Medicaid Cuts in FY 2020-21 NYS Budget

Focus on Medicaid Eligibility & Home Care Access

Plus COVID-19 Medicaid Rules

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updated Slides 10, 11 4/29/20

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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.

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Agenda

1. State Budget – MRT; Medicaid Financial Eligibility Wins & Losses – Focus on New 30-Month Lookback
2. State Budget – Medicaid Home Care – Eligibility & Assessment Changes
3. Covid-19 – Overview of Medicaid changes making it easier to apply for and retain Medicaid

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THE "MRT" AND NEW LOOKBACK FOR HOME CARE

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

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FY 2020-21 budget adopted 4/1/2020

- Gov. Cuomo appointed a "**Medicaid Redesign Team**" (**MRT**) to recommend savings of $2.5 billion *before* pandemic. MRT mostly made up of industry insiders. Pandemic increased fiscal pressure to make cuts.
- MRT recommendations made just a week before budget deadline, approved $2.2 million Medicaid cuts – one-third in long-term care.
- **RED ALERT:** New powers allow the Budget Director to make further cuts in 2020 if revenue is not at 99% of anticipated levels

See https://healthlaw.org/resource/overview-of-the-medicaid-related-provisions-of-the-coronavirus-response-packages/

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State budget law S. 5608 available at https://legislation.nysenate.gov/pdf/bills/2019/S7506B.

FY 2020-21 budget adopted 4/1/2020

- Covid-19 Stimulus packages will give NYS as much as $6.2 billion in additional federal Medicaid funds, but only if NYS maintains eligibility standards, methodologies, and procedures that are no more restrictive than what existed January 1, 2020 **("Maintenance of Effort"** (MOE) requirement*).
- This is why most changes are effective 10/1/20 and law allows State Budget director to delay them up to 3 months after state emergency declared over.
- **Red Alert:** Gov. Cuomo still pushing to END the MOE requirement in later Stimulus bills.

See https://healthlaw.org/resource/overview-of-the-medicaid-related-provisions-of-the-coronavirus-response-packages/

State budget law S. 5608 available at https://legislation.nysenate.gov/pdf/bills/2019/S7506B.

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WINS IN BUDGET

- **SPOUSAL REFUSAL** lives on – it was not eliminated as proposed.
- **Spousal Impoverishment resource allowance** - the spouse of an MLTC member, nursing home resident, or TBI/NHTDW waiver participant may keep $75,000 rather than only $25,000 (rounded)
- **Prescriber prevails** – continues for prescriptions for non-Medicare recipients

- That's it for the wins! The rest is downhill….
- **WARNING**: Views here are the author's. NYS Dept. of Health will be issuing policies to interpret the law.

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Lookback for NURSING HOME CARE

- Federal law REQUIRES a lookback for nursing home care.
- A Medicaid application for nursing home care must include ALL FINANCIAL records of the applicant and their spouse during the **FIVE YEARS** prior to the application. This is the **lookback period**.
- **A TRANSFER of an asset is a transfer for less than fair market value** by the applicant or spouse during the LOOKBACK period.
- If the transfer was not "exempt," a **TRANSFER PENALTY** is applied.
  - In 2020, for every **$12,844** transferred (NYC)*, the penalty is ONE MONTH that Medicaid will not pay for nursing home care.

Penalty rate in other regions at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma01.pdf

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NEW 2.5 Year Lookback for Home Care

- **States MAY require a lookback for Medicaid home care. NYS never did *until now*.**
- **WHAT**: If applying for Medicaid to obtain home care or other community-based long term care service, there will be a "lookback" of **30 months (2.5 years**)
- If a "non-exempt" transfer was made in the 30 months, Medicaid will not pay for community-based long term care services for the penalty period.
- Medicaid application must include 30 months of all financial records for **applicant and spouse**.
  - Even if using "spousal refusal," must document spouse's assets during lookback period. Spousal Refusal is still in effect, but doesn't protect from transfer penalty.

WHICH SERVICES WILL THE LOOKBACK APPLY TO?

- Personal care services (likely will include CDPAP)
- Home health care services
- Private duty nursing
- Assisted Living Program
- DOH may designate others by regulation.
- Presumably the lookback will block enrollment in MLTC, Medicaid Advantage Plus and PACE plans.
- **NEW INFO added 4/29/20:** In a presentation to plans dated 4/17/20,* DOH indicated the NHTDW, TBI, & OPWDD waivers, and mainstream Managed care would be exempt from the lookback.

On file with NYLAG EFLRP
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When does the change take effect?

- Will apply to applications for Medicaid coverage of community-based long term care service filed **after 10/1/2020**
  - NYS Budget Director authorized to delay it up to 90 days after STATE disaster emergency declared over.
  - Would apply to "upgrade" of coverage, with submission of Supplement A for someone who had regular Medicaid without long term care coverage

– **NEW**: DOH must first amend 1115 waiver and State Medicaid plan to implement

How long is the Transfer Penalty?

- Medicaid will total up every uncompensated transfer in the lookback period to determine the length of the penalty.
- Then 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 that nursing home stay – and now will not pay for home care/ALP.

	Total Transfers		Regional Nursing Home Rate		Penalty Period (in Months)
EX.	$39,000	÷	$12,844	=	3 months

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Exceptions to Transfer Penalty – assets other than the home

No transfer penalties 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 someone else
4. **Transfer of an exempt asset** has no penalty – ie. Holocaust restitution, assets under $15,750

18 NYCRR § 360-4.4 (c)(1)(ii).

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More Exceptions to Transfer Penalty

5. Meant to sell asset for its **fair market value**;
6. Transfer was made **exclusively for a purpose other than to qualify for Medicaid long term care**
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 Penalty would cause "Undue Hardship"

- Denial of eligibility 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
  - **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 has been hard to obtain in the nursing home context - cannot be claimed**:
- If after payment of medical expenses, the individual's or couple's income and/or resources are at or **above the allowable Medicaid exemption standard** for a household of the same size.
  - **COMMENT**: DOH developed this policy in 1996-ADM-08, and continued it with the DRA in 2006 ADM-05 p. 20. Since at the time no penalty applied to community-based care, this limit didn't really matter, since institutional budgeting limits the applicant's income to only $50/month anyway.
  - But in the community, this would deny the hardship exception to anyone with income above the Medicaid limit. This must be changed by DOH in implementation!
- Must invoke the hardship waiver at the time of application – when you might not realize it will be needed (if one is claiming another exemption that is denied)
- If denied, consumer entitled to notice with fair hearing rights.

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

Transfer of the home

DOH has not yet set policy on this, but we believe transfer of the home should be exempt.

1. A house/apartment that one lives in is exempt for community Medicaid if equity is under the limit ($893,000 - 2020).
   - No equity limit applies if a spouse, minor or disabled child live there.
2. For nursing home Medicaid, transfer of the home is exempt only to certain parties (spouse, disabled child, caregiver child, sibling with equity interest). Soc. Serv. L. § 366(5)(e)(4)(i).
3. Since, subject to equity limit, a home is exempt for community Medicaid, transfer of the home should be exempt as a transfer exclusively for a purpose other than to qualify for medical assistance. Soc. Serv. L. § 366 subd. 5 (e)(4)(iii)

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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Will the lookback delay acceptance of Medicaid applications?

- Probably. Medicaid applications must be decided within 45 days, or 90 days if requires a determination of disability.*
- "Immediate need" applications must be decided in 12 days including the home care authorization.**
- However, even now, many applications take longer.
- The lookback adds work for the local district/HRA, causing delays that will affect all applicants – including *the poorest who never transferred* any assets.

*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?

- A transfer penalty applies not only to transfers of ASSETS but to transfers of INCOME. This raises question about whether pooled trusts can be used for people age 65+ who are disabled
  - clearly OK <65 if determined "disabled"
- **Our view is that pooled trusts may still be used –**
- NYS DOH 2008 GIS MA/020: As long as pooled trust paid for expenses to meet the needs of the individual, there is no penalty for nursing home care.
- CMS Medicaid Manual § 3259.7(B)(2)**: "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…"

** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 (CH. 3)

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May income still be placed in a pooled trust? Con'd.

- Pooled trusts may not be used when in a nursing home with institutional budgeting.
- Just because transfer of asset rules will also apply to community home care does not mean pooled trusts cannot be used.
- The reason pooled trusts cannot be used in nursing homes is because of "post-eligibility" budgeting rules used in nursing homes. 42 CFR § 435.832. These rules do not allow pooled trusts. This budgeting is not used in the community, which allows pooled trusts.

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When does penalty begin?

- New law says "The period of ineligibility shall begin … **the first day the otherwise eligible individual is receiving services** for which medical assistance coverage would be available based on an approved application for such care 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. Penalty can begin in month of application or during the retroactive period.
  - In the community, one cannot **receive** home care that Medicaid would cover until Medicaid is approved, and then has been determined eligible for home care by Conflict-Free assessment or HRA/DSS. Can't pay privately for MLTC, CDPAP, etc.

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

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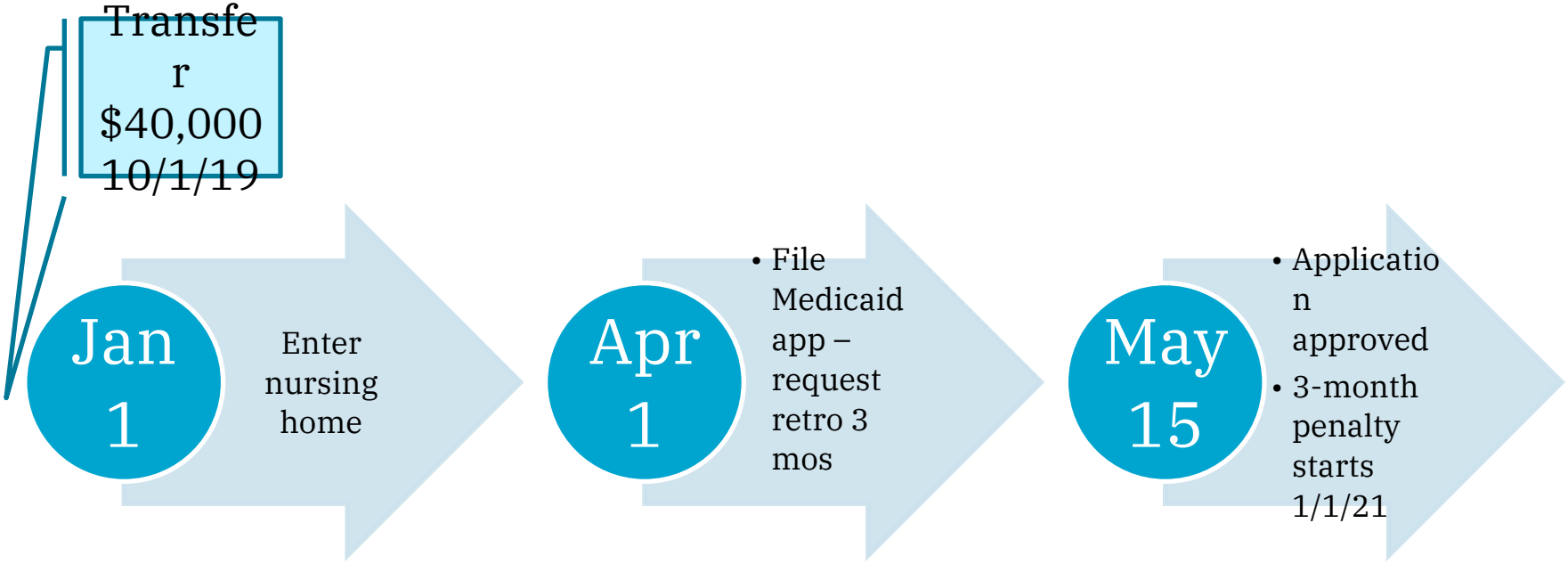
Start Date Penalty – Nursing Home



Medicaid penalty 3 mo's
1/1 – 3/31

Medicaid covers from
4/1/21

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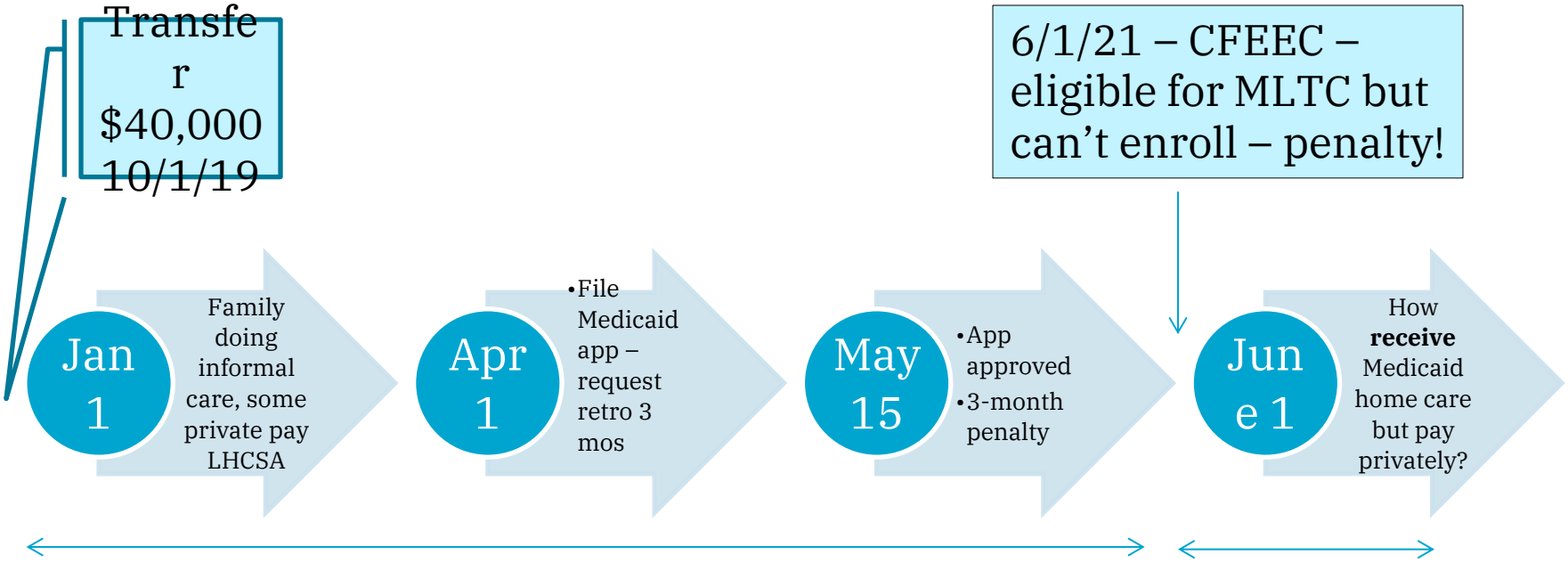
Start Date Penalty – Home Care (TBD!)



Informal, private paid care thru 8/1. Medicaid would not cover that so penalty does not run!

Penalty starts 6/1. MLTC starts 9/1 after 3 month penalty?

What is 1st day client is **receiving** services for which medical assistance coverage would be available but for penalty? Which services will count?

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Start date of penalty – DOH or legislature action needed

- Sole CMS guidance on start date of penalty is for 1915(c) waivers.* Says penalty begins when "**would otherwise be receiving" home care services at required level of care**. Guidance may not apply because MLTC is an 1115 waiver.
- A procedure is needed so that at time application filed, applicant can be determined eligible to receive services that Medicaid would pay for but for penalty. HRA/DSS or NY Medicaid Choice must do eval.
- Must allow penalty to start running on date "**would otherwise be receiving" home care services at required level of care , not when actually receiving them .**
- **Must count if receiving informal care or care by non-Medicaid providers.**
- **Otherwise, the transfer policy would be much more favorable in the nursing home setting** than in the community. Could violate *Olmstead* and ADA. To do this, must have procedure to decide eligibility to receive home care services so penalty can run.

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CHANGES IN HOME CARE ELIGIBILITY & ASSESSMENT

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RAISING THE BAR OF WHO is ELIGIBLE for PERSONAL CARE OR CDPAP

- **CURRENT LAW:** if need **any** assistance with "Activities of Daily Living" for 120+ days – may enroll in MLTC.
  - If don't need ADL assistance, can still get "House-keeping" assistance up to 8 hrs/week from LDSS/HRA ("Level 1" personal care) for Instrumental ADLs
  - Non-dual – gets personal care from mainstream plan
- **New applicants for home care after 10/1/20**:
  - Level 1 Housekeeping will no longer be a Medicaid personal care service.
  - See next slide for new ADL requirements

3 ADL requirement after 10/1/20

- Applicants for personal care or CDPAP after 10/1/20 must need:
  - "Limited assistance with physical maneuvering with **more than two" ADL's** (3+ ADLs) **or**
  - Persons with dementia or Alzheimer's diagnosis must need "at least supervision with **more than one ADL**" (2+ ADLs).
- People already receiving personal care, housekeeping, or CDPAP services as of 10/1/20 "grandfathered in"
- NEW – will be determined by using an **evidenced based validated assessment instrument** to be approved by DOH
- NY Medicaid Choice will use the new standard & new assessment instrument in the conflict-free MLTC determination, and local districts/HRA and mainstream Managed care plans will use it for those not eligible for MLTC

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

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3 ADL requirement – which ADLs?

- Will DOH use the ADLs scored on the Uniform Assessment System nurse assessment (UAS):
  1. Bathing
  2. Personal hygiene
  3. Dressing (upper body/lower body)
  4. Walking/locomotion
  5. Transfer to toilet
  6. Toilet use/incontinence care
  7. Bed mobility – Turn & Position
  8. Eating
- Or add these additional "Level II" personal care tasks listed in 18 NYCRR 505.14(a)?
  1. Administration of Medications
  2. Preparation of meals with modified diets
  3. Providing routine skin care
  4. Changing of simple dressings

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3 ADL Requirement

ADL counts only if need "Physical Maneuvering"

- Unless the individual has dementia or Alzheimer's diagnosis, an ADL will count toward the minimum 3 ADLs 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 Dementia diagnosis**
4. **Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight. This is minimum amount of need to count.**
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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TREATING PHYSICIAN'S ROLE IN PRESCRIBING PERSONAL CARE OR CDPAP IS REPLACED

- **NEW**: Personal care and CDPAP services must be prescribed by a "qualified independent physician selected or approved by" DOH. DOH may use Maximus (NY Medicaid Choice).

COMMENTS:

- A contract physician **lacks familiarity** with the consumer's condition, compared to a long-time trusted physician, and will likely not **specialize** in the consumer's particular diagnosis,
- Will add **more delays** to applying for services – must arrange an assessment by independent physician to apply.
- Though a physician's order is now required for both personal care and CDPAP, MLTC plans have generally not required them for personal care, but have required them for CDPAP. This may change.

§ § 2, 18 & 20 of budget law, amending §365-a subd. 2(e), Public Health Law §4403-f subd. 7(b)(v)

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New standardized task-based assessment tool will be procured to determine hours by April 1, 2021

- Tool will be "evidence-based" and used "to assist managed care plans and local DSS to make appropriate and individualized determinations for … the number of personal care services and CDPAP hours of care each day."
  - Now, the number of hours is determined by each plan using their own "tasking tool." A uniform tool *may* be an improvement.
- The tool is supposed to identify how need for assistance with ADL's can be met through:
  - T**elehealth** - How would telehealth assist with assisting a consumer with transferring, dressing, and toileting?!
  - **Family and social supports** -- Now, their assistance is voluntary. Often plans wrongly presume family is available. Even if they are, their assistance must be acceptable to consumer. 18 NYCRR 505.14(b)(3)(ii)(*b*), 18 NYCRR-ADM-21 GIS 97 MA/033

Sec. 21 of budget law, not specifically amending any statute

"Independent Assessor" to replace DSS, MLTC and Medicaid managed care plans in determining hours

- The assessor will determine how much Personal care and CDPAP to be authorized.
- The law allows DOH to expand the Maximus contract to do conflict-free assessments to include this function, instead of doing a new RFP.
- Will make all home care determinations by the local districts for those exempt or excluded from MLTC or Medicaid managed care, plus Immediate Need, and MLTC and mainstream plan determinations of hours.
- To be established by 10/1/2022

Budget Law Sec. 11 adds SSL §365-a subd. 10.

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More consideration of whether capable of "safely remaining in the community"

- Both for CDPAP and personal care, law adds language: "**In establishing any standards for the provision, management or assessment of … services the state shall meet the standards set forth in *Olmstead* and consider whether an individual is capable of safely remaining in the community**." Olmstead *v. LC by Zimring*, 527 US 581 (1999)
- *Olmstead* held that unjustified institutionalization is a form of disability discrimination under the ADA, and that States must provide Medicaid services in the "most integrated setting" (community vs. nursing homes) as a reasonable accommodation to avoid discrimination.
- The heightened concern for safety seems to address the requirement in the ADA that the individual must meet the essential eligibility requirements of the program. However, lack of "safety" in the community is often because of inadequate hours of home care – it's the resistance to authorizing 24/7 care – and paying its cost – that is driving the safety concern.

Budget L. §2-a, adding new (v) to SSL §365-a subd.2 (e)(v)(Personal care); §2-b, amending SSL §365-f, subd. 2 (CDPAP)

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Extra Review of High-Hour Consumers for whether Capable of Safely Living in the Community

- For personal care recipients, the law goes a step further in its stated concern for "safety." The law authorizes DOH to adopt standards, by emergency regulation, for provision, management and assessment of services for individuals "**whose need for such services exceeds a specified level** to be determined by DOH"
- MRT recommended this level as 12+ hours/day
- Assessor will consider whether consumer, with the provision of such services, is capable of safely remaining in the community in accordance with the standards in *Olmstead*, 527 US 581 (1999)
- Who is the arbiter of "safety?" What about the consumer's autonomy – their right to the "dignity of risk" in choosing to accept some risks that may exist in the community in order to live at home as they choose? Generally if provided enough hours of care, safety can be reasonably ensured.

Budget law §2 amending SSL §365-a subd. 2 (e) (ii)

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ADA Regulations Warn about Using Safety as a Pretext for Discrimination

ADA regulations provide:

- **(h)** A public entity may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.*
- "Reasonable expectation of safety" is already required (92 ADM-49) and has been an issue in cases involving dementia, psychiatric impairment, and anyone needing high hours of care, where DSS or MLTC plan says nursing home placement or "higher level of care" is necessary.
- Denials of home care on safety grounds are rife with the generalizations and stereotypes the ADA and its regulations prohibit.
  - E.g. FH 5794578Q, FH 7117119Q

*28 CFR §35.130(h) General prohibitions against discrimination.

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Consumer Directed Personal Assistance Program (CDPAP) Under Fire

- DOH blames CDPAP program growth for large MLTC enrollment growth.
- Unique program – allows family other than spouses to be paid caregivers; aides may do "skilled" tasks normally prohibited; more flexibility in structuring hours.
- **New applicants for home care will no longer be notified of availability of CDPAP program**
- Limits opportunity to apply to "no less than annually" (DOH may try to limit enrollment in CDPAP to 1x/year?)
- Previous budgets sharply reduce number of CDPAP "fiscal intermediaries," which may limit access.
- Cuts in "recruitment & retention" funds that allowed some CDPAP agencies to pay higher wages to ensure can attract aides in rural areas, etc.

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Encouraging MLTC plans to combine with Medicare Advantage into hybrid plans

There are 2 types of MLTC plans:

1. **Partial capitation** plans – provide only Medicaid services; member has separate Medicare coverage
   - **253,175 members statewide** (3/2020) –
   - most people pick this type, can keep preferred Medicare (Original Medicare or Medicare Advantage)
2. **Full capitation** plans – hybrid plans that provide all Medicare & Medicaid services, combining Medicare Advantage + MLTC in one. TWO types:
   - **26,378 members statewide (**3/2020)

   TWO types of fully capitated plans (since FIDA ended 2019):
   a. **Medicaid Advantage Plus** plans (20,655 members statewide)
   b. **PACE** plans (5,723 members statewide)

Push to slow MLTC growth, convert MLTC to hybrid Medicaid/Medicare plans

- Moratorium on approving new or expanded "partial capitation" MLTC plans
- Law caps MLTC enrollment growth to slow down fast growth in some plans. 2 largest plans driving growth:

Plan	NYC Enrollment 2/20	% increase 1 year
Centers Plan Healthy Living	35,188	23%
Integra	24,124	68%
All NYC MLTC	190,925	12%

- DOH will withhold 3% premium for plans whose growth exceeds cap that will be set individually.
- Will plans reduce enrollment of high-need consumers, cherry-pick low-need ones?

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COVID-19 PROTECTIONS

Medicaid easier to RETAIN and APPLY for

See NYLAG Resources on Medicaid & Covid-19

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

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No Medicaid Discontinuances/

- No Medicaid case will be discontinued after 3/18/20
- If case was up for renewal, will be automatically renewed even if don't submit renewal, and even if renewal reported changes that show ineligible
- If SSI or PA cash case closed, Medicaid automatically authorized, instead of usual recertification process (Stenson or Rosenberg)
- If met spenddown or "pay-in" for March 2020 or later months, will get 6 months coverage

NYS DOH GIS 20 MA/04

Easier to Apply for Medicaid

- Tho many Medicaid offices closed in NYC, HRA now accepting e-FAX applications:
  - PUBLIC e-fax 917-639-0732
  - Authorized Submitters (C-Rep) 917-639-0731
- May "attest" rather than verify income & assets, even if for nursing home or home care. Medicare enrollment not required. Still need to complete App & Supp 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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Fair Hearings

- Being held by telephone only during emergency.
- Appellants or representative may **email** documents in advance of the hearing to otda.sm.fhdocuments.submissions@otda.ny.gov FAX 518-473-6735
- OTDA GIS 3/12/2020, http://otda.ny.gov/policy/gis/2020/20DC014.pdf

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Medicaid Home Care

- **UAS assessments** – nurses may do with telehealth/ by phone, except still unclear whether NY Medicaid Choice may do conflict free assessment by phone.
  - 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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THANK YOU

More information at nylag.org

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