Medicaid Cuts in FY 2020-21 NYS Budget

Focus on the new Lookback & Home Care Eligibility and Assessment

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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. Past budget cuts now being implemented –Lock-In & Nursing Home disenrollment from MLTC
2. New 30-Month Lookback starting Jan. 1, 2022
   - New Supplement A form in NYC
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.
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 some MLTC members who are in Medicaid Advantage Plus plans http://www.wnylc.com/health/entry/225/
   - Special fair hearing protections for homebound consumers appealing denial of a home care increase - http://www.wnylc.com/health/entry/228/

NOW IMPLEMENTING CHANGES ENACTED IN EARLIER YEARS

MLTC Lock-In

Disenrollment from MLTC plans if in Nursing Home 3+ Months

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New MLTC Lock-In

- Until now, member could change MLTC plans at any time.
- For people new to MLTC or who changed MLTC plans **on or after Dec. 1, 2020**, MLTC enrollees:
  - 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:
  - moving 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 in MLTC plan since before 12/1/20, may change plans any time, but then may change plans during 90-day grace period, then 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/

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.
  - When received Immediate Need personal care or CDPAP from CASA and then required to enroll in an MLTC plan after 120 days
  - 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/

Involuntary MLTC plan changes – Member DOES have Transition Rights

- After transition period, plan may reduce hours only for "cause" –
  - medical condition improved,
  - change in social circumstance
  - Mistake in original authorization
- **BEWARE**: State has proposed regulation changes to allow plans to reduce hours after transition period just based on plan's view of "medical necessity."

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

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.* Notices should not be sent to members identified by plan or NH as having an **active discharge plan**.
- Right to (1) request fair hearing or (2) call NY Medicaid Choice 1-888-401-6582 and request assessment to be discharged home
- Disenrollments in batches – last was April 1, 2021 – over 20,000 so far (most outside NYC).
  - If disenrolled, right to re-enroll within 6 months

* See note here: http://www.nyhealth.gov/ and Copy at http://www.wnylc.com/health/file/722/ GIS 20-MA-06

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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 LDSS/HRA. In NYC:
  - if the nursing home Medicaid application was approved, fax form to 917-639-0736.
  - If the Medicaid application is still pending, ask the 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/

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.

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 now* – enacted in State Budget 4/2020.
- 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"*

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

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 want these?)
   a. Nursing Home Transition (NHTDW)
   b. Traumatic Brain Injury waiver
   c. OPWDD waiver
2. Mainstream Managed care (provide most of the above services for those without Medicare)
3. Acute, primary care, hospital

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

Who is grandfathered in?

- 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 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**. *During pandemic, may attest to*

*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

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

- Starting Jan. 1, 2021, NYC is using a **new Supplement A** form. Download DOH-5178A at 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).

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

Some gray area about who is "Grandfathered in" and does not have to do lookback

- NYLAG asked State to grandfather these groups in without a lookback.
- Those who had MAGI Medicaid before they had Medicare, then enroll in Medicare and must have Medicaid redetermined under non-MAGI rules after 1/1/2022–
  - We said should not need to do lookback with the redetermination if received home care from managed care plan. DOH disagrees.
- If Medicaid is discontinued for renewal problem and has to reapply (ie client is *re*-applying not *newly* applying)
  - DOH said they'll think about it.

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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.
- Jan. 1, 2022 – Lookback is 14 mo. Back to 10/1/20
- July 1, 2022 – Lookback is 20 mo back to 10/1/20 … And add a month each month until –
- April 1, 2023 – Lookback is 30 mo. back to 10/1/20

TIP:

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

If lookback is delayed further, will still be back to Oct. 1, 2020.

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Lookback for Married Applicants – Spouse's Records

- Medicaid applications once lookback starts 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 doesn't protect from lookback and transfer penalty
- Ex: 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 a Pat's asset (subject to DSS claim for support)
- but the $50,000 transfer DOES count! Pat will have a transfer penalty.

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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 that nursing home stay – and now will not pay for home care/ALP.

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

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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 mortgag

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* 2006 ADM, p. 18.

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

Transfer of the home

DOH has said the same transfer penalty exemptions will apply in the community as in the nursing home. 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 – but DOH says only if lived with applicant for 2 or 1 year before institutionalized, which is the definition for nursing home. Makes no sense in the community!

We believe ALL transfers of the home should be exempt – but NYS DOH disagrees. No final state policy yet.

Since a home is exempt for community Medicaid (if single and equity < $906,000 or married or minor or disabled child live there), advocates say transfer of the home should be exempt because exclusively for a purpose other than to qualify for medical assistance. Soc. Serv. L. § 366 subd. 5 (e)(4)(iii)

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 - definition makes no sense for community care!**
- **No hardship** if, after payment of medical expenses, the individual's or couple's **income** and/or resources are **above the allowable Medicaid exemption standard** for a household size. ($884/mo).
  - **COMMENT**: DOH developed this policy for nursing home care, where this limit didn't really matter, since institutional budgeting allows a personal allowance of only $50/month anyway.
  - But in the community, this **would deny the hardship exception if income is above the Medicaid limit – anyone with a spend-down.**
  - **DOH MUST change this rule for home care!**
- **Must invoke the hardship waiver at the time of 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

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

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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* (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.
- However, even now, many applications take longer.
- The lookback adds work for the local district/ HRA. Even though the poorest applicants won't be required to submit lookback, delays will affect them too.

*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.nydc.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.** The problem is that a ***transfer penalty*** applies not only to transfers of ***ASSETS*** but ***transfers of INCOME***.
  - If a deposit of income into a pooled trust is a TRANSFER, it puts use of trusts at risk if age 65+
  - OK <65 and "disabled"→ Exempt transfer. But >65?
- BUT – see 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**…."**
- **DOH policy is awaited. We hope they say that as long as trust paid 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.

** https://www.cms.gov/Regulations-and-Guidance/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

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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 in 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. **Could violate *Olmstead*** and ADA.

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*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 set yet.

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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, can still get "House-keeping" assistance 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. 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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3- or 2- ADL requirement

Eligibility for PCS/CDPAP & MLTC will now 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 services or *applied for* CDPAP or *continuously enrolled in* MLTC before effective date

§ 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 and toilet use
  6. Bed mobility – Turn & Position
  7. Eating
- What's Missing??
  1. Administration of Medications
  2. Transfer – other than for toilet use
  3. Toileting should include incontinence care for those who don't actually use toilet
  4. IADLs – next slide

Leaves out IADLs – Housekeeping services

- **Instrumental ADLs or IADLs** are housekeeping tasks – shopping, laundry, cleaning, meal prep. Need for IADLs is not considered in whether one qualifies for Personal Care – to meet 2 or 3 ADL requirement.
- If one needs ADL assistance, the personal care/CDPAP aide does both ADLs and IADLs.
- If one does not need ADL assistance but needs IADL assistance, before could apply to Local DSS/HRA for Housekeeping services. **THIS IS ENDING.**
- **Current "Housekeeping"- only recipients grandfathered in** (633 NYC cases in 7/2020) –
  - 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.
- NO other Medicaid home care options. Alternative – non-Medicaid **EISEP** services through County office of the aging/ NYC DFTA.**

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

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

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 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.

Caution on "Supervision"

- Since a 1999 court decision, NY Medicaid does not cover "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 an ADL (or IADL) with which client needs supervision or cueing 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 with confusing language

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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:

1. **Independent Assessment (IA) –** by ***NY Medicaid Choice 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. This will replace that.
2. **Independent Practitioner Panel (IPP)**- exam by PHYSICIAN, physician's ass't. or nurse practitioner from ***NY Medicaid Choice***. In MLTC, this is NEW. Doctor's orders (M11q) had not been required.
3. **HRA/DSS or Plan authorizes services if needs > 12 hours/day.**
4. **If HRA or Plan say needs > 12 hours/day →Must refer for High–Need "Independent Review Panel" (IRP)**- also ***by NY Medicaid Choice*** – determines 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.**
5. **Annual** reassessment, not every 6 months – UAS **by NY Medicaid Choice, not plan.** All assessments described above required.
6. Mid-year request for increase? Same process as above, with some exceptions.
7. **TELEHEALTH** – DOH encouraging use for ALL

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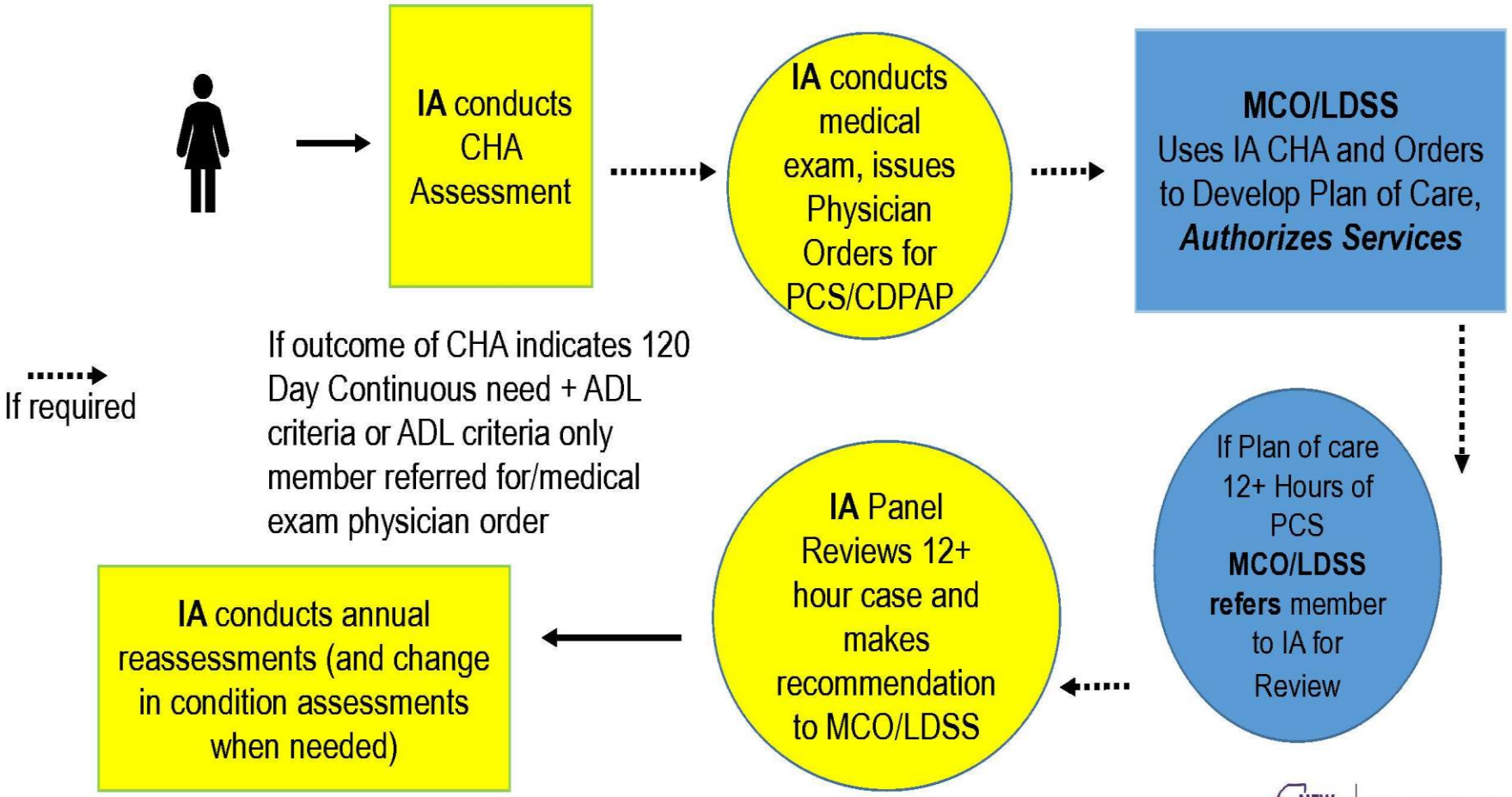
Role Independent Assessor and MCO/LDSS in New PCS/CDPAP Authorization Process



ADA Regulations Warn about Using Safety as a Pretext for Discrimination

Arguably – if not safe, does not meet essential eligibility requirements of the program, so no ADA violation. However, lack of "safety" is often because of inadequate hours of home care.

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.*

* 28 CFR §35.130(h)

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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

The proposed regulations only 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 for Medicaid AND home care approval

*Proposed 505.14(b)(3)(i), 505.28(e)(i)(7) (pp. 40, 102).

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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).

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 April 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

- Tho 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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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 or FAX 518-473-6735
- OTDA GIS 3/12/2020, http://otda.ny.gov/policy/gis/2020/20DC014.pdf
- extended to March 12, 2022 – GIS 2021-DC-013 https://otda.ny.gov/policy/gis/2021/21DC013.pdf (March 2021)

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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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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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