NYS Medicaid Home Care Changes 2022

CLE Webinar Jan. 26, 2022

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ABOUT NYLAG

The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services, financial counseling, and engages in policy advocacy efforts to help people experiencing poverty.

The Evelyn Frank Legal Resources Program (EFLRP) at NYLAG focuses on access to Medicaid for older people and people with disabilities for long term care.

https://nylag.org/evelyn-frank-legal-resources/

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Agenda

1. COVID issues
2. Proposed increase in Medicaid limits – Good news!
3. Independent Assessor – May start Mar. 1, 2022
4. New Reg Allows MLTC Plans to reduce services after transition from Immediate Need
5. Involuntary Disenrollment from MLTC – allowed to resume on limited grounds
    - Long Term Nursing Home Disenrollment from MLTC
6. Other Changes coming in 2022
    1. Home Care Eligibility – ADL Thresholds/ Minimum Needs (will be later)
    2. Lookback - won't be discussed today
7. What is ICAN? Get HELP!

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- THANK YOU!

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COVID issues

Aide Shortage Exacerbated by COVID

- Chronic aide shortage is national.
- *Fair Pay for Home Care* bill sponsored by Senator Rachel May (Onondaga, Madison) and Assembly Health Chair Richard Gottfried (New York Co.) would set wages for home care workers at 150% of the highest minimum wage in a region, or $22.50/hour.
- Meanwhile – file grievance with MLTC plan and complaint with NYS DOH -**1-866-712-7197 or e-mail mltctac@health.ny.gov .** Plans must use out-of-network providers if can't staff case.*

*42 CFR 438.206(b)(4); MLTC Partial Capitation Model Contract, Article VII, Section D]; FH No. 7735470N.

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COVID ISSUES

Fair Hearing Scheduling Delays

- State is invoking Public Health Emergency exemption from usual 90-day time limit on issuing FH decisions from date of request.*
- OTDA not scheduling hearings that have Aid Continuing, prioritizing those that do not.
- Hearings with interim *Varshavsky* increases that kick in 45 days after request are considered Aid Continuing, so are on hold. Good for clients! See http://www.wnylc.com/health/entry/228/
  - WARNING: about 10% MLTC members are in "Medicaid Advantage Plus" (MAP) plans – a type of MLTC all-in-one plan that also includes Medicare services.
  - OTDA denies them *Varshavsky* increases – so you must pursue these MAP "FIDE" hearings aggressively (Fully Integrated Dual Eligible). See special MAP-FIDE FH procedures - http://www.wnylc.com/health/entry/225/ or do External Appeals

https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf p. 16; 42 CFR § 431.244

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More COVID issues

1. **Conflict Free Assessments** – Huge delays with NY Medicaid Choice scheduling.
   - **TIP**: Apply to HRA/DSS for **Immediate Need** services instead. See Fact Sheet.*
2. **Medicaid renewals** – Since 3/2020, Medicaid extended automatically 1 year without sending in renewal. NYC HRA sends out renewals, but not other counties.
   - Public Health Emergency (PHE)– Maintenance of Effort – States get extra Medicaid $ and in return cannot cut or reduce Medicaid. GIS 20 MA/04; see more cites**
   - PHE likely to end in 2022, so renewals will again matter. Check for updates at http://www.wnylc.com/health/news/86/.
   - With Social Security COLA increase – spend-down may increase. Help clients increase Pooled Trust deposit to keep spend-down at ZERO, and submit proof with renewal.

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*http://www.wnylc.com/health/download/637/

**http://www.wnylc.com/health/news/86/#2.%20NYS%20Medicaid%20Policies%20-%20MOE

GOV. HOCHUL PROPOSES TO EXPAND NON-MAGI MEDICAID LIMITS – STARTING JAN. 2023

For Age 65+/ Disabled/Blind

Increase Medicaid Income Limits & Eliminate Asset Test

See text of proposed amendments

https://www.budget.ny.gov/pubs/archive/fy23/ex/fy23bills.html

Scroll to Health & Mental Hygiene Bill & Memo in Support – Part N

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1. Increase non-MAGI Medicaid Income Limits (age 65+, blind, and disabled) to MAGI levels

1. Income limits increased to MAGI amounts (138% Federal Poverty Line – see chart next slide).
   a. Will still be non-MAGI, using those budgeting rules (including spend-down). Just the income limit is being increased to the MAGI limit.
   b. If income above these limits – we believe should still be able to use a Pooled Income Trust.
   c. Many people who have MAGI Medicaid on NY State of Health marketplace will be able to keep full Medicaid with no spenddown when they get Medicare at 65 or based on disability. Until now, they would "fall off the cliff" when they transition to non-MAGI Medicaid and have a big spenddown, or lose Medicaid for excess resources.
   d. Nursing home budgeting won't change – calculation of NAMI.

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Monthly Income Limit Comparison with Proposed Change

	Non-MAGI 2022	Proposed increase = MAGI Limits 138% FPL	
		2021	2022 (estimated)
single	$934	$1,482	$1,563 ↑64%
couple	$1,367	$2,004	$2,105 ↑54%

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2. Elimination of Asset Test

- If passed, and approved by CMS, there will be NO ASSET TEST for non-MAGI Medicaid –same as for MAGI Medicaid.
- Would apply to Institutional Medicaid & Community Medicaid for MLTC. No spousal refusal required for assets.
- Unclear how lookback and transfer penalties will work– since proposal does not change SSL 366 subd. 5 re transfer of assets.
  - Transfers done exclusively for purposes other than to qualify for Medicaid are exempt, which includes transfer of exempt resources.
  - Lookback and transfer penalty DO apply to MAGI Medicaid recipients who need nursing home care.* **GIS 14 MA/16**, 15 OHIP/INF-1
- Why? Current rules biased against people of color who statistically are more likely to have cash assets, not homes & retirement funds, so they don't benefit from those exemptions. Reduce racial disparities in health care access.

*CMS State Medicaid Director Letter #14-001, *Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules and Post-Eligibility Income Rules to MAGI Individuals*, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-001.pdf

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Medicaid increases – practical issues

- CMS approval will be required for this to go into effect.
- Proposed **effective date is Jan. 1, 2023.**
- **Estate recovery will continue** under current rules.
- Old rules continue **for this year** – **new applicants** must use existing asset and income limits.
- **COVID NOTE – Current recipients** have not gone through annual renewals since Public Health Emergency (PHE) started March 2020. Federal "Maintenance of Effort" have banned cutting off Medicaid or increasing spend-down even if ineligible or has excess income.*
  - Public Health Emergency expected to be declared over in 2022 – and all 7 Million NYS Medicaid recipients will be evaluated in renewal process that will take the State a year. Depending on timing, the renewals will use either the OLD rules or these NEW rules. Makes it hard to plan!

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*http://www.wnylc.com/health/news/86/#2.%20NYS%20Medicaid%20Policies%20%20MOE.

"INDEPENDENT ASSESSOR" FOR HOME CARE - MLTC & DSS

Home Care Regulations adopted 8/31/21 – regs were effective Nov. 8, 2021 but implementation to start March 1, 2022

ADOPTED REGS eff. 11/8/2021 posted at https://regs.health.ny.gov/regulations/recently-adopted or direct link

https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/Personal%20Care%20Services%20and%20Consumer%20Directed%20Personal%20Assistance%20Program.pdf

NYLAG & NYSBA COMMENTS on proposed regs http://www.wnylc.com/health/download/771/ (3/13/21)

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Home Care Changes - overview

NYS Budget April 2020 made huge changes:

1. **New Independent Assessor (IA) procedure** for both HRA/DSS, MLTC and mainstream managed care plans – Expanded role for Maximus
   - New "high need" review if need > 12 hours/day
   - Supposed to start **March 1, 2022** - doubtful
2. New **minimum number of ADLs** required for eligibility for Personal Care Services (PCS)/Consumer Directed Personal Assistance (CDPAP) & MLTC enrollment
   - Delayed later than IA because COVID Public Health Emergency (PHE) "Maintenance of Effort" (MOE) requirements – States can't restrict eligibility (also why can't implement the Lookback)
3. **Lookback** for home care, ALP

When? Final regulations for #1 and #2 above effective **11/8/21** but roll-out to start 3/1/22 for IA only (#1)

New 'Independent Assessor – DSS & Plans

NY Medicaid Choice ("NYMC" or Maximus) has huge new role. Until now they just do Conflict Free Assessment for MLTC.

New assessment procedure for MLTC, mainstream managed care AND all Local DSS applications for PCS/CDPAP (including Immediate Need)

1. **TWO "Independent assessments" by *NY Medicaid Choice (NYMC) –*** *can be by telehealth (not telephone) unless consumer requests in-person*

   A. **Independent Assessment (IA) –** NYMC nurse does all "Uniform Assessments" (UAS) a/k/a Community Health Assessment (CHA) previously done by plan or LDSS nurse. MLTC plan will no longer do a separate assessment for new enrollee – uses the IA.

      - Also this replaces nurse assessment by LDSS in Immediate Need or mainstream managed care, all other DSS cases

   B. **Independent Practitioner Panel (IPP)**- exam by NY Medicaid Choice PHYSICIAN, physician's ass't. or nurse practitioner who prepares Practitioner's Order **(PO) –** likely will use State Form DOH-4359 (from GIS 10-LTC-006)

When are the new IA & IPP needed?

Both of these 2 assessments must be done:

1. For enrollment into MLTC (replaces CFEEC)
2. For Immediate need application or other requests for PCS/CDPAP to Local DSS (replaces M11q/physician's order & Nurse assessment)
3. Annual reassessments (no longer 6-month) – MLTC, mainstream & DSS
4. Every request to plan or LDSS for a ***new*** PCS/CDPAP authorization, ***increase*** or on ***discharge from NH, hospital***.

TOTAL: about 300,000/year of each – IA and IPP!

New 'Independent Assessor – DSS & Plans

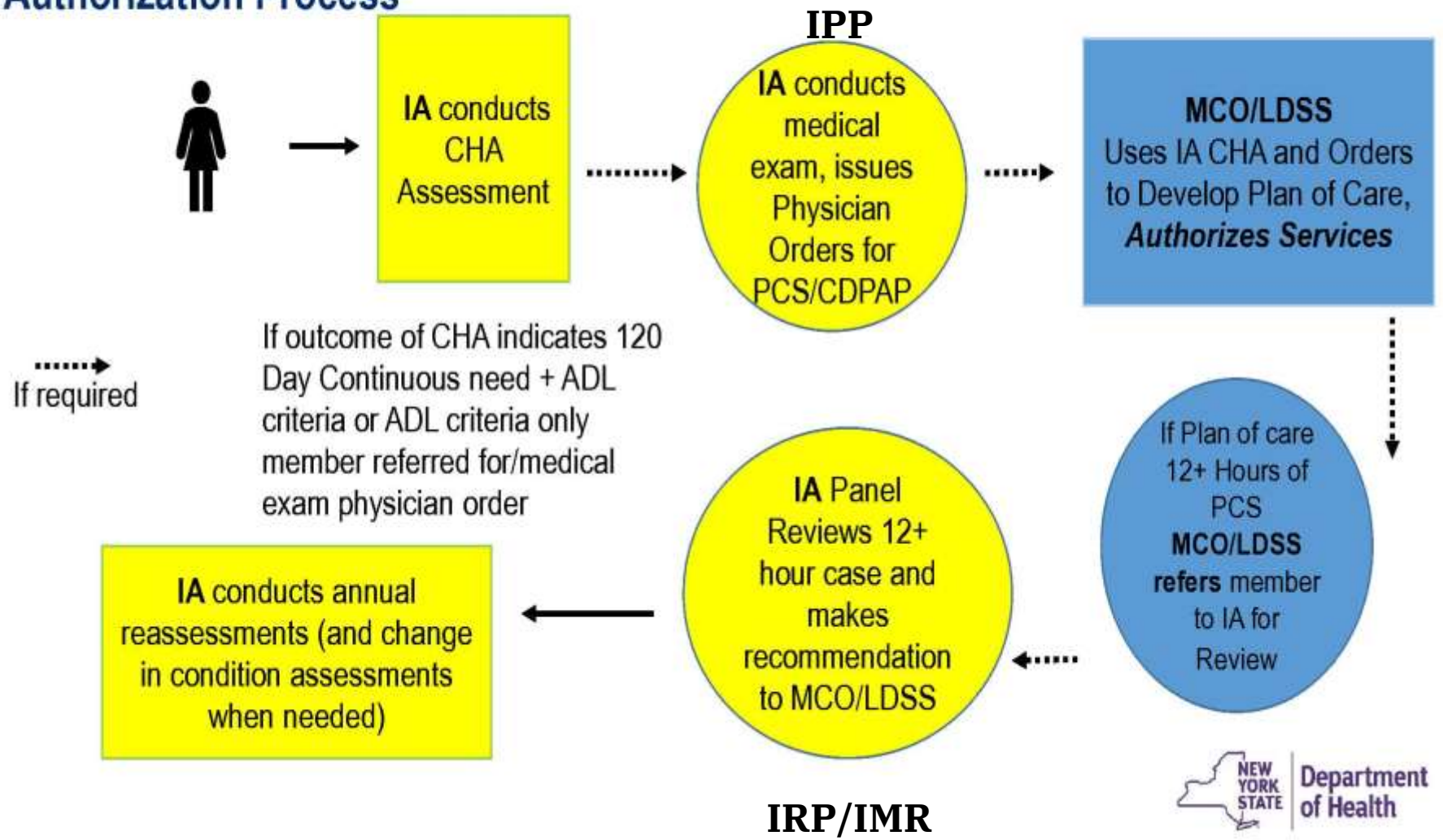
2. **HRA/DSS or Plan uses the IA and IPP to develop plan of care and authorize services if they find needs < 12 hours/day.**
   a. But may also dispute the IA if plan/DSS has "material disagreement" affecting plan of care. Then IA may make requested change or has 10 days to do a *new assessment*.
   b. Will plan/LDSS still have a nurse assess client? Gray area. DOH acknowledges that the UAS/CHA has gaps – doesn't assess night-time needs or informal caregiver availability. So they still need to assess but won't be paid for it!
3. **If HRA or Plan say needs > 12 hours per day** → see next slide.

New Assessment System – DSS & Plans *con'd*

Independent Review Panel (IRP) for High-Need cases > 12 Hrs/day

4. **If DSS or Plan say needs > 12 hours/day →Must refer for "Independent Review Panel" (IRP)** a/k/a Independent Medical Review (**IMR**) ***by NY Medicaid Choice*** – recommends whether proposed plan of care is "reasonable and appropriate" to maintain health & safety in the home.
   a. **ALERT: Saying "unsafe" can be pretext for denying needed high hours → force into nursing home – violate *Olmstead* and ADA.** A "public entity must ensure that its safety requirements are based on **actual risks**, not on **mere speculation, stereotypes, or generalizations** about individuals with disabilities."* 28 CFR §35.130(h)
   b. IRP may recommend changes in plan of care but NOT specific amount of hours. 505.14(b)(2)(v)(f)(p. 50)
   c. **Grandfathering** - IRP not required on reassessment if IRP previously reviewed plan of care of > 12 hours/day. 18 NYCRR 505.14(b)(4)(xi)(b) DOH told advocates it will clarify anyone now getting > 12 hours will be grandfathered in, the IRP not required.
5. **Plan/DSS make final decision and issue notice**. Does not have to take IRP recommendation. 505.14(b)(2)(iii)(f)

Role Independent Assessor and MCO/LDSS in New PCS/CDPAP Authorization Process



NEW YORK STATE | Department of Health

MLTC enrollment with IA

Our best understanding of how it will work – this is a guess!

1. **Consumer contacts NYMC to do CFEEC** just as now. Now when calls NYMC, they will schedule BOTH the IA (nurse) and the IPP (MD/nurse practitioner). The CFEEC is now the "IA."
2. IA still used to determine eligibility for MLTC – **NYMC sends notice that can enroll in MLTC.**
   - IPP not required for NYMC to determine MLTC eligibility, but may be scheduled pre-MLTC enrollment.
3. Plan still does enrollment visit and *may* do supplemental nurse assessment to fill in for what DOH acknowledges the UAS doesn't cover well – informal caregiver availability, night-time needs
   - Will plan still tell consumer approved hours? *UNCLEAR*.
4. Enroll in MLTC the same as now. Plan uses IA and IPP to determine plan of care; if that is > 12 hours – refers for IRP/IMR. See previous slide.

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Delays!

New assessments will cause inevitable delays in each of the instances listed on slide 10:

1. MLTC enrollment & Immediate Need applications at HRA/DSS
2. Annual renewals by DSS/MLTC (these will no longer be every 6 months)
3. Requests for new services or increases in hours - DSS, MLTC, mainstream managed care
4. All Hospital & Rehab discharges.

Final regulations say little about deadlines:

- HRA/DSS must determine hours within **7 days** of receiving back all of the assessments…but no deadlines on conducting assessments!*
  - Immediate Need deadline – 12 Days after application filed
  - Plan deadlines are on next slide. Impossible to meet these time limits!
- In response to concerns about delays **–** regs say **DSS/Plan *may* (not *must*) authorize "temporary" care > 12 hours/ day pending the High Need IRP Review* if can't meet deadlines****
- Added delay if DSS/Plan disputes "material fact" in IA –NY Medicaid Choice has **10 days** to schedule 2nd assessment (reg pp. 44, 111).

* 505.14(b)(3)(ii), 505.28(g)(2) (p. 51, 127)
**505.14(b)(4)(vi), 505.28(e)(4) (pp. 54, 121).

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MLTC/ mainstream plan unlikely to comply with federal deadlines to decide requests for Increase or New Services

Type of Request	Maximum time for Plan to Decide
Expedited*	**72 hours after receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Medicaid covered home health care services following an inpatient admission**	One business day after receipt of necessary info; except when request made the day before a weekend or holiday, **no more 72 hours** after receipt of the request for services.

42 C.F.R. 438.210(d). *Expedited if delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. 42 CFR 438.210

**NY Insurance Law § 4903(c)(1).

Independent Assessor Concerns

Lack of guidance, public information

- No ADM or MLTC policy yet issued, no webpage, no public webinar held, no FAQs (as of 1/11/22)
- LDSS/plans must operationalize huge systems changes, communications & data feeds with NY Medicaid Choice, issue internal procedures, train staff
- Sole guidance issued – 21 ADM-04 & MLTC Policy 21.06 (12/13/21) don't touch on IA, only on relatively minor changes in regs:
  - Reassessments now annual not every 6 months
  - CDPAP: only one FI per consumer; designated rep for non-self directing consumer must be present at all assessments, new agreement between consumer/rep and LDSS/plan
  - M11q/physician's order may be signed by Nurse practitioner, physician's assistant, Osteopath – not just MD
  - Tweaks permitted reasons for reductions in MLTC Policy 16.06;
  - Tweaks policy on "safety monitoring" under NYS DOH GIS 03 MA/003 and MLTC Policy 16.07

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Independent Assessor - Concerns

Capacity of NY Medicaid Choice to Handle New Assessments

Does NY Medicaid Choice have:

1. **Nurses** to do all of the new IA assessments?
   - Huge nursing shortage aggravated by COVID.
   - Not doing just the initial CFEEC for MLTC, but ALL Immediate Need & other LDSS applications, all annual reassessments for MLTC/ mainstream and LDSS cases, all hospital/NH discharges – **about 300,000/year**!
2. **MDs**, Nurse practitioners, PA's to do the Physician Order/IPP & Independent Medical Review – also 300,000/year!
3. **Call Center capacity** – Just calls for CFEECs go into voicemail, calls not returned. How will handle massive increase to schedule the new assessments?
   - DOH said referrals by LDSS for the IA will be by a 3-way call with consumer to NY Medicaid Choice.

Independent Assessor – Concerns

IA & IPP Don't Know the Consumer!

- The **Nurse** doing the IA likely will not know the consumer.
  - Where nurse would normally have an M11q/physician's order for diagnoses, meds, basic info – those forms have been *eliminated*, such as for Immediate Need.
  - MLTC nurse won't get to know consumer and do annual reassessments– unlikely that NYMC will send the same nurse. So won't notice changes.
- The **physician**/ nurse practitioner doing the IPP/PO & the high-need IMR/IRP will not know the consumer or have expertise in their diagnoses.
- Disability community lobbying for a panel of specialist nurses/ NPs/PA's knowledgeable about particular disabling conditions– ie MS, rheumatoid arthritis, quadriplegia.
- **TIP: Obtain Letter of Medical Necessity from treating physician** with key info to give to all assessors and plan/LDSS.

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Independent Assessor – Concerns

Appeal & Fair Hearing Rights

- Reg says plan/LDSS ***may not*** authorize > 12 hours wo/ high-need Independent Review Panel (IMR/IRP) unless ordered by a Fair Hearing or court. 18 NYCRR 505.14(b)(4)(vi).
- What if consumer requested 24-hour care, but plan/LDSS approved just 8 hours, so they don't refer for the high-need IMR/IRP? **In FH, can ALJ order 24-hour care?**
  - Reg unclear, DOH said intent is YES – will clarify (otherwise ALJs will remand for the IMR/IRP, causing more delay).
- Reg omits that plan must comply with an External Appeal decision of NYS Dept. of Financial Services (alternate appeal option under Title II of Article 49 of NYS Insurance Law). See http://www.wnylc.com/health/entry/184/#external%20appeals. NYLAG asked DOH to clarify.
- **EVIDENCE PACKET** – must be clear consumer entitled to all assessments & related documents, including IAs that plan disputed as having a material factual error.
- Will **NY Medicaid Choice be a party** to a hearing?

Is it really happening March 1st?

- At meeting on Jan. 4, 2022 with NYLAG & Medicaid Matters NY, **DOH acknowledged NYMC & nurse capacity issues** and vowed not to implement if not ready, but *still not postponing date*.
- **DOH Considering phasing it in** – unclear how.
  - Just start with DSS not MLTC or vice versa?
  - Start in one county?
  - Start just with initial MLTC enrollments not requests for increases or annual reassessments?
- See Letter to DOH Dec. 15, 2021 from NYLAG & Medicaid Matters NY, with 1/6/22 update
  http://www.wnylc.com/health/download/801/
  with consumer concerns about implementation

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RECENT HOME CARE CHANGES NOW IN EFFECT

1. MLTC Lock-In
2. Reductions in Hours after a “Transition Period”
3. Disenrollment from MLTC plans if in Nursing Home 3+ Months
4. Other Grounds for Disenrollment

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Involuntary MLTC plan changes – Member Has Transition Rights – What are They?

- Where member received Medicaid home care services, whether through a managed care/MLTC plan or through LDSS, then was REQUIRED to enroll in or change MLTC plans, they have ***Transition*** or ***Continuity of Care*** Rights
- The new MLTC plan is required to:
  - continue the **same plan of care** (**same hours** of home care or other services, e.g. adult day care, PT)
  - In some but not all cases allow the **same providers**, even if they are "out-of-network" of new MLTC plan
- **HOW LONG IS TRANSITION PERIOD?** This period is usually **90 days** (**120 days** if the reason consumer enrolled in the new plan was because the old MLTC plan closed).

*NYLAG Fact Sheet on Transition Rights at http://www.wnylc.com/health/download/797/

Involuntary MLTC plan changes –
When Does Member Have Transition Rights?

1. Their old MLTC **plan closed**.*
2. **Received Immediate Need** personal care or CDPAP from HRA/DSS for 120 days, then was required to enroll in MLTC plan
3. **Had Medicaid before enrolled in Medicare**, so was in a "mainstream" managed care health plan. Then got Medicare at age 65 or after 2 years of SS Disability. **If received home care from Medicaid health plan, will be assigned to an MLTC** or Medicaid Advantage PLUS (MAP) plan ("Default enrollment")**
4. Was **involuntarily** disenrolled from MLTC plan and assigned to a different plan (more on this later)

*Rights when Plan Closes – see **MLTC Policy 17.02** and

**Default Enrollment - see http://www.wnylc.com/health/entry/226/

Involuntary MLTC plan changes – What happens after Transition Period (90 or 120 days?)

- **Before Nov. 8, 2021**, MLTC plan could reduce hours only for same limited reasons that restrict *any* reductions in hours. These are in MLTC Policy 16.06 (as modified by 21-ADM-04). 16.06 resulted from litigation based on *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996).
- **Plan notice must specify reason, and plan must prove**:
  1. Medical condition improved, reducing need for assistance
  2. Social circumstances changed (ex. daughter moved in)
  3. Mistake made in original authorization (very limited ground)
- **BEWARE**: **Eff. Nov. 8, 2021**, change in State regulation allows plans to reduce hours *after transition period* if plan claims that HRA/DSS or previous plan "authorized more services than are medically necessary," without proving any *change*. Plan notice may simply:
  - indicates a clinical rationale that shows review of the client's specific clinical data and medical condition**
- The new regulation only applies after a Transition Period ends. MLTC Policy 16.06* still restricts other MLTC reductions otherwise.

**New regs 18 NYCRR 505.14(b)(4)(viii)(c)(3)(vii), 505.28(i)(4)(iii)(h) –Personal Care reg at https://regs.health.ny.gov/regulations/recently-adopted pp. 60, 137

Involuntary MLTC plan changes –

If Plan Wants to Reduce Hours after Transition Period

Plan must still send a written NOTICE of a reduction, which member still has the right to appeal -- in 2 stages:

1. ***Initial Adverse Determination*** to reduce or deny an increase → request internal PLAN APPEAL. See sample next slide.

   If that appeal is denied, Plan sends --

2. ***Final Adverse Determination*** to reduce or deny increase → request FAIR HEARING. In request, check that client is Homebound. This gives special extra rights.

- Right to **AID CONTINUING ONLY** if appeal quickly within 10 days of date of BOTH above notices. This means old hours continue while appeal pending. .

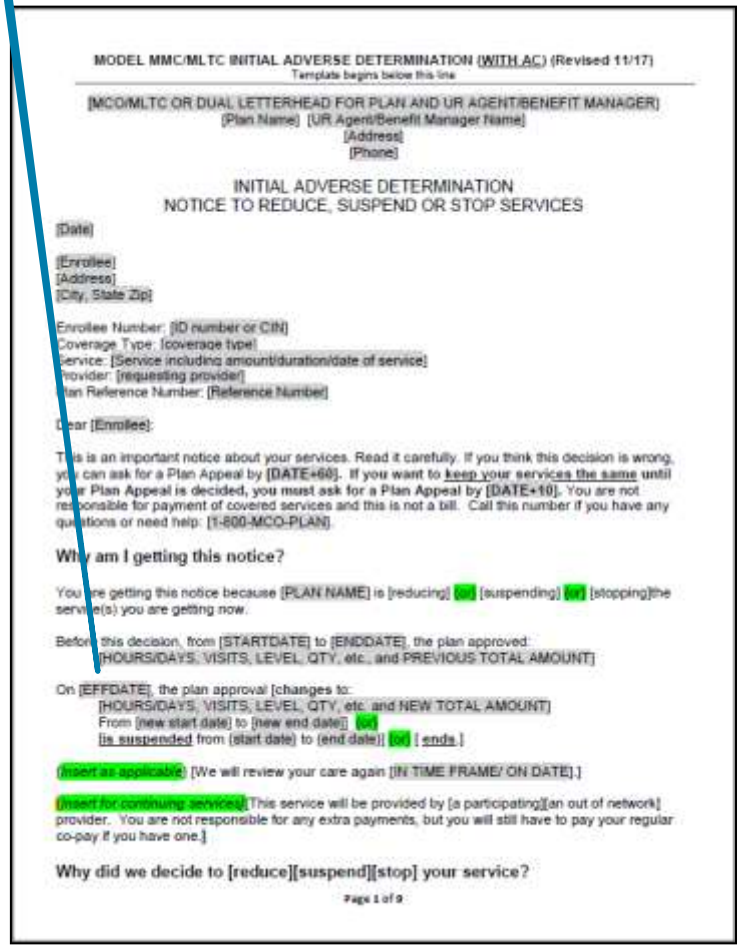
FOR HELP CONTACT ICAN 1-844-614-8800 or EFLRP Mon. 10 AM – 2 PM eflrp@nylag.org 212-613-7310

NYLAG Fact Sheet on MLTC appeals at http://www.wnylc.com/health/downloads/654/ and longer article at http://www.wnylc.com/health/entry/184/

You have the right to written notice

- Whenever your plan takes an **action** regarding your services, they must send you an **adequate, written notice**
  - Among other things, this notice must state the action being taken, the **reason for the action**, and the effective date of the action
- If the plan proposes to **reduce or discontinue** a service you are already receiving, the notice must also be **mailed to you 10 days before the effective date**

10-day Deadline to request Plan Appeal



MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) (Revised 11/17)
Template begins below this line

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [Service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by [DATE+60]. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by [DATE+10]. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

Why am I getting this notice?

You are getting this notice because [PLAN NAME] is [reducing] [or] [suspending] [or] [stopping]the service(s) you are getting now.

Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [EFFDATE], the plan approval [changes to:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT]
From [new start date] to [new end date] [or]
[is suspended from (start date) to (end date)] [or] [ends.]

[Insert as applicable] [We will review your care again [IN TIME FRAME/ ON DATE].]

[Insert for continuing services] [This service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

Why did we decide to [reduce][suspend][stop] your service?

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42 C.F.R. § 438.404; 18 NYCRR § § 358-2.2, 358-2.23 & 358-3.3.

You have the right to appeal

- If you disagree with your plan's action, you have the right to request a **plan appeal**.
  - This means you are asking your plan to take another look at their decision, and if they agree with you that they made a mistake, change it.

- **Requesting a plan appeal**
  - Use the plan appeal form included with the notice – can fax.
  - You can request an appeal over the phone, but (unless it is fast-tracked; see next slide) you must also confirm it in writing.
  - You can have another person request the appeal for you by signing a letter giving them permission.

Plan appeal timelines

- **Aid Continuing**
  - If the proposed action is to reduce or discontinue your services, you can keep your services the same until your appeal is decided. This is called **aid continuing**.
  - If you want aid continuing, you must **request a plan appeal within 10 days** of the notice date, or by the date the change is supposed to start, whichever is later.
- For other kinds of actions (or if you don't want aid continuing), you must request the plan appeal within **60 days of the notice date**.
- The plan must give you a written decision within **30 days** of your request.
  - **Fast Track** – You may be eligible for a decision within **72 hours** if a delay will seriously risk your health, life, or ability to function; and certain other situations.
  - **Extension** – The plan may take up to **14 days** longer if they can show that they need additional information and it would be in your interest.

Fair Hearings

- If you lose your plan appeal, you have the right to request a **Medicaid fair hearing**.
  - A fair hearing is where you can have an impartial hearing officer listen to you and the plan and decide who is right.
- If you want to keep your services the same until the fair hearing is decided, **you must request the fair hearing within 10 days of getting the plan appeal decision** notice, or by the date the change is supposed to start, whichever is later.
  - You can get aid continuing at this stage even if you did not get it during the plan appeal stage.
- You must complete the plan appeal before you can request a fair hearing.
  - Since 5/1/18, you can no longer request a fair hearing until ***after*** you've received a decision from the plan appeal.

42 C.F.R. § 438.402; 18 NYCRR § 358-3.1.

MLTC Lock-In – Limit on *Voluntary* MLTC Plan Changes

- Until 12/2020, you could voluntarily change MLTC plans any time.
- **Since 12/1/20** – If you **first enrolled** in or **changed MLTC plans on or after Dec. 1, 2020**:
  - **90-day grace period** to change plans for any reason
  - **9-month Lock-in** - May change plans only for **good cause** during the next **9 months.** See next slide re Good Cause.
- **What if enrolled before 12/1/20?** May change plans any time, but after 90-day grace period in new plan, locked in for 9 months.
- **Which plans –** Lock-in only for "MLTC plans" - may transfer to or from a PACE or Medicaid Advantage Plus (MAP) plan any time.
- NY Medicaid Choice sends out "End of Lock-in Notices" 60 days before end of 9-month lock-in period.

Sample notice to current MLTC members of new lock-in in Appendix and posted at http://www.wnylc.com/health/download/753/; see more at http://www.wnylc.com/health/entry/114/#LOCK-IN

MLTC Lock-In – What is Good Cause to Change plans?

- **Good Cause** to change plans **after 90-day grace period:**
  1. Member moves from the plan's service area,
  2. Plan fails to furnish services,
  3. Member did not consent to enrollment
  4. Plan and member mutually agree that transfer is appropriate
  5. Aide is no longer working with current plan
- Just because you CAN change plans is it a good idea?? NO. See next slide

See DOH MLTC Policy 21.04 and FAQ at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

COMPARE: VOLUNTARY Plan Changes
No Transition Rights

- If MLTC member changes plans:
  - Within 90-day grace period after enrollment, or in
  - 9 month Lock-in Period with Good Cause to change plans.
- Member has ***no continuity of care or "transition rights"***
- **New plan is not required to continue the same plan of care of former plan**
  - **New plan may give fewer hours,** without proving a change in medical condition or social circumstances
    - Doesn't even have to give advance notice of a "reduction," with right to appeal with Aid Continuing, because DOH does not consider it a reduction.
  - **Member has right to request an increase and appeal** if denied, but has
  - **No "Aid Continuing" rights** to keep old hours during appeal

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MLTC INVOLUNTARY DISENROLLMENTS

Starting Again 2021-2022

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Involuntary Disenrollments Resuming

MLTC plans may disenroll members involuntarily for certain reasons.* All disenrollments were banned during the pandemic. DOH is allowing some disenrollments to resume. GIS 21 MA/17 and GIS 21 MA/24.

The allowed reasons are:

1. **Long Term Nursing Home stay** 3+ months – more below
2. Enrollee **moved out of plan's service area**, within NYS.
3. **MAP plans only – (Medicaid Advantage Plus**) - If member changes their Medicare plan, they are disenrolled from the MAP plan because the MAP plan requires enrollment in the particular Medicare Dual-SNP (Medicare Advantage Special Needs Plan) operated by the same company.**

For #2 & #3 – GIS says case will be referred to LDSS which must continue same plan of care pending a reassessment. Advocate needs to be proactive to demand this or to ask NY Medicare Choice to enroll in MLTC plan – likely disruptions in services.

*Involuntary disenrollment grounds are in Model MLTC contract, Art. V. D. 3 -4 https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf at pp. 21-23

**List of 13 MAP plans with their aligned Medicare D-SNP by county at http://www.wnylc.com/health/download/784/

2 More Disenrollment Grounds – GIS 21 MA/24 -

4. **Behavior** of member or their family seriously impedes plan's ability to deliver home care
   - For reasons other than resulting from member's "special needs" or diagnosis
   - FH rights with Aid Continuing; if don't win or don't request FH – assigned to another MLTC plan.
5. **Member absent from the service area for more than 30 days** (90 days for MAP).
   - Because of COVID, members were allowed to pause services – while staying with family or to limit exposure.* Plan required to show tried to contact member.
   - NYMC will notify member that may transfer to another MLTC plan. If they don't pick one, dropped from MLTC and not assigned to another MLTC plan.

COVID-19 Guidance for Voluntary Plan of Care Schedule Change 4/23/20
https://health.ny.gov/health_care/medicaid/covid19/2020-04-23_guide_volplanofcare.htm
(See ***NYLAG Know Your Rights Fact Sheet for MLTC Members*** - ***http://www.wnylc.com/health/download/739/***

Procedure for Involuntary Disenrollment

1. Plan sends member **30-day Notice of Intent to Disenroll**. This notice is NOT appealable.
2. Plan refers case to NY Medicaid Choice, which sends member **10-day Notice of Disenrollment**.
   - Member **can request FAIR HEARING** of this notice. Must request hearing within 10 days before effective date to get AID CONTINUING. This allows staying in plan until hearing decided.
3. Member should be **assigned to a new MLTC plan after disenrollment**. Member has Transition Rights to same hours and services for 90 days. See above for what happens after Transition Period.

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NEW 3-ADL MINIMUM NEEDS REQUIREMENT

Restricts who is Eligible for Personal Care, CDPAP, & MLTC

ON HOLD because of Public Health Emergency

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NEW: 3 ADL "Minimum Needs requirement"

Eligibility for PCS/CDPAP & MLTC will require the need for:

1. *Limited assistance* with **physical maneuvering** with **3 ADLs** ("more than 2" ADLs), with sole exception if have
2. **Dementia** or Alzheimer's diagnosis - need **cueing or supervision** with **2 ADLs** ("more than 1 ADL")

ADLs = Walking/locomotion, bathing, personal hygiene, dressing, eating, toileting/incontinence care, transfer on/off toilet

Compared to Now – just need **ONE ADL** to enroll in MLTC or get PCS/CDPAP from HRA/DSS thru Immediate Need, etc.

- Now, if don't need help with ADLs, can apply to HRA/DSS for Housekeeping up to 8 hours/week. This program is ENDING – no new applicants once changes take effect. Will add to EISEP waiting lists for age 60+.

WHEN? Sometime in 2022 TBD

Current recipients will be grandfathered in – in MLTC, housekeeping, DSS If services authorized before implementation date – even if don't meet new criteria

S.S.L. §§ 365-a subd.2 (e), 365-f, subd. 2, 18 NYCRR § 505.14(a)

3 ADL Requirement

ADL counts only if need "Limited Assistance with "Physical Maneuvering"

Unless dementia or Alzheimer's diagnosis, ADL counts toward the minimum only if needs "at least limited assistance with physical maneuvering."

The **UAS instructions** define seven degrees of assistance as follows, with "7" being the most assistance:

1. Independent
2. Independent, setup help only – Article or device placed within reach, no physical assistance or supervision in any episode.
3. **Supervision – Oversight/cuing.** **Will Not Count unless has Dementia diagnosis (or "serious mental illness"- see next slide)**
4. **Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight.** **This is minimum amount of need to count. Does this include "Contact guarding" (hovering)?**
5. Extensive assistance – Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.
6. Maximal assistance – Weight-bearing support (including lifting limbs) by two or more helpers; or, weight-bearing support for more than 50% of subtasks.
7. Total dependence – Full performance by others during all episodes.

Who is left out - needs "supervision" but not physical maneuvering with ADLs?

- Only **Dementia** or **Alzheimer's** diagnosis qualifies with 2 ADL's based on needing "supervision" not hands-on assistance
- Leaves out:
  1. Traumatic Brain Injury
  2. Developmental Disability
  3. Visual impairments
  4. Other cognitive, neurological or **psychiatric impairment***
- This discriminates based on diagnosis and is illegal in our view. Should include anyone who needs supervision because of *any* impairment.
- *In response to comments published with final regulations, DOH agreed to qualify people with "**Serious Mental Illness**" who need cueing assistance with 2 ADLs – treat the same as Dementia. But ***no one else***. And not added to regulation – only says in comments that they will create a procedure to request an exemption as a reasonable accommodation*

*See slide 26 to link to final regulations – see p. 244

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Caution on "Supervision"

- A person has dementia is eligible for MLTC or Immediate Need only if they need **cueing or supervision with 2 ADLs**.
- Medicaid **DOES** cover safety monitoring, supervision or cognitive prompting ***to assure safe completion of ADLs, but not stand-alone general supervision.****
- **TIP: Always identify the ADL for which client needs supervision or cueing to assure safe performance,** instead of saying client needs general **"safety monitoring" or "supervision."**
  - Eg**.** Needs cueing and prompting **for** safe ambulation, or **for** toileting, etc. And describe **how** supervises (remind to use walker, remind to do post-elimination hygiene), etc.
- New regulation doesn't change the rule but will lead to more denials for people with dementia, if don't find 2 ADLs client needs supervision with.

*Rodriguez v. DeBuono, 175 F.3d 227 (2nd Circ. 1999; MLTC Policy 16.07 (https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-07.htm); MLTC Policy 21.06: 21ADM-04

LONG TERM NURSING HOME STAY (LTNHS) DISENROLLMENT FROM MLTC

If in nursing home 3+ months and approved for Nursing Home Medicaid

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Change in How MLTC Works with Nursing Homes

- **2015 – 8/2020** - MLTC members stayed in MLTC plan if they went into a nursing home, even if permanent NH stay. MLTC plan paid NH and collected the NAMI (member's income contribution).
  - Even then, member still had to submit Medicaid application for NH coverage to HRA/DSS with 5 year lookback.
  - If transferred assets, Medicaid and MLTC were both cut off.
- **Since 8/2020** – MLTC only covers short-term stays up to 3 months. If stay > 29 days, Member must still apply to HRA/DSS for NH Medicaid with 5-year lookback.
  - **If NH Medicaid is approved** → disenrolled from MLTC plan if in NH 3+ months and Medicaid pays NH directly "fee for service." "Long Term Nursing Home Stay" disenrollment Procedure on next slide. **20,353 MLTC members disenrolled** so far in batches since 10/2020. Next batch is Feb. 2022.
  - **If NH Medicaid is denied** → Medicaid and MLTC are cut off.
- **Why do we care?** If MLTC member hopes to return home from NH, much harder to reinstate home care if they are disenrolled from MLTC plan. They do have right to re-enroll within 6 months, but after that must do conflict-free assessment, etc.

MLTC members disenrolled if in Nursing Home (NH) 3+ months ("LTNHS")

- Since 8/1/20 -- MLTC members who are "**Long Term Nursing Home Stay**" are disenrolled from MLTC plan.
- LTNHS = in NH 3+ months AND approved for Nursing Home (NH) Medicaid after 5-year lookback.
- Plan, NH & Open Doors --https://ilny.us/programs/open-doors --are asked to identify members with **active discharge plan**, who should not be disenrolled.
- Members receive **2 notices before disenrollment**:
  1. **NEW 30-day Notice from plan* -** Heads up that will be disenrolled because in NH 3+ months. Explains may request assessment to return home & stay in plan. Copy sent to designated rep.
  2. **10-day Notice** from NY Medicaid Choice** with **right to (1) request fair hearing** and/or (2) call NY Medicaid Choice 1-888-401-6582 and request assessment to be discharged home. Either stops disenrollment.
- Right to re-enroll within 6 months – call NY Medicaid Choice 1-888-401-6582
- Only NY Medicaid Choice, not plan, may initiate disenrollment for LTNHS

* http://www.wnylc.com/health/download/793/
**http://www.wnylc.com/health/download/722/
See GIS 20-MA-06; More at http://www.wnylc.com/health/entry/199

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How to make sure Notice sent to Family/Rep

1. **30-day Plan notice** should be sent to representative known to plan – may be a family member. If client is in NH approaching 90 days and applied for NH Medicaid, check with plan to make sure family/social worker listed and will get notice.
2. **10-day Notice from NY Medicaid Choice** is only sent to Authorized Rep listed on the NH Medicaid app. To be listed, submit *Form DOH-5247 - Medicaid Authorized Representative Designation/ Change Request* ** to HRA/ Local Dept. Social Services (DSS). In NYC-
   - if the nursing home Medicaid application was approved, fax form to 917-639-0736.
   - If Medicaid application is still pending, ask nursing home to submit it or fax to 917-639-0735. Note the name and address of nursing home. Read more at http://www.wnylc.com/health/entry/199/.

Call ICAN 844-614-8800 and Dept. of Health MLTC Complaints – **1-866-712-7197 if:**

- MLTC Plan refuses to reinstate home care when member ready for discharge, claiming not "safe" to go home. After 3 months, will be disenrolled and then it will be harder to go home.
- If someone was already disenrolled who should not have been.

**https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/17ma017_english.pdf

Stay up to date

- Sign up for NYLAG EFLRP e-lerts with updates here http://eepurl.com/deQxtr - select TOPIC: Elder Law (Medicaid, long-term care)
- See Resource Sheet in materials for other links
- NYS **DOH MLTC Complaint Line:**

  Tel 1-866-712-7197

  or email mltctac@health.ny.gov
- For Help – Call ICAN – next slides

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Introduction to ICAN

What is ICAN?

ICAN stands for **Independent Consumer Advocacy Network**.

ICAN
Independent
Consumer Advocacy
Network

ICAN is the New York State Ombudsprogram for people with Medicaid who need long term care or behavioral health services.

We assist New Yorkers with understanding how to enroll in and use managed care plans that cover long term care or behavioral health services.

What do we do?

- **Answer your questions** about managed care plans.
- **Give you advice** about your plan options.
- **Help you enroll** in a managed care plan.
- Identify and **solve problems** with your plan.
- Help you **understand your rights**.
- Help you **file complaints** and/or grievances if you are upset with a plan's action.
- Help you **appeal** an action you disagree with.

Get help

(844) 614-8800

ican@cssny.org

icannys.org

Who do we help?

We help anyone enrolled in a **Medicaid managed care plan** who needs:

- **long term care services** (like home attendant, adult day care, or nursing home); or
- **behavioral health services** (help recovering from and living with mental illness or substance use disorder.)

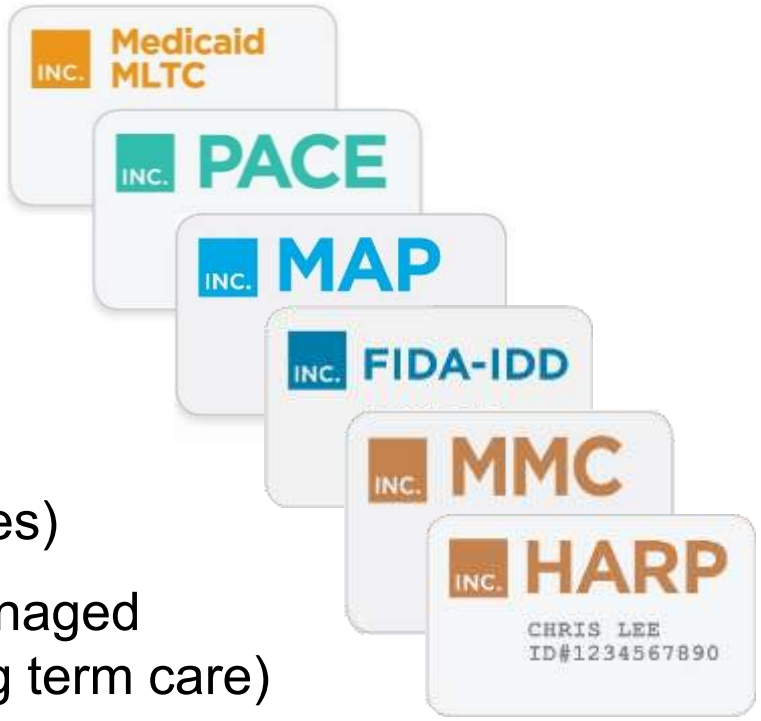
We also help educate people who are newly eligible for enrollment in a Medicaid managed care plan.

We can talk to friends, family members, social workers, providers, and anyone else who is helping people with their healthcare decisions.

What kinds of plans does ICAN work with?

The plans we work with are:

- **MLTC** (partially capitated MLTC)
- **PACE** (Programs of All-inclusive Care for the Elderly)
- **MAP** (Medicaid Advantage Plus)
- **FIDA-IDD** (FIDA for People with Intellectual or Developmental Disabilities)
- **MMC-LTSS** (Mainstream Medicaid Managed Care for those enrollees who need long term care)
- **HARP** (Health And Recovery Plans)

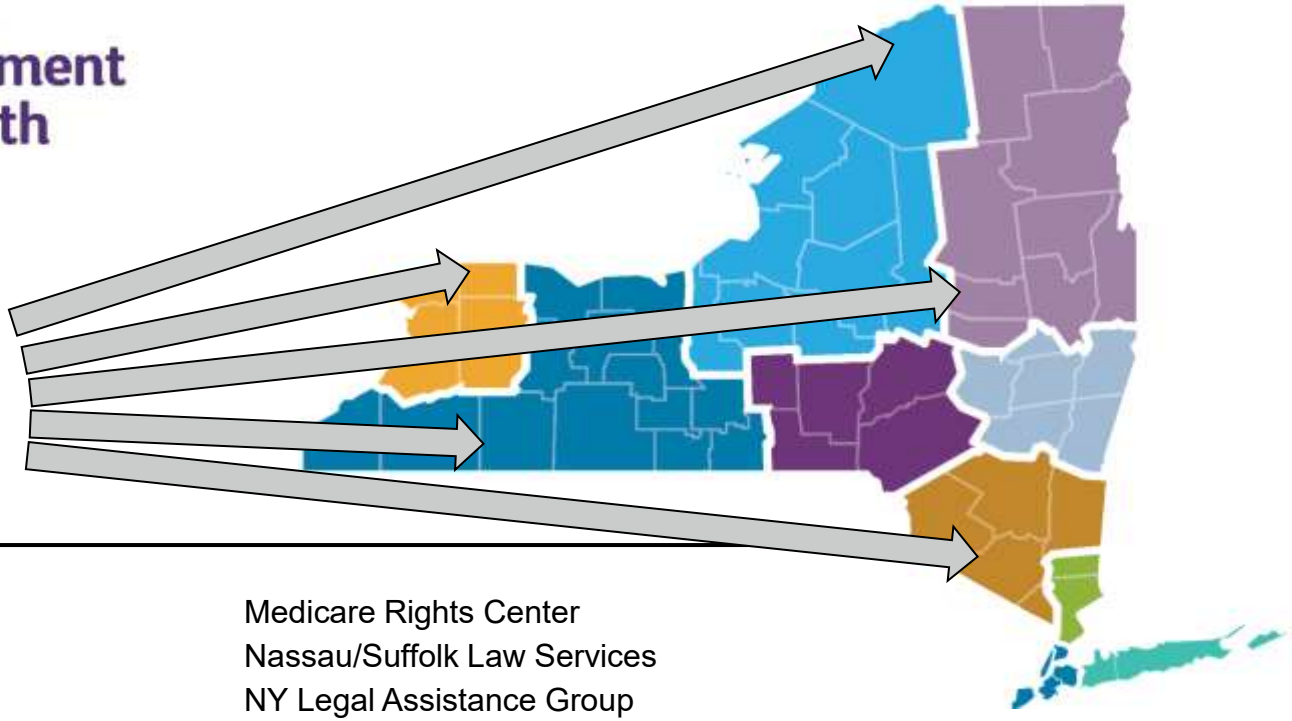


* FIDA is no longer available after 2019.

Who is ICAN?

NEW YORK STATE | Department of Health

Community Service Society | Fighting Poverty Strengthening New York



Our Network of Agencies:

ACR Health
Action for Older Persons
BronxWorks
Center for Independence of the Disabled NY
Healthy Capital District Initiative
Korean Community Services
Legal Assistance of Western New York
Legal Services of the Hudson Valley
Medicare Rights Center
Nassau/Suffolk Law Services
NY Legal Assistance Group
South Asian Council for Social Services
Southern Adirondack Independent Living
Urban Justice Center
Westchester Disabled On the Move
Western NY Independent Living

How we help

Our trained counselors answer our **toll-free telephone hotline** Monday-Friday, 9am-5pm (also email and online chat)

Our services are completely **free and confidential**.

Our counselors speak English, Spanish, Russian, and Mandarin Chinese.*

We'll meet you **in person** at our offices or at your home.

We give **educational presentations** to consumers, caregivers, and professionals.

We monitor our cases for **potential trends** and report them to the state.

Community Service Society | Fighting Poverty Strengthening New York

ICAN

* Interpreters are available for all other languages.

Please donate if receiving CLE credit!

- We are not charging for CLE credits.
- We suggest a $75 donation if you are requesting CLE credit (or even if you're not! ☺)
- Please send a check payable to "NYLAG" earmarked to EFLRP and send to:
  - Helen Murphy – NYLAG, 100 Pearl St., 19th fl. NY NY 10004
- Or donate at https://nylag.org/donate-now/ and earmark for EFLRP/ Evelyn Frank program
- THANK YOU!

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More information at nylag.org and nyhealthaccess.org

Please donate to support us!

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