Medicaid Cuts in FY 2020-21 NYS Budget

Focus on the new Lookback & Home Care Eligibility and Assessment

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updated Slides 10, 11 4/29/20
Valerie Bogart eflrp@nylag.org

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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 Background, Federal CURES Act – Maintenance of Effort
2. New 30-Month Lookback
3. Medicaid Home Care Eligibility & Assessment Changes Enacted in FY 20-21 NYS Budget
4. Past budget cuts now being implemented – Nursing Home disenrollment & Lock-In

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THE "MRT II"& THE CURES ACT – MAINTENANCE OF EFFORT

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 "**Medicaid Redesign Team II**" (**MRT II**) to recommend savings of $2.5 billion *before* pandemic. MRT mostly made up of industry insiders. Pandemic increased fiscal pressure to make cuts.
- **MRT I** in 2011 led to Mandatory MLTC
- MRT recommended $2.2 billion Medicaid cuts – one-third in long-term care.
- **RED ALERT:** New powers allow the Budget Director to make further cuts later in 2020 or early 2021 if revenue is not at 99% of anticipated levels.
  - Could be Across the Board cuts. State playing game of chicken – hoping federal bill passed to give $ to States.

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

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COVID "Maintenance of Effort" -- Some NYS Budget Cuts can't start til Public Health Emergency Ends

- Covid-19 Families First law gives NYS $6.2 billion in extra federal Medicaid funds, but with strings –
- **"Maintenance of Effort"** (MOE) requirement:
  - States cannot make eligibility standards, methodologies, and procedures more restrictive than what existed Jan. 1, 2020*
  - MOE is til end of Public Health Emergency, which now ends 10/25/20. If HHS extends emergency, lookback and other cuts may be delayed further. Won't know til late October.
  - **MOE also says anyone who had Medicaid on March 18, 2020 or obtains it thru 10/25/20** can't have Medicaid cut off or reduced thru 10/31/20 – renewals granted automatically, retain MAGI Medicaid even if become Medicare enrolled.**

*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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MOE – Maintenance of Effort

- Because of MOE:
  - Lookback won't start til January 1, 2021
  - Home care changes won't start Oct. 1, 2020 as scheduled. Not likely to begin until Jan. 1, 2021.. But unclear.
- Red Alert: Gov. Cuomo lobbied for Congress to END the MOE requirement for NYS in future Stimulus bills.
  - The House Heroes bill – eliminates MOE for NYS only.
  - Health advocacy community lobbying to keep MOE in any Senate bill and law that may be enacted.

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STATE BUDGET – NEW LOOKBACK FOR HOME CARE

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

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WINS IN NYS BUDGET FY 2020-21

- **SPOUSAL REFUSAL** remains intact – 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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Basics: What is a Lookback?

- Lookback is part of test for Financial Eligibility for Medicaid. Only certain services require a Lookback.
- If a lookback is required for a service, the Medicaid application must include **ALL FINANCIAL records of the applicant and their spouse** during the **lookback period** – a period of time prior to the application.
  - Nursing home lookback is **FIVE YEARS**.
  - New community-based LTC lookback **will be 2.5 years**.
- **HRA/DSS reviews the lookback documents** to identify **transfers of assets** 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 – and now for home care and other community-based long term care (CB-LTC)

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

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New Lookback for Home Care & CB-LTC

- Under federal law, states **MUST** do a 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.
- States **may NOT** require a lookback for community Medicaid for hospital care, acute & primary care.
- No regulations or guidance issued yet but some details in request to amend the MLTC "waiver"*

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

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When does the change take effect?

- Will apply to **applications** for Medicaid coverage of community-based long term care services **filed after 1/1/2021**
- If HHS extends MOE past 10/25/20 for another 3 months, should be delayed til **Feb. 1st** or later
  - Will also apply to requests to "**upgrade**" of coverage, **with submission of Supplement A**, after 1/1/21 if had regular Medicaid without long term care coverage

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

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NEW 2.5 Year Lookback for Home Care + CB-LTC

- **WHAT**: If applying for Medicaid to obtain home care or other community-based long term care (CB-LTC) service, there will be a "lookback" of up to **30 months (2.5 years)** (phased in)
- If a "non-exempt" transfer was made in the 30 months, Medicaid will not pay for CB-LTC services for the penalty period.
- Medicaid applications after 1/1/21 must include 30 months (after phase-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, but doesn't protect from lookback and transfer penalty
  - Ex: Spouse transferred $50,000 3 months ago. She still has $200,000. She can do spousal refusal so $200,000 won't count (subject to claim for support) but the $50,000 transfer DOES count!

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To Which Community-Based Long Term Care Services WILL THE LOOKBACK APPLY?

1. Personal care services
2. CDPAP
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) – *We think short-term CHHA services should NOT be included*
8. "Limited" licensed home care services agency (operated by adult homes, assisted living for residents?)

No lookback for:

1. Nursing Home Transition (NHTDW),
2. Traumatic Brain Injury waiver
3. OPWDD waiver
4. Mainstream Managed care (provide most above services for those without Medicare)
5. Acute, primary care in community, hospital

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

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Phase-In Period

- **Any transfers of assets BEFORE 10/1/2020 will NOT be subject to a penalty.**
- Lookback will never look back before 10/1/20.
- Jan. 1, 2021 – Lookback is 3 months **back to 10/1/20**
- Jan. 1, 2022 – Lookback is 15 months back to 10/1/20
- Jan. 1, 2023 – Lookback is 27 months back to 10/1/20 … And add a month each month until –
- **April 1, 2023 – Lookback is 30 months.**

TIP: Advice to clients -- transfer before 10/1/20!!!!

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Who will not have to do lookback - Eligibility categories

NEWS: Not every new Medicaid applicant after 1/1/21 for long-term care services must do lookback.

- **NO lookback required if*:**
  - Eligible with **no spend-down** – have **low income under the Medicaid limit** (does this include DAC, Pickle?)
  - **MAGI -eligible** (few dual eligibles qualify)
- **Lookback is required for**:
  - Anyone with a **spend-down** (including those who use pooled trust)("Medically Needy")
  - Medicaid Buy-in for Working People with Disabilities (MBI-WPD) > 65, disabled, and working
- Good that poorest applicants won't be burdened with lookback.
  - **BUT** hard for HRA/DSS to administer - must calculate budget to know if lookback required?
  - How does client know if they have to submit lookback?.

DOH Request to amend 1115 waiver- 8/19//2020
https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback.htm

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Who will not have to do lookback? Those Seeking NHTDW/TBI/OPWDD waivers

- DOH said people seeking enrollment in Nursing Home Transition (NHTDW), Traumatic Brain Injury, & OPWDD waivers do not have to do lookback.
- But – how will HRA/DSS know which Medicaid applicants are seeking these waivers?
- Can't be determined eligible for them until have Medicaid!
- **We are asking that applicant can SAY they want NHTDW and not have to do lookback.**
- Also, no lookback required to enroll in "mainstream" Medicaid managed care. But if have a spenddown or Medicare, not eligible to enroll anyway.

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Who will not have to do lookback? Who is "Grandfathered in"?

- Will DOH take strict view –only those **actually receiving services on Jan. 1, 2021** do not have to do lookback?
- What if Medicaid application approved before Jan. 1, 2021 but not yet receiving services?
  - If CFEEC done and approved before 1/1/21?
  - If MLTC enrollment set but not effective til 2/1/21?
- NYLAG urging liberal view –
  - any application filed before Jan. 1, 2021 should not need lookback IF includes Supplement A (which is necessary for MLTC or any CB-LTC services)
  - And if Medicaid discontinued for renewal and has to reapply in 2021

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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); 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

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* 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)

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More on Undue Hardship

- **Undue hardship - hard to obtain for nursing home**

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. ($875/mo).

  - **COMMENT**: DOH developed this policy for nursing home care, where 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**– 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 (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)

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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 penalty for transfer of the home unless transferred to certain people:

- spouse, disabled child, "caregiver" child (lived with applicant for 2 years), sibling with equity interest.

We believe transfer of the home should be exempt –but will have to see what NYS DOH says.

1. A house/apartment that one lives in is exempt for Medicaid for home care services if equity is under the limit ($893,000 - 2020).
   - No equity limit applies if a spouse, minor or disabled child live there.
2. Since a home is exempt for community Medicaid, our view is that 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)

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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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. pooled trust)
- "Immediate need" applications must be decided in 12 days – we ask DOH to allow applicant to "attest" no transfers made.**
- 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.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***
- 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
- **DOH *should* say as long as pooled trust paid for expenses to meet the needs of the individual, there is no penalty** NYS DOH 2008 GIS MA/020. May require spend money quickly every month – a problem if save for annual homeowner expenses – taxes, etc.
- 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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When does penalty period begin? – Nursing Home

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. See Slide next page.

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

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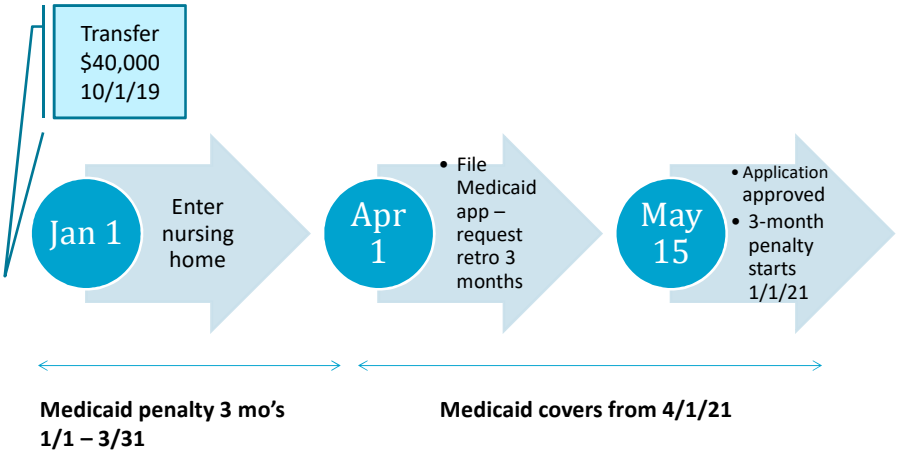
Start Date Penalty – Nursing Home



Penalty runs from date of admission because receiving services Medicaid would pay for, if "otherwise eligible" except for transfer penalty

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When does Penalty Begin? Community

- **One cannot receive home care** or other CB-LTC **that Medicaid would cover until Medicaid is approved.**
  - ➢ can't pay privately for MLTC, CDPAP
- Medicaid won't approve home care until:
  1. Medicaid application accepted AND
  2. Approved for home care based on FUNCTIONAL eligibility -- by Conflict-Free assessment or HRA/DSS
- **Solution** - CMS guidance on 1915(c) waivers* (NHTDW, TBI) says penalty begins when "**would otherwise be receiving" home care at required level of care**. MLTC is 1115 waiver so this guidance doesn't directly apply – but DOH could apply it.
- May require client submit physician's statement with application to show functional eligibility – would otherwise be receiving services.
- **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

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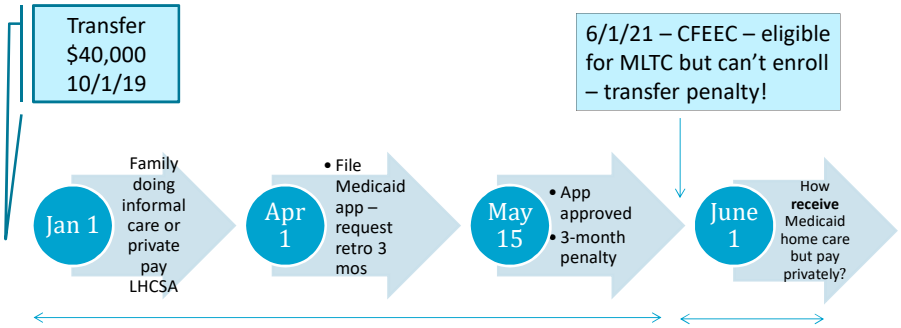
Start Date Penalty – Home Care (TBD!)



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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CHANGES IN HOME CARE ELIGIBILITY & ASSESSMENT

Proposed regulations to implement budget changes issued 7/15/20; comments due 9/14/20

https://regs.health.ny.gov/sites/default/files/proposed-regulations/Personal Care Services and Consumer Directed Personal Assistance Program.pdf

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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
   a. New "high need" review if need > 12 hours/day
3. Easier for plans to **REDUCE hours**

News – None of these starting Oct. 1st. Jan. 1, 2021?

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

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- **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-duals – gets personal care from mainstream plan
- **New applicants for home care after 10/1/20(?):**
  - Level 1 Housekeeping - no longer a stand-alone Medicaid service,if don't also need ADL assistance
  - See next slide for new ADL requirements

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3 ADL requirement

Applicants for PCS/CDPAP must need:

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

WHEN? Law says applicants after 10/1/20. DOH said not likely before 1/1/21.

WHO? People already *receiving* PCS services or who *applied for* CDPAP before 10/1/20 or *continuously enrolled in* MLTC "grandfathered in." Current "Housekeeping"-only recipients (Thru CASA because excluded from MLTC) grandfathered in.

§ 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 Proposed regulation lists SEVEN ADL's:
  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 – why not count them if have at least 1 ADL?

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3 ADL Requirement

ADL counts only if need "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 Dementia diagnosis**
4. **Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight.** **This is minimum amount of need to count. Is this "Contact guarding" ?**
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 qualifies if need "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 impairment.

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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.

Rodriguez v. DeBuono; MLTC Policy 16.07

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New Assessment System – DSS & Plans

1. **Nurse does UAS** – not from HRA/LDSS or plan – from NY Medicaid Choice. Called "independent assessment"
   - Uses new 2-3 ADL criteria to decide if eligible for PCS/CDPAP or MLTC enrollment. If so →
2. **Independent medical exam**- Referred to a PHYSICIAN from NY Medicaid Choice. Unclear if home visit. May be examined by physician's ass't. or nurse practitioner, but doctor signs it.
3. **HRA/LDSS or plan authorize services, but if needs > 12 hours/day then →**
4. **Refers for High–Need "independent assessment panel"**- also by NY Medicaid Choice – that determines if whether the proposed plan of care is reasonable and appropriate to maintain health and safety in his or her own home.
5. **Annual** reassessment, not every 6 months

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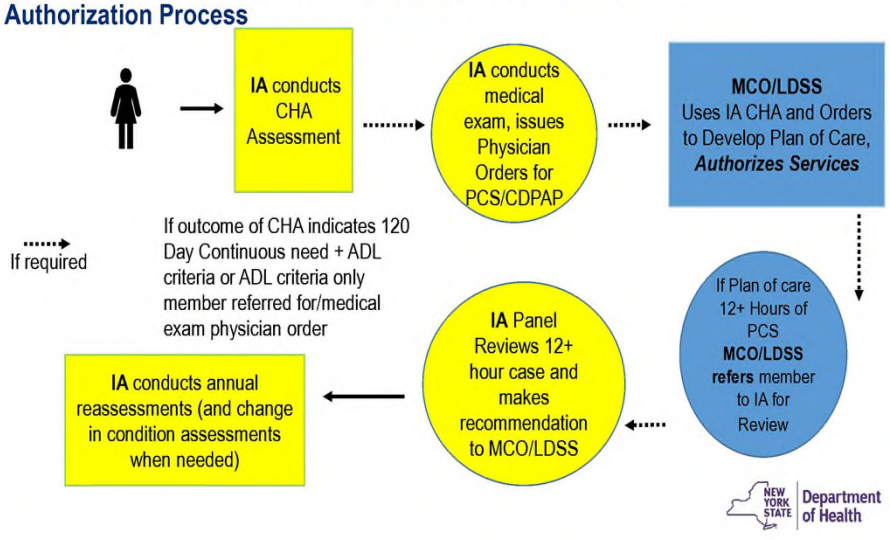
Role Independent Assessor and MCO/LDSS in New PCS/CDPAP Authorization Process



1. "Independent Assessment " – UAS by NY Medicaid Choice nurse

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- Now– Conflict Free assessment already done by NY Medicaid Choice but later assessments by DSS or plan (reassessments, or if change).
- NEW: **All** nurse assessments will be done by NY Medicaid Choice
- Proposed regulations allow HRA/DSS or plan to *direct* nurse to "correct factual inconsistencies" in assessment. How is that "independent?"
- Missing from assessment per proposed regulation
  - Right of family member, rep to be present
  - Should determine if consumer "**self-directing**" or has someone to direct care
  - Should assess **acceptability of informal caregivers** to consumer, and their specific availability
  - Assess **night-time needs** and sleeping accommodations

Budget Law Sec. 11 adds SSL§365-a, subd. 10, proposed reg at pp 27, 88-89,

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2. NEW: "Independent" Medical Exam by NY Medicaid Choice physician

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Proposed regulation should but **does not say**:

1. Must consult with **treating physician**. No letter from consumer's doctor is part of the assessment process!
   - **TIP**: Submit it anyway at both nurse and medical assessments.
2. Right of family member, rep to be present
3. Examining professional must sign it – whether PA or NP. Only says lead physician must sign it.
4. Examiner must have minimum amount of relevant experience
5. Must conduct in home if client can't travel.

Examiner must give opinion on whether consumer can be safe at home – but how can they without knowing proposed plan of care?

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3. NEW Review of High-Hour Consumers for whether Capable of Safely Living in the Community

- After they review the 1st 2 assessments, HRA/DSS or plan authorize services UNLESS --
- If Plan/DSS determine **more than 12 hours/day** is needed, they refer case to High Need Review Panel to decide if, with services, consumer is capable of safely remaining in the community in accordance with the standards in *Olmstead*, 527 US 581 (1999)
- OUR READING OF LAW should allow this only for PCS not CDPAP, but proposed regulations apply to both.
- **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. **Saying "unsafe" can be pretext for denying needed hours – force into nursing home.**

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

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3. High Needs Review – More Concerns

- Panel should be given HRA/plan's proposed "plan of care" **and consumer's requested plan of care**.
  - If needs turning & positioning every 2 hours at night, and HRA/plan propose plan of care of 8 hours/day – High Need reviewer would have to say it's unsafe. We recommend must also be given *requested* plan of care (2x12) to review.
- Proposed reg says **must not recommend specific hours of services or an alternative plan of care.** If entire point of review is whether needs 24/hour care, how can they do that without recommending hours? If HRA/plan proposes live-in, and reviewer determines that split shift is necessary, how can they be prohibited from recommending that?
- **Reviewer may but not required** to:
  - Consult with or even read letter from treating physician
  - Examine consumer.
- **What if plan doesn't refer to High Need Review because decides 12 or fewer hours needed?** Will consumer be prevented from appealing – at a hearing can ALJ order 24/hour care with no High Need Review?
  - If so, plan MUST be required to refer for this review if consumer requested 24/hour care.

More concerns about determining who is capable of "safely remaining in the community"

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- 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: Unjustified institutionalization is a form of disability discrimination under the ADA, and States must provide Medicaid services in the "most integrated setting" (community vs. nursing homes) as a reasonable accommodation to avoid discrimination.
- Arguably – if not safe, does not meet essential eligibility requirements of the program – no ADA violation. However, lack of "safety" is often because of inadequate hours of home care.

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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ADA Regulations Warn about Using Safety as a Pretext for Discrimination

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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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Medicaid Regulations Warn about Using Safety as a Pretext for Discrimination

Managed care "Person-centered service plans"* must assess:

1. the nature, duration and severity of the risk,
2. the probability that the potential injury will actually occur,
3. And whether reasonable modifications of policies, practices or procedures will mitigate or eliminate the risk.

Proposed DOH regulations fail to guide assessors through this analysis, which will lead to speculative predictions about safety not based on actual risks.

* 42 CFR § 441.301(c)(2)(vi), incorporated by cross -reference in § 438.208(c)(3)(ii) and 2013 US DOJ letter available at https://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf

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Delays from the new Assessments!

Adding in these new assessments will cause inevitable delays in:

- MLTC enrollment & authorization of services
- Immediate Need applications at HRA/DSS
- 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 assessments!*
  - Immediate Need deadline – 12 Days for Medicaid AND home care approval
- MLTC/MCO's must comply with federal regs – but that is impossible! See later slide.

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

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MLTC Enrollment – Changes

- In call with DOH 9/7/20, we asked about delays this will cause in MLTC enrollment.
- At first they said BOTH the (1) Independent nurse assessment and the (2) Independent Medical exam must be done before enroll in MLTC.
- When we pointed out huge delay, they said they'd consider just requiring (1) nurse assessment – which is as it is now with CFEEC – to enroll in MLTC.
- Would still need (2) Medical exam and, if plan of care > 12 hours, the (3) high-need eval, but we asked if these could be done after sign enrollment form and awaiting enrollment to start. They will consider.
- NEW: CFEEC will not expire after 75 days. Good for a year.

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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 (standard on next slide)	**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); **NY Insurance Law § 4903(c)(1).

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When must MLTC/ managed care plan Expedite Request for Increase?

- If the plan determines or the provider indicates that a delay would **seriously jeopardize** the enrollee's **life or health or ability to attain, maintain, or regain maximum function.**
- **Must specifically ASK that request be expedited** and explain why criteria apply in this case.

How will HRA/DSS and plans meet these deadlines?

42 CFR 438.210

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Proposed Regs Would make it Easier for MLTC/managed care plans to Reduce Hours

Now, PCS/CDPAP hours may only be reduced if HRA/DSS or plan send notice that specifies:

1. A specific **medical improvement, change in social circumstances** that reduces need
2. A **mistake** made in a previous assessment
3. A **technological development**, which the notice must identify, renders certain services unnecessary or less time-consuming

DOH issued strong policy strictly limiting when a plan may reduce hours. DOH MLTC Policy 16.06.*

DOH proposes to add 2 new grounds for reductions and change the 3rd ground.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-06.htm

based on regulations that implemented *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996),

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First New Ground to Reduce Hours

- *Client's needs can be met either without services or with a reduced level of services by fully utilizing available informal supports, or other supports and services documented in plan of care & identified in notice.*
- COMMENT: If there is a CHANGE in informal support available, this was already a basis for reduction – with burden of proof on PLAN or DSS/HRA to prove change. Proposal removes burden of proof. Plan/DSS can just say we think you can do with less care because your family can help.

Proposed 505.14(b)(4)(vii)(c)(2)(vii); 505.28(h)(4)(ii)(h) (pp. 46-47, 113).

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Second new Ground for Reducing Hours

- *Assessment of the client's needs demonstrates that the immediately preceding DSS or Plan authorized more services than are medically necessary, following any required continuity of care period.*
- During continuity of care period, MLTC plan cannot reduce hours:
  - For **90 days** after transition to MLTC from:
    - Immediate Need or PCS/CDPAP obtained through DSS
    - Mainstream managed care plan when required to transition to MLTC when enroll in Medicare. DOH MLTC Policy 15.02.
  - For **120 days** after move to a new MLTC plan after old plan closed. MLTC Policy 17.02
- After continuity of care period, plan could arbitrarily reduce hours merely by stating that the higher hours were not "medically necessary," **without pointing to any specific change in medical condition or circumstances** This would eliminate consumer due process protections

The policy would depart from hearing decisions that require a change before reducing services after continuity period, ie No. 7728587Q, 9031535N

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3rd ground for Reduction – Adds Telehealth

- PCS/CDPAP could always be reduced if a "technological development" reduced the need for services. Past litigation stopped them from swapping in PERS for home care.
- Now they would add telehealth services or assistive devices that can be demonstrated and documented to reduce the amount of services that are medically necessary
- For which ADLs or IADLs could telehealth substitute for an aide? Or reduce the need?

Proposed 505.14(b)(4)(iv)(c)(2)(iv), 505.28(h)(4)(ii)(d) (pp. 45, 112).

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Consumer Directed Personal Assistance Program (CDPAP) Under Fire

- DOH blames CDPAP program for large MLTC enrollment growth. Allows family (not spouses) to be paid caregivers; aides may do "skilled" tasks normally prohibited; more flexibility in schedul-ing. Important upstate with aide shortage –and in COVID!
- **New applicants for home care will no longer be notified of availability of CDPAP program**
- NEW - **Limits opportunity to apply for CDPAP to "no less than annually"***
- Proposed regs – require designated representative for non-self-directing consumers to be physically present for assessments (proposed §505.28(g)(2)(p. 108 of reg)
- Previous budgets reduce number of CDPAP "fiscal intermediaries," which may limit access.**

*Sec. 17 amending SSL 365-f, subd. 2, **MLTC Policy 20.01

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

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- 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. But may set bright lines or formulas that don't account for individual need. Lawsuits in Arkansas challenging task tool.
- The tool is supposed to identify how need for assistance with ADL's can be met through:
  - **Telehealth**
  - **Family and social supports** -- Now, their assistance is voluntary. And must be acceptable to consumer. 18 NYCRR 505.14(b)(3)(ii)(*b*), 12 OHIP-ADM-01, GIS 97 MA/033

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

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Push to slow MLTC growth

- Moratorium on approving new or expanded "partial capitation" MLTC plans. MLTC Policy 20.02
- Law caps MLTC enrollment growth to slow down fast growth in some plans. 2 largest plans driving growth.
- 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?

Plan	NYC Enrollment 7/20	% increase since 12/18
Centers Plan Healthy Living	37,272	34%
Integra	27,577	108%
All NYC MLTC	190,925	14%
All NYS	258,017	15%

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

- For new enrollments or plan transfers on or **after Dec. 1, 2020**, MLTC enrollees may transfer to another MLTC plan:
  - Freely during the first 90 days of a 12-month period or
  - with **good cause only** during the last 9 months.
- MLTC member may transfer to or from a PACE or Medicaid Advantage Plus (MAP) plan any time.
- MLTC plans will send announcements and Member Handbook inserts early October 2020
- **Good Cause** -details not yet available but likely reasons:
  - moving from the plan's service area,
  - the plan fails to furnish services,
  - the enrollment was non-consensual
  - Aide no longer working with current plan
- In 2018, 35,000 members changed plans 1x, 4500 2-6x
- No "continuity of care" rights when voluntarily transfer plans

CMS approved lock-in 12/2019, https://www.health.ny.gov/health_care/managed_care/appextension/2019-12-19_cms_stc.htm; DOH Medicaid Update 6/2018 –planned to implement then - https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-06.htm

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Involuntary MLTC disenrollment if in Nursing Home 3+ months

- 12/2019 - CMS approved change disenrolling members from MLTC plans if "Long Term Nursing Home Stay" 3+ months.
  - Only if HRA/DSS determined eligible for Nursing Home Medicaid.
- August 1, 2020 - **15,561members were disenrolled**– 6% of all MLTC members in NYS. 200 people were NOT sent notices because plan or NH identified them as having an active discharge plan.
- Going forward, beware of plans refusing to reinstate home care when ready for discharge, claiming not "safe" to go home. After 3 months, will be disenrolled and will be harder to go home.
- If disenrolled, right to re-enroll within 6 months
- Links to GIS 20-MA-06, DOH NOTICE sent to consumers, and NYLAG/Legal Aid Society letter protesting disenrollment at http://www.wnylc.com/health/news/78/.
  - Received notice with right to request fair hearing but with families not allowed to visit nursing homes, didn't have help to understand notice or appeal.

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MORE COVID-19 PROTECTIONS

See early slides re 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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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 or FAX 518-473-6735
- OTDA GIS 3/12/2020, http://otda.ny.gov/policy/gis/2020/20DC014.pdf
- extended to March 12, 2021 - GIS 20 TA/DC-076: "Allowing or Requiring Fair Hearing Appearances by Written, Telephonic, Video, or Other Electronic Means" (July 2020)

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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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