassiri, and Deputy Secretary Profeta:

Advocates for Medicaid consumers and representatives of Managed Long Term Care (MLTC) plans share serious concerns about implementation of the New York Independent Assessor (NYIA) and the harm to consumers currently being caused by the NYIA. To protect consumers, together we request that the State take the steps outlined below and consider alternative policies to NYIA if these problems cannot be resolved within the next couple of months. The NYIA program has disrupted access to long term care for some of New York's most vulnerable people, has led to more harm than good, and shows little sign of resolution in the near future. ***If the problems highlighted in this letter cannot be resolved in the near term, the State should reconsider NYIA altogether.***

Here are the minimum steps we believe are needed to protect consumers:

1. **Further postpone the date for NYIA to begin conducting immediate need and expedited initial assessments and routine and non-routine reassessments.** We do not believe that NYIA will have the capacity to meet the short mandatory deadlines for expedited

processing,[1] causing more delays for the standard-time requests, or to take on the *substantial* volume of reassessments that plans and the local districts continue to complete.

2. **Halt the Clinical Assessment, the second step of the NYIA assessment process.** DOH should stop implementation of the clinical exam conducted by a clinician on a NYIA Independent Practitioner Panel (IPP) until there is sufficient capacity to complete both the Community Health Assessment (the first step) *and* the Clinical Assessment within 14 days (and within 6 days for expedited assessments), as required under the DOH's existing policies.

3. **Limit populations required to use NYIA until there is sufficient capacity, procedures and training to properly address each consumer's unique situation**. To provide some immediate relief to NYIA's capacity issues, DOH should suspend the use of NYIA for individuals applying to their local department of social services (LDSS).

4. **Substantially increase NYIA training and oversight; evaluate the validity of virtual assessments.** DOH should also provide better training for NYIA assessors and any representative interacting with consumers and plans, and increase its oversight of NYIA calls and consumer interactions. Training must address issues with unreliable and poor quality of assessments (e.g., improper coding of individuals' needs, failure to frame questions effectively and follow up on responses to elicit accurate and complete information)—major issues cited by plans since NYIA began—as well as eligibility and enrollment policies. Further, DOH should evaluate how NYIA assessors are completing the UAS-NY assessment tool, particularly when done virtually.

5. **Provide greater flexibility for plans to perform assessments, in light of NYIA's impact on the nurse assessor workforce and the fact that plans continue to perform all reassessments for managed care enrollees.** For example, DOH should allow plans to use any assessment that has been performed in the last 12 months, no matter the circumstance (e.g., assessments done for any type of plan-to-plan transfer), for enrollment and care planning purposes.

6. **Publish monthly data.** DOH should regularly make public data on NYIA performance, including but not limited to: call volume and wait times; Community Health Assessments and Clinical Assessments conducted within 14 days, 21 days, 28 days, 6 weeks, 8 weeks, and by longer periods, with separate data for in-person and telehealth assessments; percent of cases denied; reasons for denials; number of variance requests received from plans, with separate data for factual variance requests and clinical variance requests; numbers of each type of variance request upheld and overturned; and other data that provides greater transparency on NYIA performance and the consumer experience (e.g., instances of nurse assessor and practitioner "no shows").

[1] Standard requests to managed care plans must be processed and decided within 14 calendar days, subject to a 14 day extension if the plan justifies a need for additional information and how the extension is in the enrollee's interest. *42 CFR 438.210*. Expedited requests to managed care plans must be decided within 72 hours, subject to the same 14-day extension. *Id*. "Immediate need" requests for personal care services (PCS) or consumer directed personal assistance program (CDPAP) services must be authorized within 12 days of receiving an application. *18 NYCRR 505.14(b)(6)(iv); 505.28(l)*.

7. **Initiate monthly stakeholder calls to report numbers, review guidance, answer questions and address stakeholder concerns.**
8. **Consider alternative policies to NYIA if problems cannot be resolved within the next couple of months.** The NYIA program has disrupted access to long term care for some of New York's most vulnerable people, has led to more harm than good, and shows little sign of resolution in the near future.

We urge DOH to address the following problems with NYIA immediately:

SCHEDULING DELAYS AND ERRORS

DOH policies require that Maximus schedule and conduct the two assessments to determine threshold eligibility for personal care services (PCS) and/or consumer directed personal assistance program (CDPAP) services within 14 days of the initial request. NYIA is not in compliance with this requirement. Clinical appointments are often scheduled four or more weeks away. The timeline is even longer if the consumer asks for an in-person assessment, either because they cannot or prefer not to use telehealth. Consumers who need an assessor who speaks a language other than English face even longer delays. Even when the appointments are scheduled, it is reported that they are often canceled by NYIA or the assessor simply does not show up.

Hospitalized individuals are facing barriers as well, with reports of some NYIA staff insisting that the hospital must request the assessment, that only a supervisor may conduct the assessment, or that the assessment must wait until the consumer returns home.

CALL CENTER PROBLEMS

From the start of the NYIA implementation, hold times have often exceeded two hours, calls have frequently been dropped, there is a lack of staff available for Limited English Proficiency speakers, and calls are frequently transferred to other agents, resulting in poor call quality and a negative experience for consumers. Consumers, advocates and plans alike report widespread inconsistency among NYIA representatives—NYIA staff often provide different information from one another and from DOH's own guidance.

We have heard multiple reports that numerous calls must often be placed to schedule the two assessments just for one consumer, with added calls if an assessment is canceled.

Family members, attorneys or social workers who call on a consumer's behalf are told they cannot schedule an assessment for the consumer. NYIA staff have insisted on setting up a 3-way call with the consumer on the phone, which is not possible for a consumer with advanced dementia, hearing loss, or other impairments. It is unnecessary and unhelpful to prohibit a family member or social worker from requesting appointments on a consumer's behalf; simply scheduling an assessment does not involve any release of Protected Health Information. The *Information Sharing Consent Form* NYIA initially posted to allow a consumer to appoint a representative and release medical records is so complicated to use that NYLAG had to

produce a *10-page* guide on how to use it.[2] While we appreciate that DOH took our recommendation to issue a more usable form to appoint a representative,[3] no form should be necessary for a family member or representative simply to schedule an assessment, and the *Information Sharing Consent Form* remains difficult to use for release of information.

INCREASES IN ELIGIBILITY DENIALS AND SCORES THAT DO NOT REFLECT NEED

DOH reported at a recent meeting that about 10-11 percent of requests are denied, which is a significant increase from the 1-3 percent denial rate DOH reported for Conflict-Free Evaluation and Enrollment Center (CFEEC) assessments a few years ago. This is consistent with the high rate of denials consumer advocates are observing, with vague notices that provide no detail on the factual basis of the denial. It appears that there are far more frequent findings that a consumer is "medically unstable" or cannot be safely maintained at home with personal care or CDPAP services.[4] Even where such a finding is correct, the consumer could still be eligible for other MLTC services, e.g., private duty nursing, certified home health care, or adult day health care, so should not be denied enrollment into the program. Similarly, those found ineligible for MLTC may still qualify for PCS or CDPAP services from a mainstream plan or LDSS, including Level I PCS (Housekeeping) services, but NYIA staff seems not to be adequately trained to understand or offer these options. We are concerned that these processes inappropriately force consumers to go through a Fair Hearing process to challenge denials.

In addition, plans report that NYIA assessments can be highly unreliable. More often than anything else, plans see frequent under-coding/lower-scoring of individuals for functional tasks/ADLs requiring assistance. When plans conduct their own assessment—something that is often necessary to create an effective and appropriate care plan—they quite often find that the consumer's need is greater than the NYIA assessor determined. (A frequent example includes a plan finding that an individual receives (and needs) help from a caregiver, though the NYIA assessment stated that the consumer can perform tasks entirely on their own—a major discrepancy.) In closely reviewing the NYIA assessments, many plan staff have come to believe that NYIA nurse assessors seem to use the UAS-NY as a checklist (as was commonly done under CFEEC, for eligibility determination purposes), rather than as a tool to comprehensively assess needs for care planning purposes, a task that requires more contextualization.

Further, plans cite a *significant* increase in assessor determinations that the consumer scores below a 5, but nevertheless qualifies for MLTC enrollment based on a need for more than 120 days of community-based long term care services, and instances where information on the

[2] NYLAG fact sheet available at http://www.wnylc.com/health/download/817/, explaining how to use original form posted at https://nyia.com/en/consent

[3] After consumer advocates complained about the original form, NYIA posted a separate *Authorized Representative Designation form* at https://nyia.com/en/can-i-choose-have-authorized-representative

[4] A recent fair hearing decision by the NYS Office of Temporary & Disability Assistance reversed NYIA's denial of eligibility because her medical condition was allegedly "unstable." See FH No. 8480913Z, dated Aug. 3, 2022, available at https://otda.ny.gov/fair%2520hearing%2520images/2022-8/Redacted_8480913Z.pdf. This hearing was scheduled unusually quickly because the consumer's representative requested that it be expedited. Few consumers know of this option, and their hearings make take months to be scheduled, held and decided.

Community Health Assessment (the first step in the NYIA assessment process) and the Clinical Assessment (the second step) differs or is at odds with one another. All of this inconsistency raises concerns that care plans prepared solely based on the NYIA assessment—per DOH policy—do not reflect consumers' actual needs.

According to DOH's report at a recent meeting, the NYIA is not experiencing a high volume of clinical variance requests relative to the number of assessments conducted. However, the number of clinical or factual variance requests is not necessarily indicative of the accuracy of the assessments, as there are several factors that discourage participants and plans from submitting variance requests, including the possibility of a second assessment which will further delay access to services.

LACK OF TRAINING AND PROCEDURES

For over eight years, everyone who called the Maximus conflict-free assessment center was seeking to enroll in an MLTC plan. Since May 16th, this same call center has become the NYIA call center, and now fields requests from a far wider population.[5] Call center staff do not seem to be trained to differentiate between the new groups and lack protocols to channel their requests appropriately. Mainstream Medicaid managed care and HARP members, for example, who DOH recently reported make 42% of all requests, are often assumed to be seeking a transfer to MLTC, even though they are entitled to obtain PCS or CDPAP services from their mainstream plans. Those in OPWDD, NHTD or TBI waivers applying to their LDSS for PCS or CDPAP are sometimes incorrectly told they *must disenroll* from that waiver—and lose its valuable services—in order to enroll in MLTC. It seems that NYIA staff needs *far* more training to discern and respond to these nuances. These are just some of the problems faced by these consumers.

POLICY CONCERNS

In a departure from eight years of previous MLTC policy, NYIA will not even take a call to schedule an assessment unless Medicaid eligibility has been approved and activated. Since Medicaid applications routinely take the 45 days allowed by federal regulations, previous DOH policy allowed a conflict-free assessment to be conducted while a Medicaid application was pending.[6] By the time the assessment was conducted and the consumer was ready to enroll in

[5] The wider population now includes mainstream Medicaid managed care members requesting PCS or CDPAP services from their plans, and people who either are permitted or required to apply directly to their LDSS for PCS or CDPAP services. If these consumers do not request services on an expedited basis, they are routed to NYIA. These LDSS applicants include people who are not allowed to enroll in an MLTC plan, such as people enrolled in home hospice or in the OPWDD, NHTD or TBI waivers. Others have the option to enroll in MLTC or to request PCS or CDPAP services from their LDSS – such as adults who do not have Medicare, or people ages 18-21.

[6] DOH FAQs 9/29/2014, https://www.health.ny.gov/health_care/medicaid/redesign/2014-09-29_cfeec_faqs.htm. Q13. Will the CFEEC apply to consumers with pending Medicaid? Is there going to be a process in place while a Medicaid application is being processed? A13. Currently, CFEEC will complete the UAS-NY and provide education to a consumer with a pending Medicaid application.

an MLTC plan, Medicaid was approved. Now, DOH policy prohibits scheduling assessments before Medicaid is approved, in conflict with DOH's own regulation that allows it.[7]

This policy is causing further delays and will cause *more* problems when NYIA takes over Immediate Need cases, which need to be processed more rapidly. State regulations require LDSS to determine eligibility for Medicaid applications based on immediate need within 7 calendar days of receipt of a complete Medicaid application and to refer applicants to NYIA within 12 days of receipt of the application.[8] Many LDSS are unable to meet the 7-day deadline for approving Medicaid now, so they will need to refer assessment requests to NYIA while they are finishing processing the Medicaid application. Under current DOH policy, NYIA will refuse to schedule these assessments, causing untold delays.

There is also a lack of clarity about when a NYIA assessment is or is not required. For example, an individual receiving PCS or CDPAP services through their LDSS, who is required to transition to an MLTC plan, is not required to go through NYIA, but consumers are repeatedly told otherwise. DOH must clarify when the NYIA assessment process is required and assure that NYIA staff is appropriately trained to understand the policy.

LACK OF TRANSPARENCY

DOH has not shared complete data on NYIA delays with our associations or the public. DOH has reported that it is only tracking the percentage of cases where both assessments are completed in 14 days and not monitoring how long it is taking to schedule the rest. In July, DOH informally reported that about 33% of cases met the 14-day standard. However, we are concerned with how long it took to schedule the other 67% of assessments. DOH recently reported that timeframes have improved but gave no specific statistics, especially for scheduling in-person assessments for those who cannot or prefer not to use telehealth. We are also concerned that cancellations are not being tracked and considered in assessing NYIA capacity. A review of more data (including the data points requested above) would enable policymakers to determine NYIA's readiness to expand its responsibilities—or whether it should be continued at all.

Further, DOH has not clearly communicated new policies to consumers, plans and other stakeholders. The DOH NYIA webpage still lacks an FAQ and consumer information even though NYIA began more than three months ago.[9] Maximus' "consumer facing" website does not clearly explain the different pathways to accessing services for different populations. The website also describes aspects of the NYIA roll-out that are not scheduled to start yet, and does not comply with NYS language access policy,[10] only offering website translation in Spanish.

We all share the common goal of assuring timely access to necessary and appropriate services for consumers in need. We do not believe that NYIA is currently meeting that goal, and that the

[7] The regulation requires only that "a member's eligibility for medical assistance … must be established *before services are authorized or reauthorized*." 18 NYCRR §505.14(b)(4)(i)(emphasis added). The regulation does not say that an assessment may not even be *requested* and *scheduled* until eligibility is approved.
[8] 18 NYCRR 505.14(b)(6)(iii)-(iv).
[9] https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/index.htm, last accessed 8/16/22; https://www.health.ny.gov/health_care/medicaid/redesign/nyia/consumers/index.htm; last accessed 8/16/22.
[10] https://www.ny.gov/language-access-policy

problems plaguing NYIA are harming consumers and must not continue. We urge you to consider the recommendations outlined in this letter.

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

Please contact Lara Kassel (lkassel@medicaidmattersny.org) if you would like to schedule a meeting.

Thank you for your time and consideration.

Sincerely yours,

Lara Kassel and Valerie Bogart for Medicaid Matters NY

Beth Shyken-Rothbart for the Coalition to Protect the Rights of New York's Dually Eligible

Al Cardillo for the Home Care Association

Karen Lipson for LeadingAge NY

Hailey Davis for the NYS Coalition of MLTC & PACE Plans and the Coalition of NYS Public Health Plans

Kathy Preston for the NYS Health Plan Association

Cc: Adam Herbst, Deputy Commissioner, DOH Office of Aging and Long Term Care

Jonathan Bick, Director, Division of Health Plan Contracting and Oversight, DOH Office of Health Insurance Programs

Susan Montgomery, Director, Division of Long Term Care, DOH Office of Health Insurance Programs