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2017 UPDATE: Immediate Need, MLTC Tips, NYS Budget Proposals

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NYLAG Evelyn Frank Legal Resources Program
February 2017

Agenda

1. Gov's Budget Proposals re Medicaid
2. MLTC Updates
3. What is ICAN?
4. Immediate Need Medicaid/ Personal Care Applications
5. Advocacy with MLTC plans
   a. Asking MLTC plans for more hours
   b. Defending against MLTC reductions
   c. Strategies on increasing hours and obtaining 24-hour care

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Gov's State Budget – Proposed Cuts:

SPOUSAL REFUSAL

- Once again, as has been proposed for over 25 years, Governor proposes to END the right of "spousal refusal" where the spouses lives at home together. It could only be used when spouses live apart or one is in a nursing home.
- Same for parents "refusing" to support sick children < 21.
- When one spouse is in MLTC or seeking "immediate need" Medicaid/PCS, harm of proposal softened because of Spousal Impoverishment protections. But those are also in jeopardy because they are part of ACA! And even under ACA they sunset after 5 years – 2019.
- And Spousal Impoverishment protections don't help with Medicaid outside of MLTC or Medicare Savings Program.
- Next slides give examples of how budgets differe.

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Example budget for COUPLE – both applying OR for ONE spouse without spousal refusal

* Applicant Spouse - $2,220/mo. Income

* "Community Spouse" - $1,500.50/mo. income

Gross monthly income – Applicant		$2,220
Gross monthly income - Spouse		+ 1,500.50
$20 disregard		-20
Health insurance premiums	(Medicare Part B x 2)	- 268
	(Medigap) x 2*	- 360
Net available income		**3,072.50**
- Medicaid Couple Level		**-1,209.00**
Excess income (need pooled trust)		**$2,418.50**

*AARP Plan N 2017 rate = $) 179/mo.

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Example budget for ONE with Spousal Refusal
* Applicant Spouse - $2,220/mo. Income
* "Community Spouse" - $1,500.50/mo. income

Gross monthly income – Applicant		$2,220
$20 disregard		-20
Health insurance premiums	(Medicare Part B)	- 134
	(**Medigap**) x 2*	- 180
Net available income		**1886**
- Medicaid Single Level		**-825**
Excess income – need pooled trust	✓	**$1,061**

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*AARP Plan N 2017 rate = $) 179/mo.

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Example budget **with spousal impoverishment**
* Applicant Spouse - $2,220/mo. Income
* "Community Spouse" - $1,500.50/mo. income

Gross monthly income – Applicant		$2,220
Personal Needs Allowance (2017)		- 384
Community Spouse Monthly Income Allowance (CSMIA)	$3,022.50 MMMNA (2017) -$1,500.50 Spouse Income $1,522.=Max CSMIA	- 1,522
Health insurance premiums	(Medicare Part B)	- 134
	(Medigap)	- 180
Excess income	✓	**$0**

DOH **GIS 14 MA/025, reinstating** DOH GIS 12 MA/013 (April 16, 2012); & NYS **DOH GIS 13 MA/018**, N.Y. Dep't of Health, MEDICAID REFERENCE GUIDE: INCOME at 278-282 (June 2010).
See http://www.wnylc.com/health/entry/185

Gov's State Budget – Proposed Cuts:

More on Spousal Refusal

- In the example above, Spousal Refusal helps but is not as good as Spousal Impoverishment budgeting.
- Sometimes Spousal Refusal eliminates ANY need for a pooled trust, depending on income amounts.
- Spousal Refusal important where:
  - **NON-applying spouse has higher INCOME** and applicant not seeking MLTC so can't use spousal impoverishment. E.g. Medicare Savings Program, regular Medicaid.
  - Non-applying spouse has high **ASSETS** that would be counted and bar eligibility for applying spouse.

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Gov's State Budget – Proposed Cuts:

Carving out from MLTC Those Not Needing Nursing Home Level of Care

- **Before MLTC became mandatory** in 2012, one could "voluntarily" enroll in MLTC (as alternative to CASA) ONLY if had "Nursing Home Level of Care" – ADL needs were enough to qualify for NH (*roughly* 8 hours/day?)
- **With mandatory MLTC, that 'level of care" requirement was lifted**. Eiigible if need *any* personal care for 120+ days. Has to be more than just Housekeeping – in only need that, obtain at CASA/DSS with maximum 8 hours/week.
- Proposal would reinstate the old NH Level of Care requirement. Those not meeting would presumably apply at CASA again, like housekeeping. Concern is that only high need members remain in plans, which lose low-need members. Plans are less able to spread the cost of high-need members, can lead to plan closings or denials of care.

Gov's State Budget – Proposed Cuts:

Trying to Slow MLTC Enrollment Growth

- After several years of promotion of MLTC growth, the State is now trying to put on the brakes.
- The proposed NH-Level of Care is one example.
- Gov. also proposes to stop including money for advertising/marketing costs in rates paid to MLTC plans. Those subway and TV ads cost money!
- 170,000 now enrolled in MLTC statewide – up from 43,500 in 2011. The growth is much more than from the transition from Fee for Service (CASA/PCS/CHHA) and Lombardi – that explains only about half of the enrollment. The rest seems to be marketing.

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Gov's State Budget – Proposed Cuts::

Transportation "carved out" of MLTC

- Medical transportation would no longer be managed by MLTC plans. State would manage it with its own contractors.
- State just cut its contract with LogistiCare, the former NYC contractor for those in mainstream Medicaid managed care.
- Upstate contractor – M.A.S. reportedly has many problems, but MLTC's also had problems with arranging transportation.
- Unclear if this is bad or good.

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MLTC UPDATES

Update about Conflict Free Assessment "CFEEC"

- **Conflict-Free Assessments by New York Medicaid Choice now good for 75 days, expanded from 60 days. See** MLTC Policy 16.08 (12/16/16):.
- After 75 days, "...a new evaluation will be required if the consumer does not select an MLTC plan but continues to seek home care."
- This addressed problem of the CFEEC going stale and having to be redone because of delays in actually enrolling in a plan.

Download MLTC DOH Polices at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

Some MLTC Plans Closing

- **"Centerlight Select" MLTC Plan closed eff. Jan. 31, 2017**. All 5,099 members were transferred to the *Centers Plan for Healthy Living MLTC* Feb. 1, 2017, if they did not enroll in a different plan before 1/11/17.
  - Centers Plan will be 4th largest MLTC in the state (after Fidelis, Guildnet, VNS Choice) – with 13,472 members.
  - If transferred to Centers Plan may still switch plans any time – effective 1st of next month if do so before the 18th of the month. Call NY Medicaid Choice. 1-888-401-6582.
- Centers Plan should honor same plan of care from Centerlight & give written notice before cutting hours. If problems, call ICAN or NYLAG-EFLRP!
- **Guildnet** also dropping Nassau, Suffolk and Westchester counties, tho staying in NYC, due to low rates.

Check for new MLTC Policies

- DOH has issued some good MLTC Policy Directives. They are discussed in the advocacy section below, but download them and read them! Good to cite to plans to advocate more hours!

- MLTC Policy 16.07: *Guidance on **Task–based Assessment Tools** for Personal Care Services and Consumer Directed Personal Assistance Services* - clarifies standards such as:
- Task-based assessment tools cannot be used to set "one size fits all" limits on hours. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs – to assess the individual time needed and frequency for client.
- Must reflect sufficient time for such **safety monitoring, supervision or cognitive prompting** for the performance of those particular IADLs or ADLs for those with dementia etc.....
  - *Gives helpful example of supervision and cognitive prompting* - "A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly."

- MLTC Policy 16.06: *Guidance on **Notices Proposing to Reduce or Discontinue** Personal Care Services or Consumer Directed Personal Assistance Services*
  - Limits when plan can claim that it made a "mistake" when it authorized more hours in a prior authorization, as a justification for reducing hours now, or
  - If claiming medical condition improved, "Notice must identify the specific improvement in the enrollee's medical condition and explain why the prior services should be reduced as a result of that change..."

Download at
https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

Introduction to ICAN

What is ICAN?

ICAN stands for **Independent Consumer Advocacy Network**.

ICAN Independent Consumer Advocacy Network

ICAN is the New York State Ombudsprogram for people with Medicaid long term care services.

We assist New Yorkers with enrolling in and using managed care plans that cover long term care services, such as home attendant services or nursing home care.

What do we do?

- **Answer your questions** about Managed Long Term Care plans.
- **Give you advice** about your plan options.
- **Help you enroll** in an MLTC plan.
- Identify and **solve problems** with your plan.
- Help you **understand your rights**.
- Help you **file complaints** and/or grievances if you are upset with a plan's action.
- Help you **appeal** an action you disagree with.

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Who do we help?

We help anyone enrolled in a **Medicaid managed care plan** who needs **long term care** services (like home attendant , adult day care, or nursing home).

We also help people who are newly eligible for enrollment in a Medicaid managed care plan, to help them choose a plan and enroll.

We can talk to friends, family members, social workers, providers, and anyone else who is helping people with their healthcare decisions.

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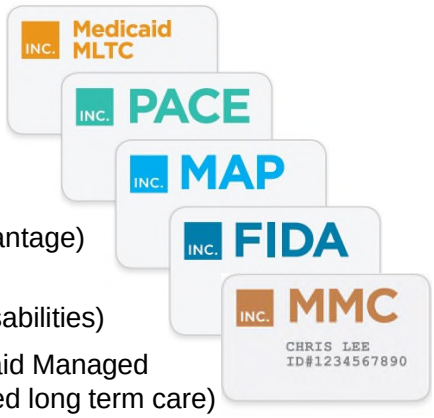
What kinds of plans does ICAN work with?

The plans we work with are:

- **MLTC** (partially capitated MLTC)
- **PACE** (Programs of All-inclusive Care for the Elderly)
- **MAP** (Medicaid Advantage Plus)
- **FIDA** (Fully Integrated Dual Advantage)
- **FIDA-IDD** (FIDA for People with Intellectual or Developmental Disabilities)
- **MMC-LTSS** (Mainstream Medicaid Managed Care for those enrollees who need long term care)
- **HARP** (Health And Recovery Plans)



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Who is ICAN?

NEW YORK STATE | Department of Health

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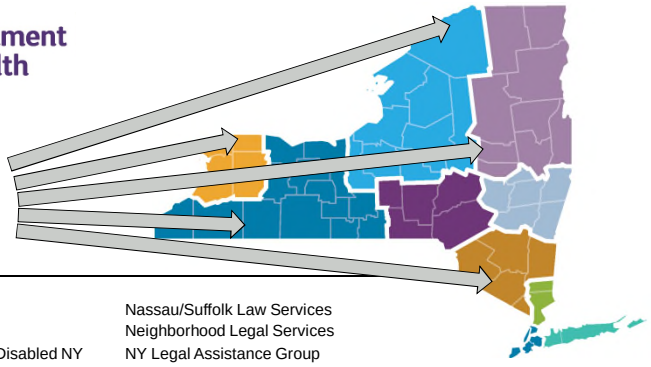

Our Network of Agencies:

ACR Health
Action for Older Persons
BronxWorks
Center for Independence of the Disabled NY
Korean Community Services
Legal Aid Society of Northeastern NY
Legal Assistance of Western New York
Legal Services of the Hudson Valley
Medicare Rights Center
Nassau/Suffolk Law Services
Neighborhood Legal Services
NY Legal Assistance Group
South Asian Council for Social Services
Southern Adirondack Independent Living
Urban Justice Center
Westchester Disabled On the Move
Western NY Independent Living

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How we help

Our trained counselors answer our **toll-free telephone hotline** Monday-Friday, 8am-6pm

Our services are completely **free and confidential**.

Our counselors speak English, Spanish, Russian, and Mandarin Chinese.*

We'll meet you **in person** at our offices or at your home.

We give **educational presentations** to consumers, caregivers, and professionals.

We monitor our cases for **potential trends** and report them to the state.

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* Interpreters are available for all other languages.

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Get help

(844) 614-8800

ican@cssny.org

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Immediate Need Personal Care Services

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Updated December 30, 2016

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MLTC – Delays in Enrollment

Statewide, an adult Medicare beneficiary 21+ who needs community-based long-term home care encounters long delays applying for Medicaid and then enrolling in an MLTC plan:

1. **Apply** for Medicaid at the County DSS/HRA — up to 45 days
2. Get a "**Conflict Free Eligibility**" evaluation from Maximus (NY Medicaid Choice) — approx. 5-7 days
3. **Pick a plan** - MLTC, Medicaid Advantage Plus, PACE or FIDA plan (Nassau/NYC only) –
   a. Schedule an in-home assessment with plan — up to 30 days
   b. Pick a plan and enroll.
   c. Enrollment paperwork must be submitted by 20th of month for enrollment to start 1st of next month. No mid-month pick-up dates. — 10-41 days

APPROXIMATELY 2-4 months

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TIPS to Expedite Medicaid Approval and MLTC Enrollment

Enrollment in MLTC can be held up by mysterious "coding issues" stemming from NY's antiquated Medicaid WMS computer system. Codes may wrongly show client is **ineligible** – leading MLTC to deny enrollment. Take these **Preventive Measures**:

1. Submit **Supplement A of Application** w/ bank statements, etc. to prove resources – do not just "attest" to resources. Otherwise not coded to enroll in MLTC - DOH-4495A except in Suffolk, Albany, or Schoharie Counties - there use Form DOH-5178A)
2. **If will have a SPEND-DOWN** - ask for "Provisional Medicaid" approval with Code 06 per GIS 14 MA/010 – so Medicaid activated even though spend-down not yet met.
3. **In NYC – apply only at HRA--HCSP Central Medicaid Unit**
   785 Atlantic Avenue, 7th Floor, Bklyn NY 11238 T: 929-221-0849
4. **Advocate with MLTC if refuses to enroll -**Give MLTC the DSS Notice approving Medicaid with a spend down. Ask to speak to supervisor.
   – Ask MLTC to request LDSS for "*conversion*" of eligibility to full Medicaid. NYC HRA has "conversion" form HCSP-3047a (updated 1/2015).

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New Expedited Medicaid Application if in Immediate Need for Personal Care or CDPAP

- April 2015 - NYS law required DOH to create procedures for local DSS to (1) process a Medicaid application in **SEVEN DAYS** for any applicant **with an immediate need** for personal care (**PCS**) or consumer-directed personal assistance (**CDPAP**) services & (2) approve PCS/CDPAP in 12 days in such cases. NY Soc. Serv. L. §366-a(12).
- July 2016 – new regulations effective. 18 NYCRR 505.14(b)(7) & (8) and 505.28(k) & (l);

DOH 16-ADM-02 - Immediate Need for PCS & CDPAP

HRA Procedures 10/19/16 - http://www.wnylc.com/health/download/615/

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New Regs & ADM for Expedited 7-Day Medicaid Applications

16-ADM-02 --Who can use the new procedures?

1. **New Applicants** - or those with a **Medicaid application pending**,
2. **Individuals who already have Medicaid but not coverage of community-based long term care** (they "attested" to the amount of their assets and did not submit "Supplement A" with the application (alternate languages and formats of forms posted at this link)
3. **Individuals who have a MAGI Medicaid** case at NY State of Health ("Marketplace" or "Exchange"), who are *not* in a managed care plan. Their Medicaid must be transferred from NYSOH to the LDSS through procedures described in pages 5-6 of 16-ADM-02 - the transfer can only be initiated with an email to hxfacility@health.ny.gov.

Includes people applying from hospital or nursing home.

See **Attestation Form**, attachment to 16-ADM-02.

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Procedures for New Medicaid Applicants with Immediate Need for PCS/CDPAP

1. **7 calendar days** after receipt of complete Application, DSS must determine **Medicaid eligibility.**
   a. If application incomplete, DSS must request missing documents within 4 calendar days after receipt of physician's order & Attestation of Immediate Need.
2. Within **12 calendar days** of receiving complete Medicaid app, Attestation form and Physician's order, DSS must:
   a. Conduct social & nursing assessments
   b. Determine eligibility for & **authorize PCS/CDPAP and Number of hours**
   c. "Promptly notify" the recipient of the amount authorized
3. DSS arranges for services to be provided "as expeditiously as possible." 18 NYCRR 505.14(b)(8)(ii).
   - DSS contracts with home care agencies to provide care or approves CDPAP

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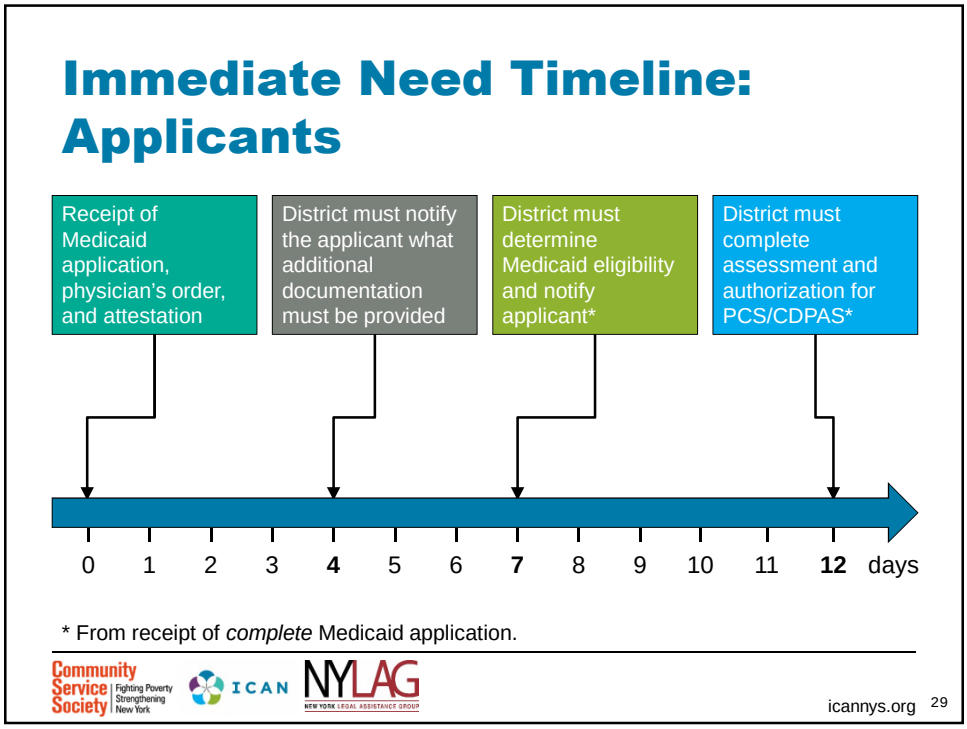
Immediate Need Timeline: Applicants
Receipt of Medicaid application, physician's order, and attestation
District must notify the applicant what additional documentation must be provided
District must determine Medicaid eligibility and notify applicant*
District must complete assessment and authorization for PCS/CDPAS*
0 1 2 3 4 5 6 7 8 9 10 11 12 days
* From receipt of *complete* Medicaid application.
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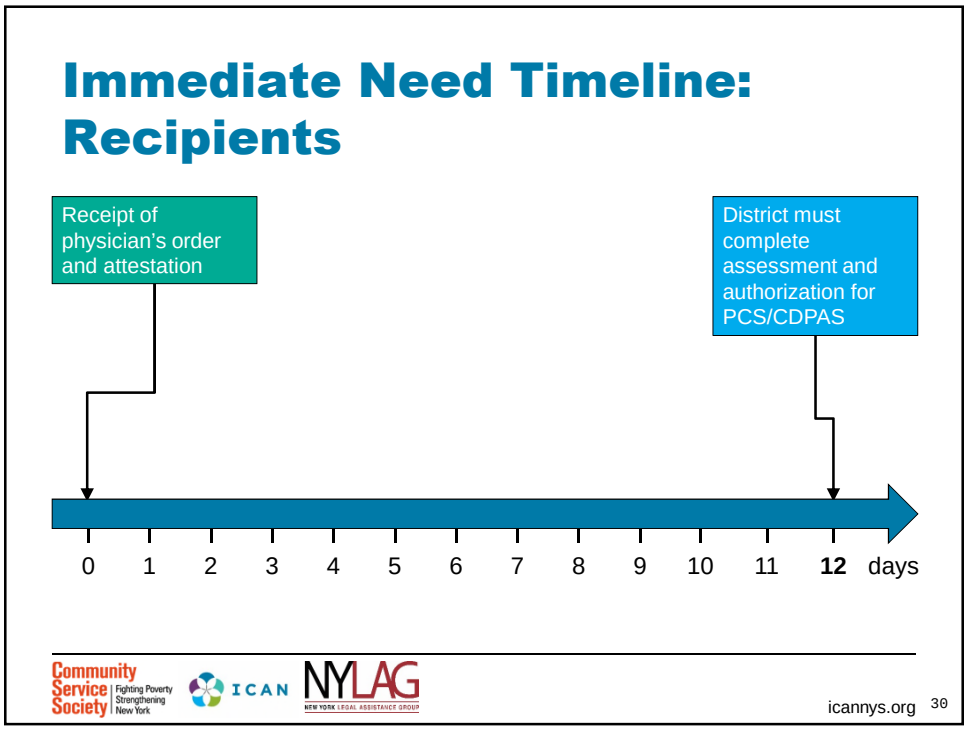
Immediate Need Timeline: Recipients
Receipt of physician's order and attestation
District must complete assessment and authorization for PCS/CDPAS
0 1 2 3 4 5 6 7 8 9 10 11 12 days
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WHERE TO FILE IN NYC:

By Hand or Certified Mail to Home Care Services Program (HCSP):

HRA--HCSP Immediate Needs Liaison
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238

- If by hand, bring a copy for HRA to Date-Stamp receipt as proof of filing!

OR **E-Fax** a copy of the complete application and all documents to **HRA HCSP 1-917-639-0665**

What to Include in Application for Immediate Need Medicaid

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1. **In NYC – Cover Sheet / Transmittal Form (**available at http://www.wnylc.com/health/afile/203/615/)
2. **COMPLETE Medicaid application (or approval Notice if already have Medicaid) with Supplement A**
   a. May "attest" to value of real property & assets – but better to verify
   b. May request Spousal Impoverishment budgeting if favorable
3. **Physician's order** for personal care (M11q)- 18 NYCRR 505.14(b)(can't be seen by MD or signed **> 30 days** before submit!)
4. Signed "**Attestation of Immediate Need**" Form – posted at https://www.health.ny.gov/health_care/medicaid/docs/ohip_form-0103.pdf - - and attached to 16-ADM-2 -described on next slide.
5. **HIPPA RELEASE** - OCA Form No. 960 - http://www.nycourts.gov/forms/Hipaa_fillable.pdf
6. **Cover letter** describing Immediate need circumstances

[1]505.14(b)(7), 505.28(k), 16 ADM 02

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New Attestation Form - Immediate Need

"Attestation of Immediate Need" Form – OHIP-0103. https://www.health.ny.gov/health_care/medicaid/docs/ohip_form-0103.pdf and attached to 16-ADM-2 . Must attest that the applicant:

a. **Has no informal caregivers** available, able and willing to provide or continue to provide care;

b. Is **not receiving *needed* help from a home care services agency;**

c. Has no adaptive or specialized equipment or supplies in use to meet your needs; and

d. Has no third party insurance or Medicare benefits available to pay for ***needed*** help.

(Arguably, even if Medicare, hospice or private services in place, explain why not enough to provide "NEEDED" help, or that won't continue etc.)

- Form says may be submitted while hospitalized or in nursing home.

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NEW: Spousal Impoverishment available on application for IMMEDIATE NEED Medicaid

Before DOH issued 16 ADM-02, a married Medicaid applicant seeking MLTC had to initially apply using regular Medicaid rules – combining both spouse's income using couple level of $1209/mo. or using Spousal Refusal. Soc. Serv. L. § 366.3(a).

This is because NYS sees Spousal Impoverishment as a "post-eligibility" budgeting methodology. GIS 14 MA/025 - Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act.

Under 16 ADM-02, married person may request Spousal Impoverishment budgeting with Medicaid application based on IMMEDIATE NEED for personal care or CDPAP.

Good for couples with combined income under $3,406.50 after deducting Medigap premiums, and countable assets under $89,670. See more at http://www.wnylc.com/health/entry/165/

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Example budget **with spousal impoverishment**
* Applicant Spouse - $2,220/mo. Income
* "Community Spouse" - $1,500.50/mo. income

Gross monthly income – Applicant		$2,220
Personal Needs Allowance (2017)		- 384
Community Spouse Monthly Income Allowance (CSMIA)	$3,022.50 MMMNA (2017) -$1,500.50 Spouse Income $1,522.=Max CSMIA	- 1,522
Health insurance premiums	(Medicare Part B) (Medigap)	- 134 - 180
Excess income		**$0**

DOH **GIS 14 MA/025, reinstating** DOH GIS 12 MA/013 (April 16, 2012); & NYS **DOH GIS 13 MA/018**, N.Y. Dep't of Health, MEDICAID REFERENCE GUIDE: INCOME at 278-282 (June 2010).

See http://www.wnylc.com/health/entry/165

Transition from Immediate Need to MLTC

Immediate Need PCS or CDPAP is only temporary.

AUTO-ASSIGNMENT - after 120 days receiving the temporary Immediate Need services, Maximus/ NY Medicaid Choice will send individual a letter that if she doesn't select & enroll in an MLTC plan in 60 days, she will be auto-assigned to an MLTC plan (partial capitation).

- TIP - Use that time to select a plan – find plan that contracts with same home care agency, if client wants to keep aides.
- No Conflict Free assessment necessary.

MLTC plan should continue the DSS Plan of Care for a **90-Day Transition Period.** MLTC Policy 13.10.* (see FH **7214923Z** (Erie Co.).

- After 90 days, plan may reassess hours but under *Mayer v. Wing*, may reduce only if alleges and proves change in circumstances. See more later re REDUCTIONs. Must give advance notice with right to request hearing with aid continuing.

http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

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Asking Plan for NEW or INCREASE in Services

Applies to MLTC and Mainstream plans

Requesting Services: Terminology

- **"Prior Authorization"**
  - Asking the plan for a **new service** or to change a service in the plan of care for a new authorization period
  - **Consumer or Provider** can make the request
- **"Concurrent Review" –**
  - Asking the plan for additional services (i.e., more of the same service) that are currently authorized in the plan of care (more hours of home care); or
  - Medicaid covered home health care services following an inpatient admission.
- **Authorization Period**: a specific time period for which plan has authorized services, must reassess & reauthorize every 6 months.

Model Contract, Appendix K, 42 CFR 438.210

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When must plan decide request for Increase or New Service?

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.

Model Contract, Appendix K. Same time for Concurrent Review & Prior Authorizations , 42 C.F.R. 438.210(d)

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When must plan Expedite Request for Increase?

- If the plan determines or the provider indicates that a delay would **seriously jeopard**ize 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.

42 CFR 438.210

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How/ when to ask for Increased or New Services?

- **WHEN** –
  - o May ask at in-home reassessment conducted every 6 months
  - o OR any time – by calling Member Services or care manager or by FAX or certified mail.
- **HOW**: Make request **in writing** – or confirm an oral request with WRITTEN request. This way you have proof that you requested it and when – starting clock for plan to respond.
  - o Letter from your doctor helpful. Use detail.
  - o Include request to EXPEDITE if urgent.

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What if Plan Doesn't Make Decision by Deadline?

- If the plan does not issue a decision on a request for services within the deadlines stated above –
- this constitutes a **denial** and is thus an adverse action, which can be appealed just as a written decision can be appealed. 42 CF.R. 438.404(c)(5). (Request Fair Hearing)
- This is why it is important to make request for increase/new service in writing - And keep proof that you made it. Otherwise you cannot appeal if plan fails to decide on your request.

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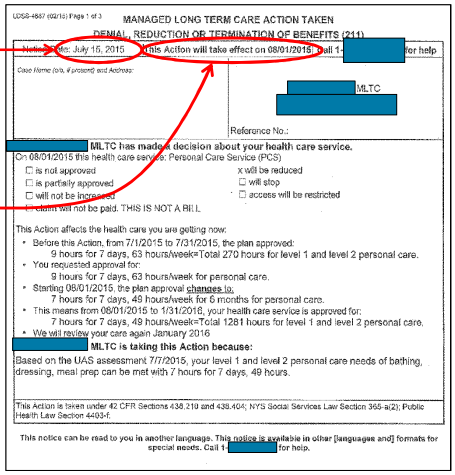
Reductions by MLTC plans

Notice Literacy: Actions

- **Adverse Determination**: when your plan refuses you care, either in writing or verbally; 3 types—
  - **Reduction**: plan authorizes less services than it did before; for home care this means fewer hours and/or fewer days
  - **Termination/discontinuance**: plan stops providing services
  - **Denial**: plan denies a request for an increase in services or denial of a new service – nursing, PT/OT, adult day care
- **Effective Date**: the date of plan's proposed action. Must be 10 days or more after date of notice or date notice is mailed, if later.
  - Note: Even if the effective date is *after* the date that the current authorization period ends, **you have the same appeal rights,** Soc. Services Law Sec 365-a, subd. 8 (amended 2014)
  - E.g., Ann has 24-hour live-in care, authorized through March 31st. She gets a notice dated March 17th that she will have 12 hours daily, as of April 1st. This is a reduction effective April 1st. Ann will get aid continuing if she requests hearing before April 1st.

How to read a notice: Dates

- **Notice Date**
  - This is the date the plan printed the notice and, hopefully, mailed it to the member
- **Effective Date**[1]
  - If the Notice Date or Postmark Date are fewer than 10 calendar days before the Effective Date, then this is a Defective Notice.
  - Get Postmarked envelope!



MANAGED LONG TERM CARE ACTION TAKEN
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)

Notice Date: July 15, 2015 This Action will take effect on 08/01/2015. Call 1- [redacted] for help

Case Name (s), if present) and Address:

[redacted] MLTC

Reference No.:

[redacted] MLTC has made a decision about your health care service.

On 08/01/2015 this health care service: Personal Care Service (PCS)

☐ is not approved
☐ is partially approved
☐ will not be increased
☐ claim will not be paid. THIS IS NOT A BILL

X will be reduced
☐ will stop
☐ access will be restricted

This Action affects the health care you are getting now:

- Before this Action, from 7/1/2015 to 7/31/2015, the plan approved:
  9 hours for 7 days, 63 hours/week=Total 270 hours for level 1 and level 2 personal care.
- You requested approval for:
  9 hours for 7 days, 63 hours/week for personal care.
- Starting 08/01/2015, the plan approval changes to:
  7 hours for 7 days, 49 hours/week for 6 months for personal care.
- This means from 08/01/2015 to 1/31/2016, your health care service is approved for:
  7 hours for 7 days, 49 hours/week=Total 1281 hours for level 1 and level 2 personal care.
- We will review your care again January 2016

[redacted] MLTC is taking this Action because:

Based on the UAS assessment 7/7/2015, your level 1 and level 2 personal care needs of bathing, dressing, meal prep can be met with 7 hours for 7 days, 49 hours.

This Action is taken under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Section 365-a(2); Public Health Law Section 4403-f.

This notice can be read to you in another language. This notice is available in other [languages and] formats for special needs. Call 1 [redacted] for help.

(1) 42 CFR § § 438.404(c)(1) & 431.211;
(2) 18 NYCRR § 358-2.2(a)(2).

Get. The. Notice. EVERY PAGE.

- This is the best source of evidence about the action being taken by the plan
- Fax, photograph with smartphone and email, scan and email, or visit
- If none of the above options of getting the notice is possible, read the notice word-for-word over the phone
- **Get the envelope too!** Postmark shows actual date of mailing – client gets Aid Continuing if mailed less than 10 days before effective date.
- If the notice is defective, you may be able to get the plan to withdraw it. If the plan refuses to withdraw a defective notice, then there will be strong grounds for reversal at a Fair Hearing.
- **Oral notice** not sufficient! But that's sometimes how client learns hours will be reduced. Ask if mail delivery reliable.

Notice Literacy: Aid Continuing

- **Aid continuing**: your services do not change until your appeal is decided; aid continuing is only available when:
  - Hearing is **requested before the effective date of the adverse action** – you get Aid Continuing even if the latest Authorization Period has expired, SSL 365-a, subd. 8, and
  - The **plan wants to take services *away* from you** (reductions and terminations; NOT denials); and:
    - In MLTC and MMC, if you ask for a **fair hearing**—there is no right to aid continuing in these plans when you ask for an internal appeal or an external appeal
    - In MAP, PACE, and FIDA, if you ask for an **internal appeal**
    - Also, in FIDA, if you requested an internal appeal before the effective date, and you lose your internal appeal, your case is auto-forwarded to the next level of appeal with aid continuing

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Reductions: Content of Notice

Notice must state specific **change in medical condition or circumstances,** such as increased availability of family to help, justifying reduction. *Mayer v. Wing*, 922 F. Supp. 902 (SDNY 1996)

- 18 NYCRR 505.14(b)(5)(c)(2) was amended in 2015 to require more specific description of change - see FH # 7284013H (5/27/2016), 7224444Y (4/26/16), 7208804Q (Tompkins Co**)**
- Not enough just to recite that not "medically necessary" or proposed hours are what their task plan shows.
- # 7060609N (NYC 8/11/2015)(notice not 10 days in advance);
- FH# 7068290Q (NYC 9/29/2015)(notice inadequate);
- #7165494N (3-year old notice found defective so hearing request not barred)
- See more detail in **DOH MLTC Policy 16.06 (11/17/16)**

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Strategies to Increase Hours or Defend against Reductions

Plans reducing hours - Strategies

1. **Request a hearing**. https://otda.ny.gov/hearings/
   a. Request before **effective date** of notice to get **AID CONTINUING**, usually within 10 days of notice date. But if notice not timely or adequate – can argue for Aid Continuing even if miss effective date. #7165494N
   b. Plan must give advance notice with right to Aid Continuing, even if plan mischaracterizes action as "denial" -- not a reduction. #7331553Q
   c. Must request FH even if request Internal appeal – No Aid Continuing on internal appeal – only hearing.
   d. Request **evidence packet** from plan to see if assessments show changes, improvement. Include HIPAA release (OCA 960) http://www.nycourts.gov/forms/Hipaa_fillable.pdf)
2. If you can't rep, refer to ICAN – Statewide Ombudsprogram for MLTC - takes referrals of cases statewide. 1-844-614-8800 icannys.org

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Get signed releases

NYS OCA 960 HIPAA Release – use for MLTC plan, doctors and other health providers, and HRA

- Standard, DOH-approved HIPAA authorization
- All MLTC plans are required to honor this form.[1] Download at http://www.nycourts.gov/forms/Hipaa_fillable.pdf

Authorization to Represent at Fair Hearing

- Attorneys do not need any written authorization, although it's probably a good idea
- Non-attorneys working with attorneys need authorization signed by the attorney or by the client. 18 NYCRR § 358-3.9

(1) N.Y. Dep't of Health, MLTC Policy 13.24, at http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-24.htm.

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OCA 960 HIPAA Release

- Screenshot of part of HIPPA form

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV+ RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

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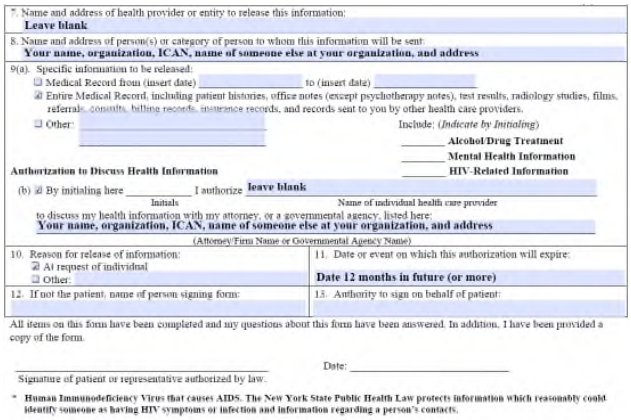
OCA 960 HIPAA Release (cont'd)



7. Name and address of health provider or entity to release this information:
Leave blank

8. Name and address of person(s) or category of person to whom this information will be sent:
Your name, organization, ICAN, name of someone else at your organization, and address

9(a). Specific information to be released:
☐ Medical Record from (insert date) _____ to (insert date) _____
☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: _____

Include: (*Indicate by Initialing*)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here _____ (Initials) I authorize **leave blank** (Name of individual health care provider)
to discuss my health information with my attorney, or a governmental agency, listed here:
Your name, organization, ICAN, name of someone else at your organization, and address
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
☑ At request of individual
☐ Other: _____

11. Date or event on which this authorization will expire:
Date 12 months in future (or more)

12. If not the patient, name of person signing form: _____

13. Authority to sign on behalf of patient: _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

- Leave #7 and first part of #9(b) blank so you can reuse for different providers
- You can use for obtaining evidence packet from plan, and for communicating with doctors or other providers to obtain evidence
- **Have client initial #9(b), sign at bottom, and date**

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Homebound status

- If the client is unable to travel to the hearing site without great difficulty, then he/she may be eligible for Varshavsky relief in the event of a non-fully-favorable decision
- Varshavsky appellants are entitled to a second hearing, conducted in their home, if they are not fully victorious in the first hearing. While awaiting the 2nd hearing in their home, hours will be increased to amount sought in hearing, if hearing not scheduled in required time.
- You will need a doctor's note to substantiate the client's "homebound status"

(1) Varshavsky v. Perales, 608 N.Y.S.2d 194 (App. Div. 1994).

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Request evidence packet

- The member (and his/her rep) is entitled to a copy of the evidence packet - documents that the plan intends to submit at the Fair Hearing - **for free**, a reasonable time before the hearing
- It is not necessarily all of the client's case file; it's only the parts that the plan wants to submit at the hearing.
- But member has **right to request additional documents – may want past assessments or initial enrollment assessments.**
- Even though plan has burden of proof when reducing services, you can affirmatively refute their claim.

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How to Request evidence packet

Call fax or appeals unit of MLTC plan to ask for the "evidence packet"

- Include HIPAA release OCA 960 (see above)
- Specify if you want additional documents from file in addition to those plan used for this decision.
- For example, if member received 12/7 care for 5 years and now plan says it will reduce hours because plan made a "mistake" or that condition "changed" – request all of the assessments and notices for last 5 years to refute basis for reduction.

It can be difficult to find out where to fax or mail a request for an evidence packet. Some plan contacts are here http://www.wnylc.com/health/entry/179/ but check as not updated. Call member services and ask for APPEALS UNIT phone and fax numbers

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Documents to Obtain Outside of Plan

1. If client received home care or other LTC services from CASA/DSS, a Lombardi program, a CHHA or other provider before enrolling in MLTC, request those records separately.
   - Need separate HIPPA release.
   - May refute claim that "condition improved" or "mistake" made
2. Medical records – hospital, clinic – may be helpful
3. Work with treating physician to write statement describing client's needs.
4. Night-time aide should keep log of all activities.

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Former standards for assessing hours in FFS/DSS apply in MLTC

- All managed care plans must make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 USC § 1396b(m)(1)(A)(i); 42 CFR §§ 438.210(a)(2), (a)(4)(i). The Model Contract states: "Managed care organizations may not define covered services more restrictively than the Medicaid Program."
- In other words, there has been **NO CHANGE** in the amount or type of services available under MLTC versus under PCA/CHHA as it was administered before by DSS/CASA offices.
- If medically appropriate for 24-hour care (even split-shift) under the PCA regulations, then should receive 24-hour care under MLTC.

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New Definitions 24-hour Care

2015 amendments to regs defining two types of 24-hour care for those who, because of medical condition, need assistance daily with toileting, walking, transferring, turning or positioning. No longer require that need "total" assistance.

1. **Split Shift** – "uninterrupted care, by **more than one personal care aide**, for more than 16 hours in a calendar day for a patient who …needs assistance with such frequency that a live-in 24-hour PCA would be unlikely to obtain, on a regular basis, **5 hours daily of uninterrupted sleep** during the aide's eight hour period of sleep."
2. **Live-in** – "care by **one personal care aide** for a patient …whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, **five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.**"
   - Home must have adequate sleeping accommodations for aide.

GIS 15 MA/024 (12/2015), 18 NYCRR 505.14(a), (b)(3)(ii)(b), MLTC Policy 15.09
https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm

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Aides entitled to Overtime

Federal labor regulations used to exempt home care aides from the Fair Labor Standards Act overtime requirements.

Eff. Oct. 13, 2015, Aides must be paid overtime if work over 40 hours/week or Live-In aides working over 3 days in a work week.

Travel time between different clients of the same employer/ home care agency must be paid. Travel to and from aide's home is not paid.

Live-in – Must be paid for 13-hour day, and more if aide reports that 3 meal periods or 8 hours of sleep time are interrupted by a client's needs. Chronic problem of plans not paying 13 hours.

http://www.health.ny.gov/health_care/medicaid/redesign/2015-11-09_flsa_decision.htm

Fallout for clients – aides limited to 40 hours per week, wage cuts

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Standards—authorizing PCS

- When you have 24-hour needs your plan cannot simply add up minutes for each personal care task (aka "task based assessment") *even if some of your care is provided by family, friends or other caregivers*;
  - No one can be compelled to provide care for you just so the plan can give you less care—but you can ask for fewer hours than the plan offers if care will be provided by others
- "**Safety monitoring**" is not a standalone personal care task that you can receive "credit" for, but time must be allotted for assistance that ensures safe performance of ADLs
  - Assistance may be verbal cueing, not only hands-on,
  - If you **cannot "direct" your own care** (e.g., if you have dementia) you are still entitled to services if there is someone else who will direct your care; such person need not live with you (92-ADM-49)
- Plans must **reinstate your services after a hospitalization** or rehab stay, at the same level you had previously GIS 96 MA-023

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Helping Clients Defend Reduction or Get More Hours

Strategies for advocacy with plan or at a hearing.

1. **Task-based assessment** --Task times are not set in stone – add time for unscheduled needs, individual traits, .. #7298776Z (NYC 8/8/2016), 7085459Y(NYC 9/16/2015) ("these maximum [task] times are not found in the regulation" and can be overridden).
2. **DEMENTIA/ Safety monitoring** – must authorize time to ensure safe performance of activities, which includes verbal cueing not just hands-on assistance. DOH GIS 03 MA/003 , FH # 7242238K
3. **Plan must cover SPAN OF TIME in which needs arise**. NYS DOH GIS 03 MA/003 --"… a care plan must … [meet] the patient's scheduled and unscheduled day and nighttime personal care needs." FH 7297626N , 7311117H

See new DOH MLTC Policy 16.07 re Task Based Assess.

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More Strategies to keep or get more hours

4. **Informal Help must be Voluntary** - 18 NYCRR 505.14(b)(3)(ii)(b); 12 OHIP-ADM-01 -"…informal caregivers …support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.");

– GIS 97 MA/033 ("…contribution of family members or friends… cannot be coerced or required in any manner whatsoever." FH #: 7085459Y (9/16/2015); 7111878L (10/16/2015).

– Have family member state clearly in writing the times they are available and willing to provide care.

5. **Mayer -3:** If client has 24-hour needs, even if family covers one shift, the plan my NOT use "task based assessment" to calculate the number of hours. They must cover the full span of time family is not available. 18 NYCRR 505.14(b)(5)(v)(d); GIS 97 MA 033, FH 7145223P and 7254996Z. **See new DOH MLTC Policy 16.07**

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Contact numbers & Other Info

New York Medicaid Choice (Enrollment Broker)
- **To request a Conflict-Free Assessment** (after Medicaid approval) **1-855-222-8350**
- **For information about MLTC** **1-888-401-6582**
- **For more information about FIDA** **1-855-600-3432**
- Website http://nymedicaidchoice.com/
  - http://www.nymedicaidchoice.com/program-materials - Scroll down to *Long Term Care plans*
  - **http://tinyurl.com/MLTCGuide** - Official guide to MLTC

NYS Dept. of Health MLTC/FIDA Complaint Hotline **1-866-712-7197**
mltctac@health.ny.gov (write "Complaint" in subject line)
NYS DOH Mainstream managed care complaint hotline **1-800-206-8125**
managedcarecomplaint@health.state.ny.us

Consumer Ombudsprogram – ICAN: **1-844-614-8800** **http://icannys.org**

New Medicaid applications (seeking home care): **929-221-0849**
Mail to: HRA, Home Care Services Program 785 Atlantic Avenue, 7th Floor, Brooklyn NY 11238

Evelyn Frank Legal Resources Program: **(212) 613-7310 or eflrp@nylag.org**

Related online articles on http://nyhealthaccess.org**:**
- **All About MLTC** - http://www.wnylc.com/health/entry/114/
- **Tools for Choosing a Medicaid Managed Long Term Care Plan** http://wnylc.com/health/entry/169/
- Appeals & Grievances - http://www.wnylc.com/health/entry/184/ with advocacy contacts
- MLTC News updates: http://www.wnylc.com/health/news/41/

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