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By email

Dear Ms. Frescatore, Ms. Earle and Mr. Bick:

We write to raise long-term care issues implicated by Covid-19, following up on correspondence including the letter we and other organizations sent on March 13, 2020. We appreciate that you are issuing extensive guidance for health care providers. There is a lack of guidance on MLTC and long term care from mainstream plans, however, and we also have questions and concerns about the guidance issued Mar. 18, 2020 on Long Term Services & Supports.. We know that CMS' approval of the state's 1135 waiver request did not address all of the State's requests, which may limit the state's flexibility in some areas.

1. **SUSPEND MLTC and MCO REDUCTIONS** - Again, we ask DOH to announce a temporary moratorium that prohibits MLTC and mainstream plans from reducing hours of home care during this emergency; it is critical to maintain continuity of care.

MLTC ELIGIBILITY & ENROLLMENT and LTSS ASSESSMENTS

2. **MORATORIUM ON MLTC DISENROLLMENTS – INCLUDING LTNHS** – We ask for a moratorium on disenrolling members for certain reasons, such as nonpayment of spend-down or being in the hospital for 45 days. Disenrollments based on moving out of the service area should be limited to permanent moves. Some MLTC members have temporarily relocated out of the service area to stay with family members during this emergency, but will return and should not be disenrolled; a mechanism to suspend but not terminate enrollment – whether for moves out of town or longer hospital stays -- would allow for reinstatement upon return home.

We urge DOH to suspend the planned MLTC disenrollments for long term nursing home stays, since it will not be feasible for members in nursing homes to request assessments for potential discharge at this time. Please advise of the status of this roll-out.

3. **PROHIBIT DISENROLLMENT OF CONSUMERS WHO DECLINE AIDE SERVICE** during this emergency. Some consumers are declining personal care services that were previously approved, out of concern for exposure to the virus and/or because family or trusted friends and neighbors are now available to help because they have been laid off.

One attorney filed a complaint with DOH that the MLTC plan threatened to disenroll the consumer if she didn't accept services.

Disenrollment should be prohibited on this ground. Once the emergency is over, and sooner for some, these members will need home care services to resume quickly. As they are still eligible, there is no basis to discontinue the services. They should not be burdened by having to re-enroll down the road, which would likely lead to gaps in coverage.

4. **SUSPEND REQUIREMENT FOR PHYSICIAN'S ORDERS FOR ROUTINE RE-ASSESSMENTS for CDPAP or PCS**.

We commend DOH for suspending routine 6-month reassessments by nurses, but the DOH Medicaid LTSS guidance of 3/18/20 does not address physician's orders required for regular reassessments. These are required by LDSS for "immediate need" or for those excluded or exempt from MLTC or mainstream managed care. They are also required by MLTC plans for CDPAP, and by mainstream MMC plans for PCS and CDPAP. For the same reason that DOH gave for suspending interim reassessments by nurses, the requirement for physician's orders should also be suspended. While the 3/18/20 DOH guidance allowing the physician to complete the order by telehealth or telephone may be helpful, it is still a burdensome request for both the consumer and physician, where there is no change in medical condition requiring a change in the plan of care.

NYLAG now has a client who received a Notice of Discontinuance of personal care from HRA effective 3/31/20 because she has not submitted a new physician's order/M11q. She has Aid Continuing because she found representation, but many others will not find an advocate and will lose critical services.

CMS approved the State's request to extend authorizations of services in Fee for service. But the State did not request it for managed care. The State has authority to do this under the 2018 federal guidance allowing flexibilities in a disaster.[1] This allows waiver of prior authorization requirements during the emergency. The State's 1135 waiver request at p. 13 requests waiver of prior authorization requirements for fee for service but not for managed care services. If NY's waive r request must be amended to accomplish this change for MCO/MLTC as well as for LDSS-approved services, we ask that you do so.

5. **ALLOW INITIAL NURSE ASSESSMENTS BY TELEHEALTH FOR ELIGIBILITY FOR MLTC – and CLARIFY the 3/18/20 GUIDANCE CONCERNING MLTC ELIGIBILITY ASSESSMENTS**.

We ask DOH to reconsider the March 18, 2020 guidance to the extent that it does not allow telehealth assessments for the initial eligibility assessment for MLTC –the conflict-free assessment conducted by Maximus. Under these circumstances, it must be allowed by telephone or telehealth to prevent intolerable delays in initiating services.. This is allowed under the 2018 Disaster Guidance, allowing waiver of prior authorization requirements, at

[1] https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/medicaid-chip-inventory.pdf, at page 23, hereinafter referred to as "2018 Disaster Guidance."

p. 23. While we recognize this is not optimal, it is possible to do using Facetime or similar technology. In scheduling the visit, NYMC should ask the consumer for someone to be present who has a smartphone or other technology for at least part of the assessment to be done visually and the rest by telephone. This should be possible in many cases.

The March 18th LTSS guidance says that the assessment to determine eligibility for MLTC must be done in person. "Until such time as the CHA can be fully completed [in the consumer's home], "the member's LDSS will develop and monitor the plan of care." This guidance leaves many gaps causing confusion and delays.

- We have heard reports that Maximus is scheduling assessments about one month away. If these were telephonic or by telehealth they could be scheduled more quickly.
- Please clarify how the process described in the 3/18/20 guidance should work, which implies that if Maximus cannot do the in-home assessment, the case is referred to the local district.

    i. Is Maximus doing some conflict-free assessments in the consumer's home, but referring others to the LDSS? Are there certain counties where Maximus cannot do the in-home assessments, and others where it is doing them? It would be helpful to have some clarity on Maximus' policy and practice going forward. If Maximus is referring them to DSS in certain counties, it would save time for consumers simply to skip the call to Maximus and to call DSS instead.

    ii. How does Maximus refer the case to the LDSS, and how is the LDSS to develop and monitor the plan of care? How is the consumer informed? Is the LDSS nurse required to conduct the assessment in-home or may it be done by telephone/telehealth?

    iii. If the LDSS develops the plan of care, who is authorizing the care – the MLTC plan or LDSS? If the MLTC plan, how and when is the individual enrolling in the plan? If the LDSS, is the LDSS assigning the case to one of its network of contract LHCSAs/ CDPAP fiscal intermediaries?

Clear information must be given to the consumer both by LDSS when it approves Medicaid for someone seeking MLTC and when calling Maximus for a CFEEC. They shouldn't just be told "we're not doing assessments for a month."

POLICIES TO ADDRESS SHORTAGE OF AIDES and INCREASED NEED FOR HOME CARE DUE TO THE PANDEMIC

6. **TEMPORARILY SUSPEND OUT OF NETWORK REQUIREMENTS**. This is permitted by the 2018 CMS Disaster Guidance but was not in the State's waiver request. See n. 1 at page 3. This is especially needed for personal care and LHCSA networks.

7. **TO ADDRESS SHORTAGE OF AIDES, REQUIRE PLANS TO CONVERT PERSONAL CARE TO CDPAP SERVICES UPON REQUEST, and STREAMLINE REGISTRATION AS CDPAP AIDES**. At our suggestion, the family member of the member threatened with disenrollment because she declined services asked the plan to substitute CDPAP for the personal care services [PCS]. Now the plan is requiring a new physician's order which is extremely difficult to get (even

though they may now be done with a telephone or telehealth assessment) with many doctor's offices closed or deluged with urgent cases. Once approved, the family member will need to find an open facility for the health exam, vaccinations and TB test, but we understand many are closed.

We ask DOH to require MLTC plans to convert PCS services to CDPAP services, upon request, with the same service plan as was approved for PCS. Since it is merely substituting one model of home care delivery for another, and not an increase in services, a new physician's order should not be required.

We ask DOH to reconsider the 3/18/20 DOH guidance that suspends the requirement for annual assessments of new CDPAP personal assistants, but not the medical tests for new CDPAP personal assistants. We hear that many sites that administer the health exams for PA's are not functioning. If deemed necessary, DOH could request the consumer or their designated representative to sign a waiver acknowledging that the proposed PA has not undergone a TB test or other health tests. While the best practice in normal times may be for P.A.s to undergo a health exam, given these extraordinary circumstances, waiver of these requirements is necessary. With CDPAP, unlike traditional PCS, the consumer takes responsibility for selecting and training the aide, so should be able to waive the health exam requirement in this emergency.

Registration of new CDPAP PA's should be simplified in other ways as well – allowing for it to be done electronically, through electronic submission of required identification and immigration status. We also ask to simplify the registration of family members as CDPAP personal assistants, allowing for electronic submission of required identification, immigration status, and waiver of medical tests normally required. The authorization should be retroactive to the inception of the work done by the new CDPAP personal assistant, provided the requisite time records are submitted retroactively.

8. **REQUIRE PLANS TO REINSTATE ADULT DAY CARE and SOCIAL ADULT DAY SERVICES BY TELEHEALTH and SUBSTITUTE OTHER SERVICES BECAUSE OF CLOSING OF ADULT DAY CARE PROGRAMS – MEDICAL and SOCIAL MODELS.**

The closing of all medical and social model adult day care programs represent a reduction in services for MLTC members. Care management staff in the plans should be reaching out to do wellness checks for members who lost day care or other services, and arrange for a combination of services to fill in for the lost adult day care hours. For many members, the plan should increase the hours of CDPAP or personal care in the same amount that had been provided through ADHC or SADC. For others, we appreciate the guidance issued March 28th that allows ADHC to provide telehealth services. We understand that both ADHC and SADC programs are providing tele-counseling for members, as well as home-delivered meals. We ask DOH to require that plans reinstate the ADHC services where available remotely, and Social ADC services as well. However, the plans must also assess whether home care is needed to fill in for the day care coverage.

In one NYLAG case, the member asked to increase the PCS hours when the adult day care closed, and the MLTC plan approved only a partial increase, with the member still having a gap in coverage that was previously provided.

This member should not have the burden of proving she continues to need the same coverage the plan had authorized before with a combination of services. The plans should be required to offer members the options of increased home care and/or telehealth services through their former adult day program – with the combined services equivalent to what was provided before.

9. **DIRECT MLTC PLANS TO CONDUCT TELEPHONE/TELEHEALTH ASSESSMENTS WHERE A CONSUMER REQUESTS AN INCREASE**. The 3/18/20 LTSS guidance suspends routine 6-month reassessments, and clarifies that the nurse assessments *may* be done by telephone/telehealth except for determining initial eligibility. *We have received reports that MLTC plans told consumers or their representatives who requested an increase that they are simply not doing any assessments..* Plans should be directed to conduct a telephone or telehealth assessment for a consumer who is temporarily in a nursing home as well as those in the community.

10. **AUTHORIZE TEMPORARY INCREASES TO 24-HOUR LIVE-IN BASED ON CONCERNS OF VIRUS EXPOSURE FOR AIDES in DAILY COMMUTE FOR SHORTER SHIFTS**.

A NYLAG client won an increase from 7 hours to 12 hours per day. The LHCSA told the client that the aides would be less exposed to the virus staffing a live-in case than a 12 hour shift, and recommended an increase to 24-hour live-in. Temporary increases to 24-hour live-in in this situation should be granted, especially where the client is authorized for 10-12 hours/day. The incremental cost to the plan is negligible and the health and safety of both the aides and the consumer is greatly increased.

HEATH AND SAFETY

10. **PERSONAL PROTECTIVE EQUIPMENT** - We have heard that home care aides are not being provided with adequate PPE, and are not adequately trained on hygiene protocols. It's critical that plans ensure that aides are provided with adequate PPE to protect themselves and the consumers. We understand that federal guidance does not require home health aides to wear masks. However, though perhaps not required, it seems that on a case by case basis it would be advisable, and should be done if the consumer requests it. At a minimum gloves are required. Yesterday the son of a NYLAG client emailed, "I am deeply concerned about my mother and having outside exposures. The Agency has neither provided attendants masks nor gloves. Neither do I see them adequately trained in mitigation."

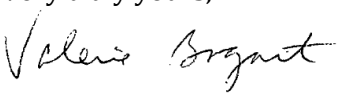
NYS' waiver request requests that rate reconciliation be permitted to compensate plans for disaster- related expenses. This should include the cost of PPE if necessary.

-Continued-

We recognize the huge task that DOH has in administering these programs in the wake of this health crisis. We appreciate your engaging with consumer advocates in creatively finding solutions for the serious problems in service delivery.

Thank you.

Very truly yours,



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