NYS Medicaid & Home Care Changes 2022

27th Annual Elder Law Forum

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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. GOOD NEWS - Increase in Medicaid income and asset limits!!!
2. Independent Assessor – Starts May 16, 2022
3. New Reg Allows MLTC Plans to reduce services after transition from Immediate Need
4. Involuntary Disenrollment from MLTC – allowed to resume on many grounds
5. Other Changes coming in 2022-2023
    1. Home Care Eligibility – ADL Thresholds/ Minimum Needs (will be later)
    2. Lookback - won't be discussed today
6. What is ICAN? Get HELP!

MEDICAID INCOME & ASSET LIMITS WILL INCREASE JAN. 2023

For Age 65+/ Disabled/Blind

Also Medicare Savings Program

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Backgrounder: Non-MAGI and MAGI

1. Since 2014 - the Affordable Care Act (ACA) increased income limits & eliminated asset limit for people under age 65 who do not have Medicare to 138% Federal Poverty Line (FPL).
    1. Called "MAGI" Medicaid – "Modified Adjusted Gross Income" because uses tax rules for income.
    2. Has NO ASSET limit.
2. But age 65+, younger disabled still have old rules. When they get Medicare at 65 or after 2 years on SSD they "fall off the cliff." Called "Non-MAGI Medicaid. Suddenly, Medicaid has a lower income limit (85% FPL), so they have a spend-down, or lose Medicaid for excess resources.

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NYS Budget April 2022: Passed Landmark Medicaid Increases

- **The SAME income limit will now be used for both younger people under the Affordable Care Act (MAGI) and for Age 65+, Blind & Disabled (Non-MAGI) =138% Federal Poverty Line (FPL).**
- **Medicare Savings Program limits also increased.**
  - **QMB will be the same as Medicaid – 138% FPL (pays for Part B premium AND Medicare cost-sharing)**
  - **QI-1 will be 186% FPL (pays for Part B premium only)**
  - **No more SLIMB program.**
- **Increases start Jan. 1, 2023 – see next slide**

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2023 Medicaid & MSP Limits – Age 65+, Blind, Disabled						
Benefit	% FPL		SINGLES		COUPLES	
	2022	2023	2022	2023	2022	2023
Income limit per Month						
Medicaid	82%	138%	$934	$1563	$1,367	$2,106
QMB	100%	138%	$1,133	$1563	$1,526	$2,106
QI-1	135%	186%	$1,529	$2107	$2,060	$2,838
Medicaid Asset Limit			$16,800	$28,134	$24,600	$37,908

More about the INCOME LIMIT Increases

a. **Age 65+, Blind and Disabled group will still be Non-MAGI, using the same budgeting rules as before (like Spend-down and Spousal Refusal).**
   a. **Just the income limit is being increased to the MAGI limit.**
   b. **May still use Pooled Trust or "spend down" excess income on medical expenses.**
b. **Before, many people with MAGI Medicaid on NY State of Health Exchange lost Medicaid when they got Medicare at 65 or based on disability, because of lower income limits. Now many will no longer** *fall off the cliff***.**
c. **Nursing home budgeting won't change – same calculation of NAMI** as before.

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Increase in Asset Limit

- **NYLAG and other advocates asked NYS to REPEAL the ASSET TEST for non-MAGI Medicaid – to be the same as for MAGI Medicaid.**
- **Why? The asset rules are biased against people of color who statistically are more likely to have savings in bank accounts, not:**
  - **Homes - which are exempt if equity under $955,000**
  - **IRAs and other retirement funds – which are exempt as long as taking distributions.**
  - **See coalition letters at http://www.wnylc.com/health/news/90/**
- **Unfair that a tenant can't save $50,000 in the bank but a homeowner can have equity of $955,000, or own a $1 million dollar IRA and shelter the RMD in a pooled trust.**
- **But – the asset test was increased but not repealed.**
- **No change in Estate recovery rules, liens, spousal impoverishment, lookback and transfer penalties for nursing homes.**

*__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*

Medicaid increases – practical issues

- CMS approval will be required for this to go into effect.
- If approved - Effective date will be Jan. 1, 2023.
- 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" rule has banned cutting off Medicaid or increasing spend-down even if ineligible, has excess income, or did not return renewal.*
  - Public Health Emergency expected to end later in 2022 – all 8.8 Million NYS Medicaid recipients will be evaluated in renewals that will take the State a year. Hopefully, timing will work out to use the new limits on the renewals
  - See tips on renewals - http://www.wnylc.com/health/entry/227/

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

"INDEPENDENT ASSESSOR" FOR HOME CARE

Medicaid Redesign Team II change enacted in 2020

Home Care Regulations adopted 8/31/21 –effective Nov. 8, 2021 but implementation to start May 16, 2022

NYLAG & NYSBA COMMENTS on proposed regs

http://www.wnylc.com/health/download/771/ (3/13/21)

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3 MRT II Changes Enacted in 2020 - Status

Medicaid Redesign Team II Change	When does it Start?
Independent Assessor for Personal Care services (PCS) & Consumer Directed Personal Assistance (CDPAP) "NYIA" will be Phased in	May 16, 2022 – MLTC enrollment, *standard* managed care and DSS requests July 1, 2022 – Immediate Need, *expedited* managed care requests Not yet scheduled – annual reassessments, requests for increases in hours, NH/hospital discharges
New minimum 3 ADLs required for eligibility for PCS & CDPAP (2 ADLS if dementia)(Slides at end)	DELAYED: CANNOT START UNTIL the next quarter after Public Health Emergency ends. If not extended, PHE ends July 2022 so earliest start date for these is 10/1/2022. http://www.wnylc.com/health/news/86/#2.%20NYS%20Medicaid%20Policies%20-%20MOE
30-Month LOOKBACK for MLTC enrollment and all Requests for PCS and CDPAP (not covered in this slide deck)	

Regulations & Guidance

- New NYS DOH NYIA website - https://www.health.ny.gov/health_care/medicaid/redesign/nyia/
- Document Repository tab on site has links to NYIA Policies
  1. Amended Personal Care & CDPAP regulations 18 NYCRR 505.14 & 505.28
  2. 22 OHIP/ADM-01 - 4/20/22 for local DSS Medicaid offices
  3. MLTC Policy 22.01 4/27/22 for MLTC plans https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/2022-04-27_mltc_22-01.pdf
  4. MMC Guidance - 4/28/22 for mainstream plans (mostly people without Medicare or other primary insurance)
- Trainings tab has many PowerPoints DOH presented to plans and Local DSS
- NOTHING for consumers and NO FAQs as of 5/14/22 – only https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care

Alphabet Soup! Learn new acronyms!

NYIA - New York Independent Assessor – replaces CFEEC (Conflict-Free Evaluation and Enrollment Center) – Has 3 functions:

1. **CHA or IA Community Health Assessment or Independent Assessment (Maximus Nurse assessment using the UAS-NY)**
2. **IPP Independent Practitioner Panel –Maximus doctor, nurse practitioner, or physician assistant who will now schedule:**
   - **CA Clinical Appointment – Examination by the IPP, which then prepares --**
   - **PO Practitioner's Order – Replaces the M-11q or DOH-4359 Physician's Order. Will be signed by IPP.**
3. **IRP Independent Review Panel –New review required if plan or LDSS proposes hours more than 12 per day on average, *for the first time***

Acronyms used here that are NOT changing --

- **PCS – Personal care services**
- **CDPAP – Consumer Directed Personal Assistance Program**
- **DSS – Local county Dept. of Social Services (HRA in NYC) --Medicaid agency that handles all applications for Medicaid and requests for PCS/CDPAP**

  (1) for people excluded or exempt from MLTC or mainstream managed care or

  (2) applying based on Immediate Need for home care
- **TBI and NHTDW – Traumatic Brain Injury & Nursing Home Transition & Diversion Waiver**
- **MMC - Mainstream Medicaid Managed Care – mandatory plans for those without Medicare or other primary insurance, and who have no spenddown. Mostly under age 65, but also includes elderly or disabled SSI recipients who don't have Medicare, often because of immigration status. Members of these plans must request PCS or CDPAP from the plan and all other Medicaid services.**

What Assessments does NYIA Do?

NY Medicaid Choice ("NYMC" or Maximus) has huge new role. Until now only did Conflict-Free Assessment for MLTC enrollment. Once phased in, NYIA will do all assessments for Personal Care (PCS) or CDPAP ("home care"):

1. **MLTC - Continues to do Nurse assessments to enroll in MLTC or Medicaid Advantage Plus (MAP), but now must also do a second medical assessment by an "Independent Practitioner Panel" (IPP) before MLTC enrollment**
   a. **Once phased in, will take over all MLTC Nurse assessments – annual reassessments, requests for increases, hospital or NH discharges. All will also require the IPP.**
   b. **NYIA does NOT assess for PACE enrollment.**
2. **Local DSS/HRA - Takes over ALL PC/CDPAP assessments by DSS/HRA – Immediate Need, or for people exempt or excluded from MLTC or mainstream MMC including:**
   a. **Enrolled In HOME HOSPICE, or OPWDD, TBI or NHTD waivers**
   b. **Adults with Medicaid but not Medicare, and people ages 18-21**
3. **Mainstream managed care (MMC) plans - takes over ALL PC/CDPAP assessments by MMC plans; does requests to transfer from MMC to MLTC.**

In all above situations, both a NYIA CHA (Nurse assessment) AND CA (medical assessment by IPP) are required (once phased in)

4. **PLUS - A new High-need review "Independent Review Panel" is required where plan or DSS determine needs > 12 hours/day if had fewer hours before.**

** **Plan or DSS still decide the plan of care (hours), using the new assessments**

Independent Assessor being phased in:

A. Starts May 16, 2022:

1. **For enrollment into MLTC/MAP (not PACE) (replaces CFEEC)**
2. **For standard *NEW* requests for PCS/CDPAP to DSS for age 18+ - if exempt or excluded from MLTC or MMC, including:**
   - **in HOME HOSPICE, OPWDD, TBI or NHTD waivers**
   - **Adults with Medicaid but not Medicare, and people ages 18-21**
3. **Mainstream managed care – *Standard* NEW* requests for PCS/CDPAP for age 18+ and voluntary transfers to MLTC**

B. Start July 1, 2022 - Immediate need applications to DSS/HRA and *expedited new* requests to mainstream managed care.*

C. Starts Later – No date set yet:

1. **Annual *reassessments* (no longer 6-month) – for MLTC, mainstream managed care & DSS/HRA**
2. **Every request to plan or LDSS for an *increase* or on *discharge from NH, hospital*.**
3. **Voluntary transfer from MLTC plan to MLTC plan**

***Standard requests must be processed in 14 days. Expedited must be processed in 72 hours, if delay would seriously jeopardize enrollee's life or health or ability to attain, maintain, or regain maximum function. Both subject to 14 day extension. 42 CFR 438.210(d)**

More on Phase In – Transition cases

- **What if requested CFEEC before May 16th?**
  - **NYMC will do CFEEC with old procedures. Will not do the CA / PO or high-need IRP review. Plan does enrollment assessment as before, but may use the CFEEC assessment instead.**
- **What if mainstream member requested PCS/CDPAP before May 16th? Or if you applied for Immediate Need before May 16th?**
  - **Requests processed under old rules. No NYIA assessments done. Plan or LDSS still do the nurse's assessment - even if merely made phone call to LDSS before May 16th to request assessment.**
  - **If consumer requested voluntary transfer from MMC to MLTC before 5/16/22, processed under old rules.**

MMC policy p. 1, ADM p. 4, MLTC policy p. 1

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The NYIA process – DSS, MMC

Step 1
- Consumer, caregiver, LDSS or plan calls NYIA to request initial assessment. Must have Medicaid (more on this below- slide 31)
- 855-222-8350, M-F 8:30am-8:00pm, Sat 10:00am-6:00pm

Step 2
- NYIA will schedule CHA and CA within 14 days
- CHA and CA can occur M-F 8:30am-5:00pm, Sa-Su 10:00am-6:00pm

Step 3
- CHA appointment
- NYIA nurse completes UAS-NY (in person or telehealth)

Step 4
- CA appointment
- IPP examines consumer (in-person or telehealth), reviews CHA, determines if self-directing and stable medical condition, and completes the PO form

Step 5
- Outcome Notice sent by NYIA. If denied PCS/CDPAP → Fair Hearing Rights.
- If approved → NYIA refers to LDSS or MMC plan, which use CHA & PO to decide plan of care. If approve 12 or less hours/day – go to Step 7. If > 12 hours/day, go to Step 6.

Step 6
- Independent Review Panel (IRP) If DSS/plan's proposed plan of care > 12 hrs/day, they must refer for IRP review. Within 6 days, panel makes recommendation to Plan/LDSS of whether plan of care maintains health and safety at home.

Step 7
- Plan/DSS use CHA & PO, and IRP if required, to finalize plan of care and send consumer notice with appeal rights.

Jargonary
- NYIA – NY Independent Assessor
- CHA – Community Health Assessment
- CA – Clinical Appointment
- IPP – Independent Practitioner Panel
- PO – Practitioner's Order

The NYIA process – MLTC enrollment

Steps 1-4

- **Same as prior slide for DSS/MMC (CHA and CA requested, scheduled and conducted)**

Step 5

- **If NYIA denies MLTC enrollment → NYIA Outcome notice has Fair Hearing Rights**
- **If NYIA approves MLTC enrollment → NYIA Outcome Notice tells consumer to call NYIA for plan options, and consumer calls a plan to enroll as before.**
- **IA & Outcome Notice good for ONE YEAR, while CFEEC expired after 75 days.**

Step 6

- **Prospective MLTC Plan Gives Plan of Care, based on CHA and CA --**
- **If plan says needs 12 or less hours → enroll (same as now) → go to Step 8**
- **If plan says needs > 12 hours, go to Step 7 but may enroll in the meantime.**

Step 7

- **Independent Review Panel (IRP) If MLTC plan's proposed plan of care > 12 hrs/day, they must refer for IRP review, but consumer may enroll & plan may submit enrollment before IRP referral or while IRP is pending. Within 6 days, panel makes recommendation of whether plan of care maintains health and safety at home.**

  Go to Step 8

Step 8

- **Plan uses CHA & PO, and IRP if required, to finalize plan of care.**

Independent Assessor Process – more detail

1. **TWO "Independent assessments" by** *NYIA– should be scheduled within 14 days.*
   - A. **Independent Assessment (IA) – NYMC nurse** *and*
   - B. **Clinical Assessment (CA) by Independent Practitioner Panel (IPP)- exam by NY Medicaid Choice PHYSICIAN, physician's ass't. or nurse practitioner who prepares a Practitioner's Order (PO). See sample of new form.***

Problem – they don't know consumer. Reg says they

> **"…may review other medical records and consult with the individual's providers and others involved with the individual's care if available to and determined necessary by the medical professional."505.14(b)(2)(ii)(e).**

But how to submit records, especially if telehealth?

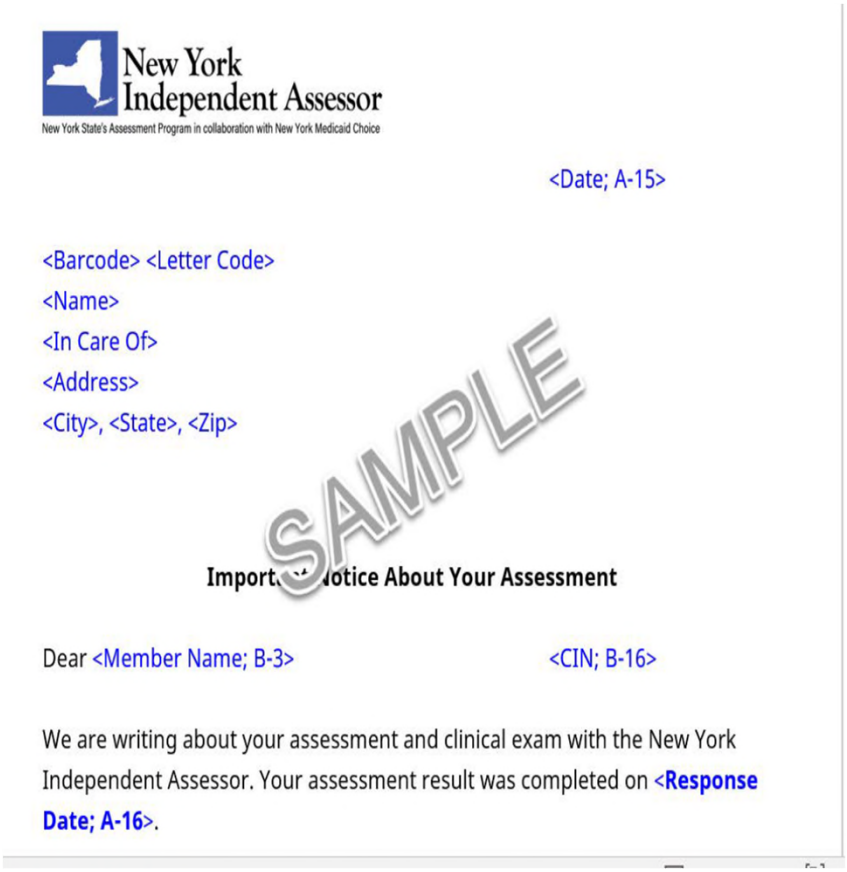
- **TIP: Submit treating physician letter or try using the old forms M11q/DOH-4359. Warning: Guidance says these forms are being** *discontinued* **(once NYIA is phased in) but we think applicant still has right to submit info, and plan/LDSS should still accept these forms for INFORMATION, not as MD "order."**

WHERE are these 2 assessments done? Expect pressure to use telehealth!

- **IA (nurse) – Reg says done where consumer located - home, NH or hospital (or may use telehealth) 505.14(b)(2)(i)(c).**
- **IPP - Reg, ADM and MLTC policy don't say where medical exam is. MMC policy p. 3 says may be in person or telehealth. But must consumer travel?**

***https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slides 11-15**

2. Outcome Notice Content



New York Independent Assessor

New York State's Assessment Program in collaboration with New York Medicaid Choice

<Date; A-15>

<Barcode> <Letter Code>
<Name>
<In Care Of>
<Address>
<City>, <State>, <Zip>

SAMPLE

Import[illegible]otice About Your Assessment

Dear <Member Name; B-3> <CIN; B-16>

We are writing about your assessment and clinical exam with the New York Independent Assessor. Your assessment result was completed on **<Response Date; A-16>**.

- **The notice will contain a section entitled Your assessment showed, which is where it informs the consumer of the outcome**
- **There are multiple possible outcomes, depending upon the consumer's situation (MLTC/Mainstream/Immediate Need) and NYIA's findings**
  - **"You are eligible for CBLTSS"**
  - **"You may be eligible for CBLTSS"**
  - **"You may qualify to receive LTSS through a MLTC plan"**
  - **"...however your health condition is not stable enough to get...care at home"**
- **These notices will be very confusing for consumers, so it's important to get a copy of the notice to properly advise them!**

2. NYMC "Outcome Notice" – if ELIGIBLE

If after the 2 assessments NYMC says eligible for PCS/CDPAP or MLTC enrollment --

- **Notice refers applicant back to NYIA to learn MLTC plan options, contact MLTC plans and enroll as before**
- **If in mainstream plan or exempt from MLTC - Tells consumer to call DSS or MMC plan to "share results" to develop plan of care.**
  - **ADVOCACY CONCERN – Why is burden on consumer to contact LDSS/ plan to move request forward. NYMC sends the results anyway to DSS/plan thru portal – that should be enough for DSS/plan to take next step.**
- **Will NYIA properly direct consumer so they don't get bounced around?**

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_ldss.pdf slides 33-35 and https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_mmco.pdf

2. NYMC "Outcome Notice" – if NOT ELIGIBLE

- **NYIA Outcome Notice of denial of PCS/CDPAP/MLTC – can request Fair Hearing.**
- **For MLTC, this is not a change. NY Medicaid Choice always sent denial notice to consumer.**
- **But for DSS/HRA and managed care plans, this is a big change. Denial notice used to come from DSS/HRA or managed care plan. Is this legal?**

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_ldss.pdf slides 33-35 and https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_mmco.pdf

Why can NYIA deny PCS/CDPAP or MLTC?

- **Personal care/CDPAP – denied if not "medically stable." 18 NYCRR 505.14(a)(3)(this is not a new requirement)**
  - **not expected to exhibit sudden deterioration or improvement;**
  - **does not require frequent medical or nursing judgment to determine changes in the plan of care;**
  - **physically disabled or frail elderly individual does not need skilled professional care in the home but does require routine supportive assistance to prevent a health or safety crisis from developing.**
  - **TIP: If client has SKILLED needs (trach, oxygen, tube feeding explain that informal caregiver will do tasks OR use CDPAP**
- **For MLTC enrollment or Mainstream MMC – even if not "medically stable" for PCS/CDPAP, could still be eligible for Private Duty Nursing or Adult Day Health Care services from MLTC plan -- so should not be denied enrollment.**
  - **For MLTC, must need Community-Based long term services & supports (CBLTSS) for 120 days (but not required for MMC)**
- **The 3 ADL criteria (2 if dementia) are NOT in effect yet!**

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DSS & Plans Develop Plan of Care

3. **HRA/DSS or Plan uses the IA and CA to develop plan of care – and authorize services if 12 hrs/day or less.**
4. **Variance – DSS or Plan may dispute the IA if they have "material disagreement" affecting plan of care. Then IA may make requested change or has 10 days to do a *new assessment*.**
    a. **More delay – MLTC must request variance "with due expediency," and has 10 business days to provide info on request from NYIA to support dispute.***
    b. **Consumer may refuse reassessment without penalty – then DSS or plan must use original IA.***
    c. **Plans get penalized if request too many variances.**
5. **Will plan/LDSS nurse still 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!**
6. **If HRA or Plan say needs > 12 hours per day → see next slide.**

*MMC Policy p. 8, MLTC Policy p. 7-8, ADM p. 12

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Independent Review Panel (IRP) – if > 12 Hrs/day

6. **If DSS or Plan say needs > 12 hours/day for the 1st time → Must refer for "Independent Review Panel" (IRP) – 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 forcing 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)**
      - **If proposed 24/7 live-in not safe, can IRP recommend 2x12?**
   c. **Grandfathered if already has > 12 hrs/day - IRP not required if consumer already receiving > 12 hours/day, including if request increase from live-in to split-shift***
   d. **Plan/DSS make final decision and issue notice. Does not have to take IRP recommendation.** 505.14(b)(2)(iii)(f)

* **MLTC Policy p. 10, ADM p. 10, MMC policy p. 6 – clarifies 18 NYCRR 505.14(b)(4)(xi)(b)**

Independent Assessor - Concerns

Capacity of NY Medicaid Choice to Do Assessments in 14 Days

Does NY Medicaid Choice have enough:

1. **Nurses and MDs, Nurse practitioners, PA's to do the CHA and IPP within 14 days of request?**
   - **Huge nursing shortage aggravated by COVID.**
   - **CFEEC's already delayed for MLTC**
   - **By 7/1/22 will start Immediate Need & Expedited assessments for MLTC/ mainstream to be done in 6 days**
   - **Once fully phased in -about 300,000/year!**
2. **Call Center capacity – Calls for CFEECs go into voicemail, calls not returned. How will handle massive increase to schedule the THREE new assessments?**

Independent Assessor Concerns -- Delays!

- **Even if NYIA can do CHA & IPP assessments in 14 days –**
- **HRA/DSS must determine hours within 7 days of receiving back all of the assessments, then**
- **Referral for IRP Medical Review will take at least 6-10 more days**
- **Add 10 days if DSS/Plan disputes "material fact" in IA.**
- **Whole process will take minimum 30 days likely much longer. But law and regulations set shorter time limits:**
  - **Immediate Need– DSS must approve Medicaid AND home care 12 Days after application filed (starts July 1, 2022)**
  - **Plans have 14 days to process a standard request, extendable up to 14 more days. Only 72 hours for expedited requests. See next slide. Impossible to meet these time limits!**
- **DSS/Plan *may* (not *must*) authorize "temporary" care > 12 hours/ day pending the High Need IRP Review* if can't meet deadlines – in regulation***

* 505.14(b)(3)(ii), 505.28(g)(2) **505.14(b)(4)(vi), 505.28(e)(4)

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slide 51

How will MLTC/ mainstream plan comply with federal deadlines to decide requests to 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.

MMC guidance p. 5 says times run from date of request *only if a current CA & IPP are on file* **– under fiction that only physician's order can start the clock. We think this violates federal reg that says time runs from receipt of the request for service. 42 CFR 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(d)**

Independent Assessor Concerns

Lack of guidance, public information

- **LDSS/plans must operationalize huge systems changes for referrals to and from NYIA in new portal, issue internal procedures, train staff – guidance was only issued April 20 – 28, 2022 (slide 13)**
- **Earlier guidance – 21 ADM-04 & MLTC Policy 21.06 (12/13/21) didn't touch on IA – about 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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Can you request the new NYIA assessments while Medicaid application is pending?

- **Unclear.**
- **Since 2014, a CFEEC could be scheduled and conducted while Medicaid application pending.**
- **New reg should allow this – it says only that Medicaid eligibility must be established before services are *authorized*. 18 NYCRR §505.14(b)(4)(i).**
- **But MLTC Policy 22-01 says, "The NYIA will only conduct the initial assessment process for individuals with active Medicaid." The ADM is inconsistent, saying in one place Medicaid can be processed concurrently with assessments, and in another Medicaid must be active to schedule the assessments (pp. 5-6).**

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Appeal & Fair Hearing Rights

- **Plan/LDSS *may not* authorize > 12 hours wo/ high-need IRP unless ordered by a Fair Hearing or court. 18 NYCRR 505.14(b)(4)(vi).**
  - **MMC Policy adds also if ordered by External Appeal of NYS Dept. Financial Services (Article 49 Title II of NYS Insurance Law), but MLTC Policy doesn't mention it. See http://www.wnylc.com/health/entry/184/#external%20appeals.**
- **In FH, may ALJ order 24-hour care if consumer requested 24-hour care, but plan/LDSS approved 8 hrs, so didn't refer for high-need IRP? Reg above implies the answer is YES, since plan must comply with FH decision even if no IRP. DOH rep said YES at a meeting, but we asked them to clarify in policy (otherwise ALJs might remand for lack of the IRP, causing more delay).**
- **EVIDENCE PACKET – DSS & MMC guidance say DSS/MMC plan give notice and responsible for compiling Evidence Packet, including all NYIA assessments. PowerPt says UAS disputed by plan/LDSS is REPLACED by new one, so appears will not be part of packet.* Unclear if consumer can request it. MLTC Policy says nothing about notice and Evidence Pkt.**
- **Will NYIA be a party to a hearing? MMC & DSS guidance says appellant or plan/DSS may call NYIA as a witness, but does not say how. (MMC policy p. 10, ADM p.11). MLTC policy is silent.**

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slide 21

Advocacy

Advocacy:

- 12/15/21 Letter to DOH from NYLAG & Medicaid Matters NY, with 1/6/22 update http://www.wnylc.com/health/download/801/
- 2/2/22 Letter - http://www.wnylc.com/health/download/807/
- 3/25/22 Letter - http://www.wnylc.com/health/download/812/
- 5/3/22 NYLAG questions about the new policies http://www.wnylc.com/health/download/814/

- See prior NYLAG comments from when regulations were proposed http://www.wnylc.com/health/news/85/#comments
- Look for updates at http://www.wnylc.com/health/news/85/ and https://www.health.ny.gov/health_care/medicaid/redesign/nyia/
- Report delays in scheduling Conflict Free assessments:
  - Independent.assessor@health.ny.gov / (518) 474-5888
  - DOH MLTC Complaint Unit 1-866-712-7197 or mltctac@health.ny.gov

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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Changes in "Transition Rights"

- **Upshot: If your client receives Immediate Need services – they should not enroll in an MLTC plan until after they receive notice from NY Medicaid Choice to enroll 120 days later.**
- **They might get some pressure to enroll earlier – by the home care agency that wants to keep the case, etc. DO NOT enroll EARLY! They will not get TRANSITION RIGHTS!**
- **Next slides explain– and see article at http://www.wnylc.com/health/entry/232/ and Fact Sheet at http://www.wnylc.com/health/download/797/**

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Involuntary MLTC plan changes – Who has Transition Rights?

- **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/**

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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.** *No rights if enroll in MLTC early!!!*
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 limited reasons in. MLTC Policy 16.06, which is based on *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996). Reasons are:**
  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/

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 – call NYMC to get "unlocked" -**
  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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COVID issues

Aide Shortage Exacerbated by COVID

- **Chronic aide shortage is national.**
- ***Fair Pay for Home Care* bill sponsored by Senator Rachel May and Assembly Health Chair Richard Gottfried didn't pass. Would have set wages for home care workers at 150% of the highest minimum wage in a region, or $22.50/hour.**
- **Instead, budget increased wages $3 over 2 years.**
- **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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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.

- **There are now 5 allowed reasons, and a 6th coming.**
- **What happens after disenrollment? Depends on which ground.**
  1. **Member assigned to a new MLTC plan OR**
  2. **Referred to local DSS for services.**

  Either way, member has Transition Rights to same hours and services for 90 days

***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/**

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.**
   - **Notice has FAIR HEARING rights. Must request hearing within 10 days before effective date to get AID CONTINUING. This allows staying in plan until hearing decided.**
3. **After disenrollment - assigned to a new MLTC plan OR referred to local DSS for services. Member has Transition Rights.**

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Grounds for Involuntary Disenrollment

1. **Long Term Nursing Home stay 3+ months – see http://www.wnylc.com/health/entry/199/**
2. **Enrollee moved out of plan's service area within NYS.**
3. **MAP plans only – (Medicaid Advantage Plus) - Member changed their Medicare plan, so is disenrolled from MAP plan that requires enrollment in "aligned" Medicare Dual-SNP (Medicare Advantage Special Needs Plan) operated by same company.****

For #2 & #3 – GIS says case will be referred to LDSS which must continue same Plan of Care pending a reassessment. Advocate must 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 FH or don't request FH – assigned to new 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/*

6th Enrollment ground coming

6. No Services provided in prior calendar month

- DOH told plans these disenrollments will be permitted starting May 1, 2022 but delayed – may start July 1, 2022. No directive yet.
- Consumers alarmed because many consumers do not receive authorized services because of AIDE SHORTAGE.
- Also, consumers were allowed to PAUSE services because of COVID (see previous slide). That guidance is still in effect.

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COMING: 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 or 2023 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

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 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.)

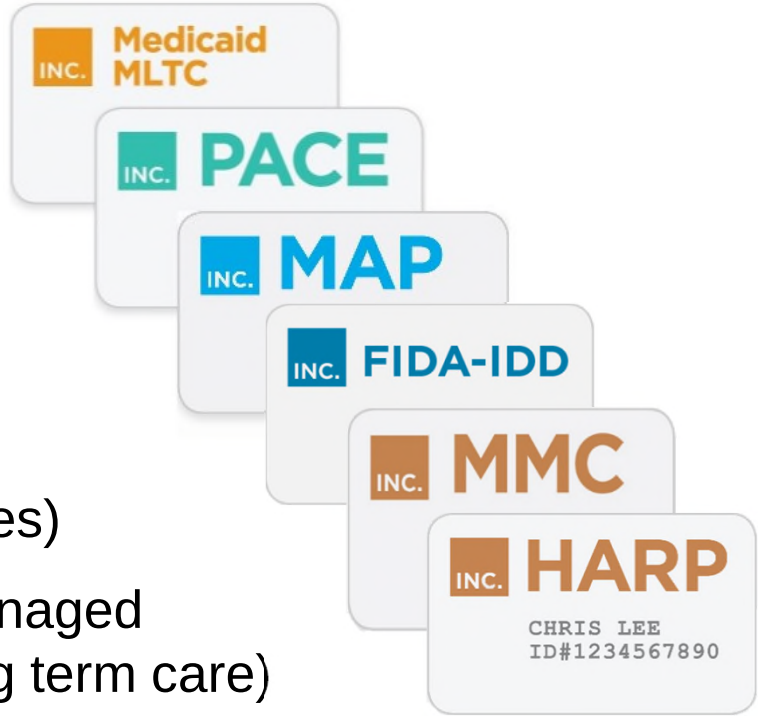
We also help educate people who are newly eligible for enrollment in a Medicaid managed care plan.

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)

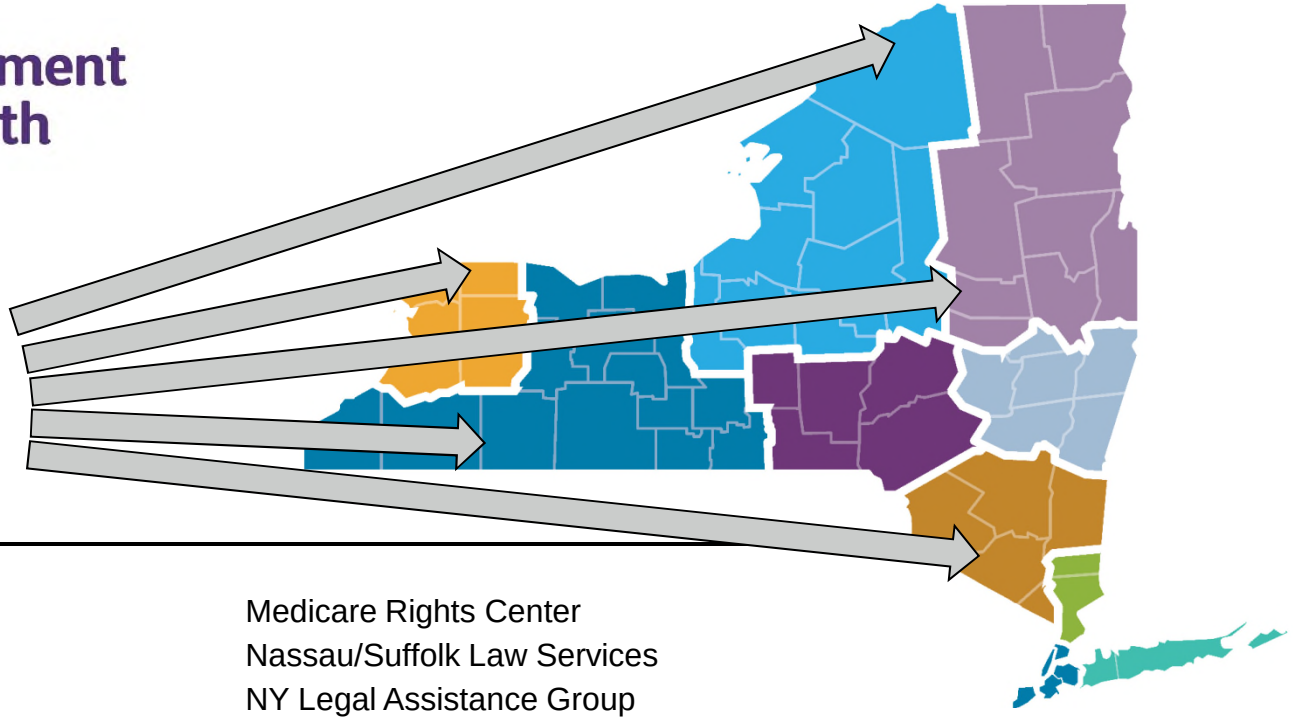


* FIDA is no longer available after 2019.

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.

THANK YOU

More information at nylag.org and nyhealthaccess.org

Please donate to support us!

https://www.nylag.org/donate-now/

At prompt please designate Evelyn Frank program!

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