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Medicaid Update: New York's New Home Care Rules and Other Developments

Medicaid Cuts Coming in 2021-2022

Focus on the New Lookback & Home Care Eligibility and Assessment

Pierro & Associates May 2021

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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 represents seniors and people with disabilities on health care access issues, trains professionals, maintains www.NYHealthAccess.org, and advocates on a policy level to improve health & long term care access.

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Agenda

1. Past budget cuts now being implemented –Lock-In & Nursing Home disenrollment from MLTC
2. New 30-Month Lookback starting Jan. 1, 2022
3. Medicaid Home Care Eligibility & Assessment Changes Coming in 2021-22
4. COVID easements - ban on discontinuing or reducing Medicaid eligibility, may fax applications, etc.

   http://www.wnylc.com/health/news/86/#NYS%20Medicaid%20Policies
5. Not covered but see online:
   - Changes for Medicaid recipients who newly enroll in Medicare – "Default Enrollment" http://www.wnylc.com/health/entry/226/
   - New fair hearing system for MLTC members in Medicaid Advantage Plus (MAP) plans http://www.wnylc.com/health/entry/225/
   - Special fair hearing protections for homebound consumers appealing denial of a home care increase – Varshavsky - http://www.wnylc.com/health/entry/228/

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NOW IMPLEMENTING CHANGES ENACTED IN EARLIER YEARS

MLTC Lock-In

Disenrollment from MLTC plans if in Nursing Home 3+ Months

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MLTC Lock-In – Limit on Voluntary MLTC Plan Changes

- Until Dec. 2020, members could voluntarily change MLTC plans at any time.
- New MLTC enrollees or those who changed MLTC plans **on or after Dec. 1, 2020**:
  - Have a **90-day grace period** to change plans for any reason
  - May change plans only for **good cause** during the next 9 months.
- Lock in only for "MLTC plans" - may transfer to or from a PACE or Medicaid Advantage Plus (MAP) plan any time.
- **BEWARE** when changing plans voluntarily - member has **no *continuity of care* rights – new plan may give fewer hours,** without proving a change in medical condition or circumstances
- **Good Cause** to change plans after 90-day grace period:
  - Member moves from the plan's service area,
  - Plan fails to furnish services,
  - Member did not consent to enrollment
  - Plan and member mutually agree that transfer is appropriate
  - Aide is no longer working with current plan
- If enrolled in MLTC plan before 12/1/20, may change plans any time, but then after initial 90-day grace period in new plan, locked in for 9 months.

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

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Involuntary MLTC Plan Changes – Member DOES Have Transition Rights

- Lock in applies to "Voluntary" MLTC plan changes.
- INVOLUNTARY changes are different:
  - When an MLTC **plan closes**.
  - After receive Immediate Need personal care or CDPAP from local Medicaid agency for 120 days, required to enroll in an MLTC plan
  - When received home care from a "mainstream" managed care plan, then got Medicare – and was switched to MLTC or Medicaid Advantage PLUS (MAP)
- The NEW MLTC plan is required to continue the **same plan of care** (same hours of home care or other services) for **90 days** (120 days if MLTC plan closed).

Rights when Plan closes – see **MLTC Policy 17.02** and NYLAG Fact Sheet at http://www.wnylc.com/health/download/757/

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Involuntary MLTC Plan Changes – Member DOES Have Transition Rights

- After transition period, plan may reduce hours only for "cause" –
  1. medical condition improved,
  2. change in social circumstance
  3. Mistake in original authorization
- **BEWARE**: State has proposed regulation changes to allow plans to reduce hours after transition period based on plan's view of "medical necessity" without proving any change

Rights when Plan closes – see **MLTC Policy 17.02** and NYLAG Fact Sheet at http://www.wnylc.com/health/download/757/

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MLTC Members Disenrolled if in Nursing Home 3+ Months ("LTNHS")

- Since 8/1/20 -- MLTC members who are "**Long Term Nursing Home Stay**" – in NH 3+ months + approved for Nursing Home Medicaid after 5-year lookback → disenrolled from plan.
- Members receive notice from NY Medicaid Choice,* with right to (1) request fair hearing or (2) call NY Medicaid Choice 1-888-401-6582 and request assessment to be discharged home
- Plan and NH identify which members have an **active discharge plan**, who are NOT disenrolled. (But they don't identify many, such as those who the plan has denied an increase, etc).
- Disenrollments in batches – last was April 1, 2021 – over 20,000 so far (most outside NYC).
  - If disenrolled, right to re-enroll without conflict-free assessment within 6 months

* Copy at http://www.wnylc.com/health/file/722/
GIS 20-MA-06, See http://www.wnylc.com/health/entry/199/

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MLTC Members Disenrolled "LTNHS" con'd.

- With visitation just opening up in nursing homes, families don't see notice so can't help member request a Fair Hearing or call NY Medicaid Choice for an assessment.
- Only person listed as Authorized Rep on the Medicaid app receive a copy of the notice. To be listed, submit *Form DOH-5247 - Medicaid Authorized Representative Designation/ Change Request*** to Local Dept. Social Services (DSS). In NYC:
  - if nursing home application was approved, fax form to 917-639-0736.
  - If the Medicaid application is still pending, ask nursing home to submit it or you can fax it to 917-639-0735. Note the name and address of nursing home. Read more here.

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

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STATE BUDGET – NEW LOOKBACK FOR HOME CARE

DOH request to CMS to amend MLTC waiver – https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm (March 2021)

Download State budget law S. 5608 at https://legislation.nysenate.gov/pdf/bills/2019/S7506B - Section MM starts at 259.

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NEW 2.5 Year Lookback for Home Care + CB-LTC

- New applications for Medicaid to obtain Community-Based Long Term Care (CB-LTC) filed **after Jan 1, 2022** will require a "**lookback**" **back to Oct. 1, 2020**
- **Lookback** = Application must include copies of all financial records **back to Oct. 1, 2020** for applicant and spouse.
- At first, lookback period will be 14 months, and add a month every month until it is **30 months (2.5 years**)
- **Transfer Penalty -** If a "non-exempt" transfer was made in the lookback period, Medicaid will not pay for CB-LTC services for the penalty period. Will use **same penalty rate** as for nursing homes (more below).
- **WHO:** For ***new*** applications and **requests for "increased coverage" filed** after 1/1/2022 (See below).
- Delayed until Jan. 1, 2022 because of federal COVID-19 protections – States can't restrict eligibility.

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More on Lookback for Home Care & CB-LTC

- **BACKGROUND** - Under federal law, states **MUST** do a **5-year** lookback for nursing home care.
- States **MAY** require a lookback for Medicaid home care and other **community-based long term care services** (**CB-LTC**).
- NYS never had a lookback for CB-LTC *until* enacted in State Budget April 2020.
- Lookback only for **long term care** services -- States **may NOT** require a lookback for hospital care, acute & primary care.
- No final regulations or guidance issued yet. Some details in DOH request to CMS to amend the MLTC "waiver"*

*https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm

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Which Community-Based Long Term Care Services WILL Require a LOOKBACK?

1. Personal care services (a/k/a home attendant)
2. CDPAP (Consumer-Directed Personal Assistance Program)
3. Private Duty Nursing
4. Assisted Living Program (ALP)
5. Adult day health care
6. MLTC, Medicaid Advantage Plus and PACE plan enrollment
7. Certified home health agency (CHHA) – *if > 29 days*

No lookback for:

1. Waivers (but how does applicant show she wants these?)
   a. Nursing Home Transition (NHTDW)
   b. Traumatic Brain Injury (TBI) waiver
   c. OPWDD waiver
2. Mainstream Managed care (these plans provide most of the above services for those without Medicare)
3. Acute, primary care, hospital, ER

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Who is Grandfathered in – so does Not have to do Lookback? And who MUST do lookback?

Who is grandfathered in?

- If applied for Medicaid with CB-LTC before 1/1/22 (does not matter if already receiving services)

Who Must Submit Lookback with Application?

- **NEW Applicants** for Medicaid coverage of CB-LTC filed after 1/1/2022 (unless delayed)
- Those who applied for Medicaid *without* long term care coverage and "attested" to the amount of resources, without verifying the amount.** If they want CB-LTC after 1/1/22, they must **request an "increase"** in coverage by submitting **Supplement A** and the **lookback** documents. *During pandemic, applicant may attest to amount of resources.*

*https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf
**04ADM-06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources

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ALERT! New Supplement A Used in NYC after Jan. 1, 2021

- Starting Jan. 1, 2021, NYC has a **new Supplement A** form -- DOH-5178A https://www.health.ny.gov/forms/doh-5178a.pdf.
  - **NEW**: **Spouse** must sign it, **even if doing spousal refusal** or **not applying**.
  - **NEW**: Supplement A must now be submitted even if NOT seeking CB-LTC. So anyone who applies and submits Supp. A with proof of assets before 1/1/2022 should be grandfathered in with no lookback.
  - See http://www.wnylc.com/health/news/89/ (HRA Medicaid Alert posted).

**04-ADM-06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources

Phase-In Period

- **Any transfers of assets BEFORE 10/1/2020 will NOT be subject to a penalty.**
- Lookback is back to 10/1/20 – not before. This is true even if lookback is delayed past 1/1/22

Apply on or after	Length of lookback
Jan. 1, 2022	14 months
Add 1 month every month so that:	
Jan. 1, 2023	26 months
May 1, 2023	30 months

TIP: If transfer was made after Oct. 1, 2020, apply before Jan.1, 2022!

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Lookback for Married Applicants – Spouse's Records

- Medicaid applications must include up to 30 months (after phased in) of **all financial records for applicant and spouse**.
- Even if using "spousal refusal," must document spouse's assets during lookback period. **THIS IS A BIG CHANGE**.
- **Spousal Refusal** is still in effect – (not repealed as proposed in April 2020 budget) but this doesn't protect applicant from lookback and transfer penalty
- **Example**: Pat's spouse Randy transferred $50,000 during lookback period. Randy still has $200,000.
  - Randy may do spousal refusal so $200,000 won't count as Pat's asset (subject to DSS claim for spousal support)
  - but the $50,000 transfer will give Pat a transfer penalty, unless it was an exempt transfer.

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How Long is the Transfer Penalty?

1. **Total up every uncompensated transfer** in the lookback period to determine the length of the penalty.
2. Divide that total amount by a number called the **Regional Nursing Home Rate** – DOH publishes it every year.* The result is the **penalty period** – the number of months that Medicaid will NOT pay for the nursing home stay OR for home care/ALP.

Total Transfers		Regional Nursing Home Rate		Penalty Period (in Months) (rounded)
EX. $39,000	÷	$13,037*	=	3 months

* This is NYC. See rate for other regions at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma12.pdf

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Exceptions to Transfer Penalty – Assets other than the home

Exceptions same as for nursing home. No penalty for transfer by the applicant or spouse of an asset other than the home to:

1. **spouse**
2. **child** who is **certified blind or disabled**
   - may transfer cash, does not require put into trust;
   - Child may be over age 65 - Disability Reviews for Adult Children over 65, GIS 08 MA/036
3. **Supplemental needs trust for disabled person <65**
   - Can be for oneself if <65 and disabled or for someone else
4. **Transfer of an exempt asset** has no penalty – ie. Holocaust restitution, assets under $15,900

18 NYCRR § 360-4.4 (c)(1)(ii); see http://www.wnylc.com/health/entry/38/ .

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More Exceptions to Transfer Penalty (assets other than home)

5. Meant to sell asset for its **fair market value**;
6. Transfer was made **exclusively for purpose other than to qualify for Medicaid long term care** (young, healthy client had stroke after gift)
7. All of the transferred **assets have been returned** to the individual.
   - Partial return reduces penalty proportionally*
8. Individual used assets to purchase:**
   - an annuity, life estate, promissory note, loan, or mortgage

* 2006 ADM, p. 18.

** must follow rules in SSL §366 subd. 5 (e)(3)(i-iii)

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Transfer of the home

Advocates believe ALL transfers of the home should be exempt –Since a home is exempt for community Medicaid (if single and equity < $906,000 or if a spouse, minor or disabled child live there).

But NYS DOH disagrees. No final state policy yet. DOH proposes to allow only the same transfer penalty exemptions that apply for nursing home Medicaid. That would mean transfer of the home to certain people is exempt:

- to spouse or disabled child
- to "caregiver" child or sibling with equity interest – only if lived with applicant for 1-2 years **before institutionalized**. Makes no sense in the community!

See more in NYLAG lookback comments - http://www.wnylc.com/health/download/746/.

Soc. Serv. L. § 366(5)(e)(4)(i); See *Mondello v. D'Elia*, 39 N.Y.2d 978, 1976 N.Y. LEXIS 2927, 387 N.Y.S.2d 232.

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Transfer Penalty Would Cause "Undue Hardship"

- Denial of eligibility because of transfer would cause an undue hardship - it would:
  - **deprive the individual of medical care** such that the **individual's health or life would be endangered**
    - Hardship if nursing home threatens discharge if Medicaid not secured and payment not made. FH 6657601M Albany,
      FH 67841713Z Schenectady; FH No. 6660774R Suffolk
  - **would deprive the individual of food, clothing, shelter**, or other necessities of life. §366 subd. 5 (e)(4)(iv) and
- **And applicant is unable to have the resources returned despite best efforts,** or can't obtain fair market value for them, or cannot void a trust fund where transferred to.

*How much cooperation & effort is required of applicant or agent with power of attorney – to get funds back – has been the subject of fair hearings. See, e.g,. FH #5153034Y (Albany Co. 5/12/09)(no hardship found), FH No. 6660774R, Suffolk Co. 3/12/2014 (undue hardship exemption granted)

More on Undue Hardship

- **Undue hardship - State created definition for nursing home Medicaid and makes no sense for community care!**
- **Undue hardship is limited to those who,** after payment of medical expenses, have income and/or resources **below the Medicaid limits**. ($884/mo. Income).
  - For nursing home, this limit didn't matter since all income except $50/mo must be paid as "NAMI" unless has a spouse.
  - But in the community, this **would deny the hardship exception to anyone with a spend-down or who uses a pooled trust or spousal refusal.**
  - **DOH MUST change this rule for home care!**
- **Must request hardship waiver with application** – when you might not realize it will be needed (don't yet know another exception is denied)
- If denied, consumer entitled to notice with fair hearing rights.

96 ADM-8 at 23; 06 OMM/ADM-5 at 19-20;18 NYCRR § 360- 4.4(d)(2)(iii)

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Lookback Will Likely Delay Medicaid Application

- Medicaid applications must be decided within **45 days**, or 90 days if require a determination of disability* (i.e. with pooled trust)
- "Immediate need" applications must be decided in **12 days** – NYLAG asked DOH to allow applicant to "attest" no transfers made.** DOH said NO so far.
- The lookback adds work for the local district. Even though the poorest applicants won't have transfers, delays will affect them too.
- In nursing home, delay doesn't hurt client because they are getting the needed care. Not true when apply for home care!

*42 USC Sec 1396a(a)(8); 42 C.F.R. Sec. 435.911; 18 NYCRR 360-2.4; see also article about delays - http://www.wnylc.com/health/entry/175/

** Soc. Serv. L. §366-a(12)

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May Income Still Be Placed In A Pooled Trust?

- **This is still unclear.** A ***transfer penalty*** applies not only to transfers of ***ASSETS*** but ***transfers of INCOME***.
  - If a deposit of income into pooled trust is a TRANSFER, this is an exempt transfer if < 65 and disabled. But what about age 65+?
- Advocates think CMS policy allows it –
  - "Resources placed in an exempt trust for a disabled individual are subject to…**a penalty… unless the resources placed in the trust are used to benefit the individual, and the trust purchases items and services … at fair market value … .These rules apply to both income and resources** placed in the exempt trusts…."**
- **We urge DOH to say that because SNTs can only pay for expenses to meet the needs of the individual, there is no penalty**. NYS DOH 2008 GIS MA/020.
- May require spending money quickly every month – a problem if need to save for annual or irregular expenses – property taxes, etc.

**CMS Medicaid Manual § 3259.7(B)(2): https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 (CH. 3)

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When Does Penalty Period Begin?

New law says "The period of ineligibility shall begin … **the first day the otherwise eligible individual is *receiving* services** for which…" Medicaid would pay but for the transfer penalty. Soc. Serv. L. §366 Subd. 5(e)(5)

- In a **nursing home**, the applicant is already **receiving** services in the NH when they apply. Even if application takes forever to be approved, once it's approved, the penalty can begin retroactively back to nursing home admission.
- In **home care**, one cannot receive MLTC, CDPAP or personal care services until Medicaid is approved. Penalty can't start running until start receiving those services. Much worse than nursing home!

*CMS State Medicaid Director Letter SMD#18-004, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18004.pdf

When Does Penalty Begin? Community

- **Solution** - CMS guidance on 1915(c) waivers* (NHTDW, TBI) says penalty begins when "**would otherwise be receiving" home care at required level of care**, rather than when "is receiving" services.
- DOH has indicated that it will require applicant to submit a physician's statement stating that the applicant has the functional need for home care.
- This way, once Medicaid is approved, transfer penalty could begin retroactively back to month application was filed, or even three months before. A short transfer penalty could expire by the time the Medicaid application is approved and client is ready for services to start.
- **Otherwise, transfer policy would be more favorable in the nursing home** than in community. This **could violate *Olmstead*** and ADA.

*https://www.medicaid.gov/federal-policy-guidance/downloads/smd18004.pdf

CHANGES IN HOME CARE ELIGIBILITY & ASSESSMENT

Proposed regulations to implement budget changes re-issued January 2021; comments were due 3/13/2021

PROPOSED REGS
https://health.ny.gov/health_care/medicaid/redesign/mrt2/express_terms_summary.htm
NYLAG COMMENTS:
http://www.wnylc.com/health/download/771/

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Personal Care (PCS) & CDPAP changes – Overview

1. New **minimum number of ADLs** required for eligibility for PCS/CDPAP & MLTC enrollment
2. **New assessment procedure** for both HRA/DSS, MLTC and mainstream managed care plans – Expanded role for Maximus
   - New "high need" review if need > 12 hours/day
3. Easier for plans to **REDUCE hours**

These changes were supposed to start Jan. 1, 2021, no new date announced.

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RAISING THE BAR OF WHO is ELIGIBLE for PCS/CDPAP – Minimum 2 or 3 ADLs

- **CURRENT LAW:** if need **any** assistance with "Activities of Daily Living" for 120+ days – may enroll in MLTC.
  - If don't need ADL assistance, may get "Housekeeping" service up to 8 hrs/week from LDSS/HRA ("Level 1" personal care*) for "Instrumental ADLs" (IADLs)
- If qualify for PCS or CDPAP – you obtain it from:
  1. An MLTC plan, or
  2. LDSS/CASA (Immediate Need or if excluded/exempt from MLTC, or
  3. If don't have Medicare – from "mainstream" managed care plan

18 NYCRR § 505.14(a)

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NEW: 3- or 2- ADL Requirement

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

- *Limited assistance* with **physical maneuvering** with **3 ADLs** ("more than 2" ADLs) **or**
- If have a **dementia or Alzheimer's** diagnosis - "at least **supervision** with **2 ADLs** ("more than one ADL")

WHEN? Sometime in 2021 or 2022. Stay tuned.

Current recipients grandfathered in – If *receiving* PCS or CDPAP services (who is grandfathered is a little unclear)

§ 2-a, 2-b, 3, 21, amending S.S.L. §§ 365-a subd.2 (e), 365-f, subd. 2

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2 or 3 ADL Requirement – Which ADLs?

- **DOH Proposes to use list of ADLs in UAS assessment:**
  1. Bathing
  2. Personal hygiene
  3. Dressing
  4. Walking/locomotion
  5. Transferring on & off toilet
  6. Toilet use/incontinence care
  7. Bed mobility – Turn & Position
  8. Eating
- What's Missing??
  1. Administration of Medications
  2. Transfer – other than for toilet use
  3. IADLs – next slide

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3- or 2- ADL requirement

Leaves out IADLs – Housekeeping services

- **Instrumental ADLs (IADLs)** = housekeeping tasks – shopping, laundry, cleaning, meal prep., phone use, medication administration- are not considered in whether one meets new ADL requirement.
- If meets the ADL requirement, the personal care/CDPAP aide does both ADLs and IADLs.
- If only needs IADL and NOT ADL assistance, until now could apply to DSS/HRA for Housekeeping services. **THIS IS ENDING.**
  - **Current "Housekeeping" recipients grandfathered in** (600 NYC cases in 12/2020)
  - But **no NEW applications will be accepted** for Housekeeping
- Will lead to falls, other accidents **--** and then will need ADLs. Not smart policy to eliminate this PREVENTATIVE service.
- Only option – non-Medicaid **EISEP** services through County office of the aging/ NYC DFTA.**

*18 NYCRR 505.14(a)(5)(i)

** https://aging.ny.gov/expanded-home-services-elderly-eisep

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3 ADL Requirement

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

If no dementia or Alzheimer's diagnosis, ADL counts toward the minimum only if needs "at least limited assistance with physical maneuvering." The **UAS instructions** define the degrees of assistance as follows:

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**
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.

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Who Is Left Out - Needs "Supervision" But Not Physical Maneuvering With ADLs?

- Only **Dementia** or **Alzheimer's** diagnosis qualifies to count ADL based on needing "supervision" not hands-on assistance
- Leaves out:
  - Traumatic Brain Injury
  - Developmental Disability
  - Visual impairments
  - 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.

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Caution on "Supervision"

- Since a 1999 court decision,* NY Medicaid does not provide aide for "stand alone" *supervision* or *safety monitoring*.
- Medicaid DOES cover safety monitoring, supervision or cognitive prompting to assure safe completion of IADLs or ADLs.
- **TIP: Always identify the ADL (or IADL) client needs supervision or cueing for to assure safe performance. Don't just say needs "safety monitoring" or "supervision."**
  - Must need 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.
- Proposed regulation doesn't change the rule but may lead to more denials

*Rodriguez v. DeBuono; MLTC Policy 16.07

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New Assessment System – DSS & Plans

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

A. **Two "independent assessments" by *NY Medicaid Choice* –** Both required initially AND on annual reassessments (no longer every 6 months), AND if consumer requests an increase mid-year based on medical change.

   1. **Independent Assessment (IA) –** by ***nurse.*** Now, NYMC already does this as the Conflict Free assessment for new enrollees. MLTC plan and HRA will no longer do a separate assessment.
   2. **Independent Practitioner Panel (IPP)**- exam by PHYSICIAN, physician's ass't. or nurse practitioner.

B. **HRA/DSS or Plan authorizes services if needs > 12 hrs/day.**

C. **If HRA or Plan say needs > 12 hours/day** → see next slide.

DOH encouraging **TELEHEALTH** for all assessments

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

C. **If DSS or Plan say needs > 12 hours/day →Must refer for High–Need "Independent Review Panel" (IRP) *by NY Medicaid Choice*** – recommends whether proposed plan of care is appropriate to maintain health & safety in the home.

- **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 generaliza-tions** about individuals with disabilities."*
- IRP not required on reassessment if IRP previously reviewed plan of care of > 12 hours/day

D. Plan/DSS make final decision.

* ADA regulation 28 CFR §35.130(h)

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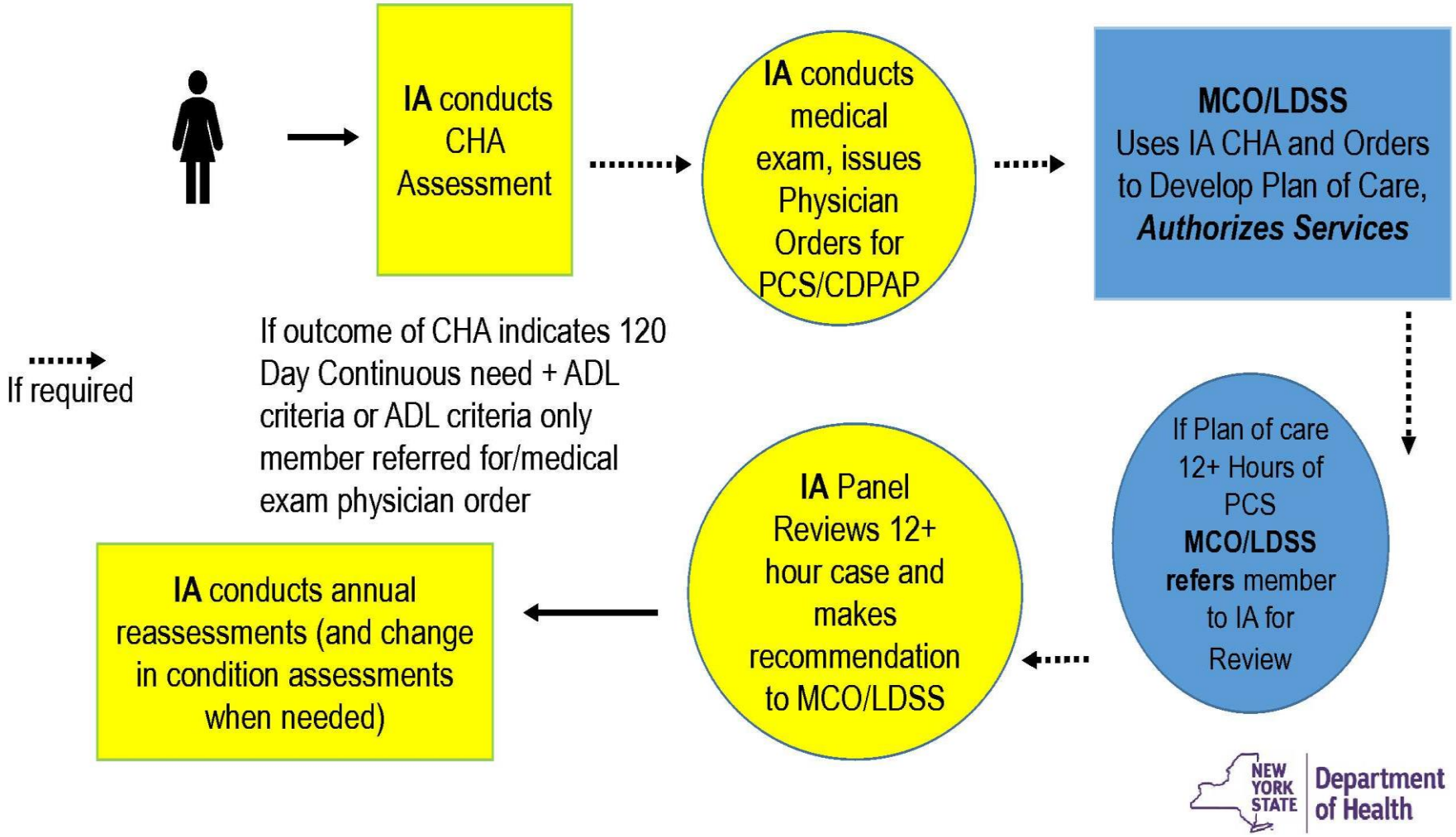
Role Independent Assessor and MCO/LDSS in New PCS/CDPAP Authorization Process



NEW YORK STATE | Department of Health

Delays from the New Assessments!

Adding in these new assessments will cause inevitable delays in:

1. MLTC enrollment & authorization of services
2. Immediate Need applications at HRA/DSS
3. Requests for increases in hours
4. Hospital & Rehab discharges where home care needed

The proposed regulations say:

- 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 to approve Medicaid AND home care
- DSS/Plan *may* (not *must*) authorize interim care pending the High Need Review.

*Proposed 505.14(b)(3)(i), 505.28(e)(i)(7)

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Delays –MLTC/ Mainstream Plan Have Short Deadlines To Decide Requests for Increase or New Services

Type of Request	Maximum time for Plan to Decide
Expedited*	**3 business days from 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**	(1) business day after receipt of necessary info; except when request made the day before a weekend or holiday, **no more than three (3) business days** 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).

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COVID-19 PROTECTIONS

See NYLAG Resources on Medicaid & Covid-19

http://www.wnylc.com/health/news/86

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COVID "Maintenance of Effort" – No Medicaid Discontinuances or Reductions in Eligibility Until PHE Ends

- **MOE prohibits terminating or reducing Medicaid eligibility** for anyone who had Medicaid on March 18, 2020 or obtains it during PHE -- thru end of month in which PHE ends (now July 31, 2021 but likely to be extended til end of 2021).
- Renewals granted automatically for 12 months, even if cut off SSI or public assistance
- You retain MAGI Medicaid & stay in managed care plan even if enroll in Medicare.*
- If meet spenddown for one month, given 6 months coverage

*https://healthlaw.org/resource/overview-of-the-medicaid-related-provisions-of-the-coronavirus-response-packages/
**NYS DOH GIS 20 MA/04 – see http://www.wnylc.com/health/news/86/

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Easier to Apply for Medicaid, Submit Pooled Trusts

- To many Medicaid offices closed in NYC, HRA now accepting e-FAX applications & pooled trusts
  - PUBLIC e-fax 917-639-0732
  - Authorized Submitters (C-Rep) 917-639-0731

  If already have Medicaid -
  - Submit pooled trusts (Spend-down unit) 917-639-0645
- May "attest" rather than verify income & assets, even if for nursing home or home care. Medicare enrollment not required. Still need to complete Application & Supplement A.
- Must verify citizenship or immigration status, but if cannot verify it, will get 90 days coverage while obtain documents, may be extended 90 more days
- Requests for Information – HRA/DSS must call or email applicant and accept info by phone

DOH Covid 19 Guidance on Medicaid Eligibility & Enrollment , NYS DOH GIS 20 MA/04; more info at http://www.wnylc.com/health/news/86/

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Medicaid Home Care

- **UAS assessments** – nurses may do with telehealth/ by phone, including NY Medicaid Choice conflict free assessment.
  - Mid-year nurse reassessments suspended for DSS/HRA, MLTC & managed care plans. M11q for reassessment also suspended, if no changes, but re-auth only for 90 days
- **M11q/physician's order** – MD may sign based on telehealth/telephone exam OR phone it in to DSS/HRA/MLTC. If phone, must submit written form within 120 days of verbal order
- **CDPAP personal assistants** not required to get annual health exam, but must still get initial exam & vaccines

DOH COVID long term care guidance – updated 4/8/2020
https://health.ny.gov/health_care/medicaid/covid19/docs/2020-03-18_guide_authorize_cb_lt_services.pdf

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Medicaid Home Care – Pausing Services

- DOH guidance April 23, 2020 allows consumer to voluntarily pause or reduce home care services on a temporary basis because of the pandemic.
- Plan must confirm the change in writing and have the consumer sign agreement.
- Plan must reinstate original service plan on 72 hours request.

DOH Guidance - http://www.wnylc.com/health/news/86/#voluntary%20service%20plan
NYLAG Fact Sheet - http://www.wnylc.com/health/download/739/

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THANK YOU

More information at nylag.org and nyhealthaccess.org

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At prompt please designate Evelyn Frank program!

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Valerie Bogart

Evelyn Frank Legal Resources Program, New York Legal Assistance Group (NYLAG)

More Information at: nylag.org

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www.nyhealthaccess.org