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Topics Covered

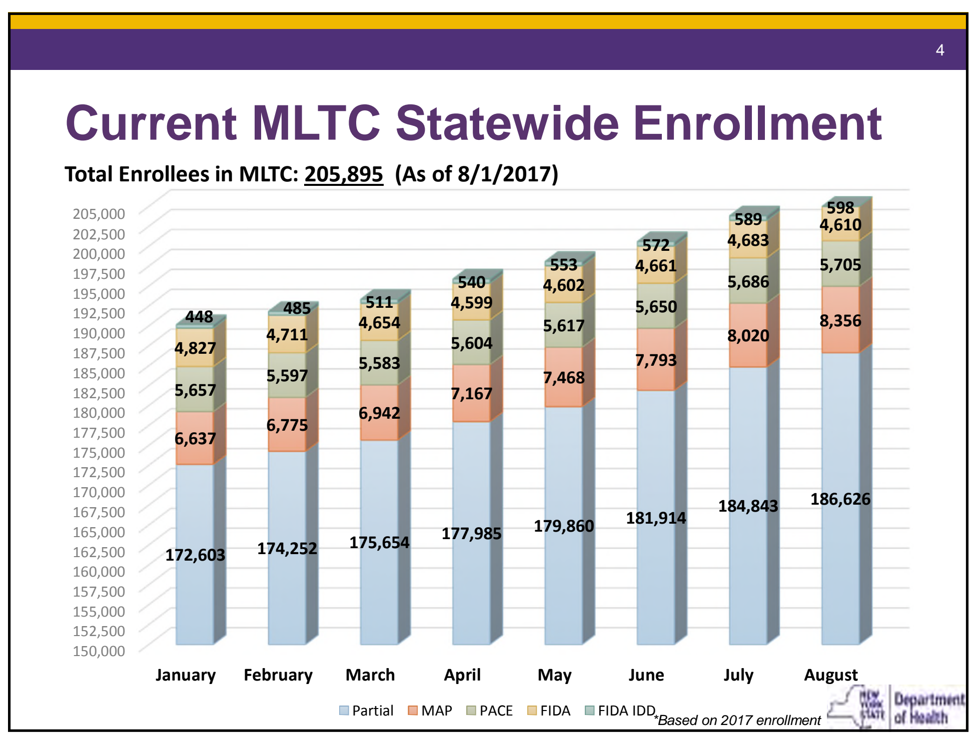
1. Background – Growth of MLTC triggering State action to reduce costs, i.e. bed hold payments cut
2. Plans closing – "transition rights" for members forced to change plans
3. Overtime and Minimum wage changes for aides – and definition of sleep-in and split shift 24 hour care
4. Fair Hearing changes coming in 2018
5. Immediate Need for Personal Care and CDPAP – fast track Medicaid and home care applications
6. Plans Reducing Hours 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.
- **186,626** now enrolled in MLTC statewide – up from 43,500 in 2011 ("Partial" capitation) .
- **19,000** more in PACE, FIDA, and Medicaid Advantage Plus - (Fully capitated – include Medicare services)
- The growth is more than State expected. Not just from moving consumers from Fee for Service. Causes:
  - **Marketing**, and
  - **Expansion of CDPAP** – Consumer Directed Personal Assistance.- addresses shortage of aides upstate. Plus now parents may be aides for adult children and adult children for their parents. *NEW*: CDPAP agencies must be certified to meet standards under 2017-18 State Budget

Current MLTC Statewide Enrollment



A look at costs..

- **Capitation rates** (estimated) - $5000- $6000/mo.
- **Aide services** estimated $18/hour –
  - 5 days x 7 hours = $2,730/mo
  - 12 hours x 7 days = $6,670/mo.
  - Live-in x 7 days @ 13 hours/day = $7,117/mo. ** but no more??
  - **Split – shift 2x12 = $13,340/mo.**
- Average Medicaid **Nursing Home** rate/month (non-specialty – excludes AIDS, Vent, pediatric):
  - NYC - $8,604/mo
- Admin & Care management costs
- Other services – adult day care, dental, supplies, transportation, audiology, nursing, etc.

High cost of Nursing Home & High Hours at Home – Impact on MLTC/managed care

- Competing Interests:
  1. **NHs** want to be paid same rate they received from State pre-managed care/MLTC ("benchmark rate"). Plans have to pay this rate until end of 2020 (extended in 2017)
  2. **Plans** say they can't absorb high NH cost. Want this paid outside of their capitation premium through a separate **"rate cell." 2017 State Budget allows DOH to discuss with CMS.**
  3. **Consumers** say a NH rate cell would incentivize plans to put members in NHs rather than give them high hours of home care they need. Consumers want **high need "rate cell" for community care** to give incentive to keep out of NH.

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High cost of Nursing Home & High-Hour Home Care – How is State Addressing?

Final NYS budget –

1. Allows State to request **rate cell** from CMS with stakeholder input.
2. **BED HOLD –** NYS has always paid Nursing Homes to hold a bed for a resident who is temporarily hospitalized, or for other therapeutic leave.
   - Must be in NH for 30 days.
   - Max 10-14 days/year.
   - Only paid if vacancy rate under 5%.

- In 2012, payment for hospital bed hold was cut to 50% of daily rate
- New changes for 2017 in State Budget..next slide

More on Hi Cost of NH and Home care

NYS Budget Cuts Bed Hold Payments

- 2017-18 Final Budget - Stops paying NH for bed hold for hospital stays for adults age 21+.
  - Continues 95% payment for therapeutic leave (family visits) 10 / yr
- NHs must still re-admit to first available semi-private bed, but if NH not paid to hold bed, no guarantee. And not bed in own room. Even when paid, problems with compliance. See Dear Admin. Letter 15-06*
- Since Managed care/MLTC plans now paying for more NH care (except for "grandfathered" residents in NHs before 2015) this cut saves plans money, not State. And hurts consumers!
- **5/12/17 – DOH Dear Admin. Letter DELAYS implementation of new law! Paid bed hold continues!**

https://www.health.ny.gov/professionals/nursing_home_administrator/#dal

MLTC PLANS CLOSING OR PULLING OUT OF COUNTIES

Protections for Members

Plans pulling out of counties or closing

- Since 2015, some MLTC plans have reduced their service area by pulling out from some counties
- **9/2015 HomeFirst (ElderPlan) – upstate 7 counties.**
- **Jan 2016 - EmblemHealth** closed its MLTC product – trans-ferred all members to Guildnet unless picked another plan. Members notified 12/2015 (NYC, Long Island, Westchester)
- **Jan. 31, 2017 - "Centerlight Select" MLTC Plan closed --**
  - All 5,099 members were transferred to *Centers Plan for Healthy Living* if they did not enroll in a different plan.
- **March, 2017- Guildnet** letter to 4000+ members in Nassau, Suffolk & Westchester said would stop services June 1, 2017
- **Sept. 2017** – **Northshore LIJ closing** – all 6,000 members to be transferred to *Centers Plan* – now 2nd largest in NYS. Affects **NYC,** Nassau, Suffolk.

More on Hi Cost of NH and Home care - Fallout

Concerns when Plans Close

- From 2015 – just last moth, DOH did not require new plans to continue same services that closing plan provided.
- In Guildnet closing - about 3000 members moved to other plans, even though plans didn't offer as many hours.
- NYLAG filed lawsuit for lack of "transition rights" – continuity of services. 3000 Guildnet members who changed plans now getting letters that they can call NY Medicaid Choice and ask for old hours to be reinstated. Call 1-888-401-MLTC or 1-888-401-6582 before Dec. 29th.
  - 930 Guildnet remaining members will be reassigned if don't choose new plan by 12/31/17

DOH issues transition policy for plan closures

- After much consumer advocacy, & a lawsuit, DOH issued 9/2017 - MLTC Policy 17.02: ***MLTC Plan Transition Process – MLTC Market Alteration*** (available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm)
- **GOOD:** Members of plan that's closing will be auto-assigned to a new plan if they don't pick one on their own.
  - The new plan **must continue the same amount of services** with the same providers for some time.
- **BAD**: New plan must only continue services for longer of (i) 120 days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care.

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More about "transition policy" in plan closing

- **Does not specifically require new plan to give notice before reducing services later – and require a REASON to reduce services -** condition has improved or some other change. This is despite clear DOH policy forbidding arbitrary reductions – see MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or CDPAP Services*
- **What is to protect member who "agrees" to a reduction not knowing his or her rights?** Policy seems to allow their hours to be reduced without notice and sooner than 120 days**.**
- **No mention that plan must give written notice BEFORE reducing services** with right to request an appeal and AID CONTINUING.
- **Will policy protect consumer who transfers plans when she hears rumor of old plan closing? Or sees in the news? –** Policy only says applies when plan closure approved by DOH. But rumors start before.

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OVERTIME & MINIMUM WAGE REQUIREMENTS FOR AIDES

Started Oct. 13, 2015

Wage Parity Changes

3 separate paths to increased wages

1. Minimum Wage – NYS initiative
2. Wage Parity – NYS initiative
3. Overtime requirements – Federal and state labor regulations, with recent State court decisions

Minimum Wage & Wage Parity

- 2016-17 State budget authorized phased-in increases to the State's minimum wage
  - Will gradually increase to $15 by 2019-2021
- Plus eff 7/1/2017 – 12/31/17**.** Public Health Law § 3614–c, Home Care Worker Wage Parity https://www.health.ny.gov/health_care/medicaid/redesign/mrt_61.htm
- 2017-18 budget includes $255.4 million in State funding to pay for the increased wages in health sector – home care, ALPs, nursing homes, hospitals. (Much better than last year which was only $32 million for this increase).
- Still a concern not enough to pay the increases.

Wage Parity Extended to CDPAP

- 2017-18 State Budget gives CDPA home care worker wage parity, with an effective date of 7/1/17 (extended to 10/13/17?). Before, only Personal Care Aides and Home Health Aides were covered.
- Requires wages and benefits totaling **$15.09 in New York City and $13.22 in Westchester and Long Island eff 7/1/17 (CDPAP 10/13/17)**
- But – must be funded with NYS reimbursement!
- 2017-18 State budget also launches a new process for State to authorize CDPAP agencies "Fiscal Intermediaries" – establishing standards. As number of FI's has grown, practices have departed from CDPAP mission.

Minimum wage/ wage parity 2017-18

1/2017	NYC- Large employer 11+ employees	NYC – small Employer < 11	Westchester, Long Island	Rest of State
Base wage	$ 11.00	$10.50	$10.00	$9.70
Benefits	4.09	$ 4.09	$3.22	
Total	$15.09	$14.59	$13.22	
12/31/2017				
Base wage	$13.00	$12.00	$11.00	$10.40
Benefits	4.09	$ 4.09	3.22	
Total	$17.09	$16.09	$14.22	

https://www.health.ny.gov/health_care/medicaid/redesign/2017/mrt61_cdpas_nyc.htm - Wage parity for CDPAP
https://www.labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm

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 this has changed. 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 1-hour meal periods or 8 hours of sleep time are interrupted by a clients' needs. Rebuttable presumption gets 11 hours "off" in a 24-hour period.
- http://www.health.ny.gov/health_care/medicaid/redesign/2015-11-09_flsa_decision.htm

Overtime for Aides

- Overtime requirements have resulted in plans reducing aide schedules to max out at 40 hours per week.
- National advocacy organizations say there must be an **Exceptions Process** so that aides can work > 40 hours for short-term emergency needs or for long-term to ensure continuity of care and prevent institutionalization – especially in places like upstate NYS with shortage of aides. See "*Key Considerations for Developing an Exceptions Process" (*Natl. Employment Law Project, Bazelon Center, PHI, etc.) (4/26/16) http://www.bazelon.org/LinkClick.aspx?fileticket=qFkSrIu15xw%3d&tabid=135
- And Fact Sheet http://www.nelp.org/content/uploads/Fact-Sheet-USDOL-Home-Care-Rules-Good-Implementation.pdf

App. Div. Decisions 2017 Reject paying live-in 13 hours for a 24-hour day

- 24-hour case home care workers must be paid for all 24 hours if they are "nonresidential," meaning they do not exclusively reside in the patient's home. *Tokhtaman v. Human Care, LLC* (1st Dept. 2017 NY Slip Op 02759); *Andreyeva v. NY Home Att. Agency*; *Moreno v Future Care Health Serv.* (2nd Dept.)
- If aide doesn't actually live with client, must be paid for 24 hours of work.
- Plans will appeal to Court of Appeals
- BUT – State amended minimum wage regulation in late Oct. 2017, which was the basis for the decisions. Now appeals court may reverse decisions.

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Impact of Court Rulings – 24 hour care

- Pressure to cut back on new live in cases. Some home care agencies reportedly refusing to accept them. Some home care agencies/ CDPAP agencies may close.
- MLTC plans will cut back on authorizing live-in care, or won't be able to staff it if authorized.
- At same time, 2x12 care also facing cuts. With increases from "wage parity" agencies refusing to authorize overtime. In a 2x12x7 case, difficult to avoid 16 hours week of overtime. (2 aides work 4 12-hour shifts = 48 hours each)(Other 2 aides work 3 12-hour shifts= 36 hours). Pressure to reduce overtime. But aides will then reduce hours and lose pay!
- Estimated $900 mill Medicaid cost to convert live-in cases to 2x12
- Will MLTC plans push nursing home care? Cheaper than 2x12. *Olmstead* implications

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Advocacy tips if can't get live-in

- File a grievance with your MLTC or managed plan.
- File a complaint with the NYS Dept. of Health if you are authorized for 24-hour live in care but the MLTC or managed care plan cannot find an agency to staff the case. 866-712-7197 or email **mltctac@health.ny.gov**.
- Mainstream managed care complaints can be filed at 800–206–8125 or managedcarecomplaint@health.ny.gov
- **MORE TIPS:** Do needs meet the standards for 2x12 split shift care? (next slide) If so, request the plan to increase your services. Call **ICAN** for help or guidance.

New NYS Definitions 24-hour Care - 12/2015

- **Split Shift** – "uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition:
  - needs assistance during such calendar day with toileting, walking, transferring, turning or positioning,
  - & 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."**

GIS 15 MA/024, Dec. 2015, 18 NYCRR 505.14(a), (b)(3)(ii)(b) at https://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm

New Definitions 24-hour Care - 12/2015

- **Live-in** -- "care by one personal care aide for a patient who, because of the patient's medical condition:
  - needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding
  - and 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.**"
  - Also takes into account if home has adequate sleeping accommodations for a personal care aide.

GIS 15 MA/024,, 18 NYCRR 505.14(a), (b)(3)(ii)(b) at https://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm. Incorporates 2010 NYS Dept. of Labor Opinion letter RO-090169

CHANGES IN MLTC HEARING RIGHTS COMING IN APRIL 2018

New "Exhaustion" requirement

New “exhaustion” requirement

- The Obama Administration revised the federal regulations that govern Medicaid managed care plans. 42 CFR Part 438. They had not been revised since 2002.
- One of the big changes is in **hearing rights.** Starting in **March 2018 in NYS,** a managed care member including MLTC may not request a Fair Hearing until she has requested an “internal appeal” of an adverse plan determination, and the plan has issued a decision. 42 CFR 438.402(c).
- If an MLTC plan sends a notice to reduce home care hours, or denies an increase, the member **must first request an internal appeal.** Only after that is decided may she request a fair hearing.

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Concerns about “Exhaustion”

- This is a huge change in NYS. 4 million “mainstream” Medicaid managed care members (those without Medicare) have never been required to “exhaust” internal appeals. When MLTC became mandatory in 2013-14, exhaustion was required, but then the State lifted that requirement, allowing direct access to fair hearings.
- **AID CONTINUING** in jeopardy: If plan is reducing hours or other services, member must request the Internal Appeal quickly to get Aid Continuing. But calling Plan’s 800 numbers -- and ensuring that the call is logged in – is difficult.
  - If Internal Appeal decision is adverse, then notice of that decision must AGAIN include Aid Continuing rights. This will be confusing!!!
- **NOTICES** must be clear about the new rules.
- DOH wants to implement the change in March 2018, one month before required. But it takes time for plans to change their notices, procedures, & train their staff. OTDA also must train staff. and develop new procedures to transfer FH requests to the plans.

Wish list for Implementing Exhaustion

- NYLAG has asked the State for a **transition period**, where requests made to OTDA for a fair hearing don't get bounced just because the individual didn't "exhaust." These requests should be forwarded to the plan and logged in as a timely internal appeal request.
- The federal regs allow for "**deemed exhaustion"** - 438.402(c)(1)(A) - allowing a FH request if the plan fails to decide the Internal Appeal on time.
  - Plan must issue written notice of resolution within 30 days from date of receipt of member's appeal request, or if an expedited appeal was requested, within 72 hours after the plan receives the appeal, unless extended by up to 14 calendar days if warranted under regs. § 438.408

Advocates want a broader list of reasons – defective n notice, etc.

NEW FAST TRACK MEDICAID APPLICATION IF "IMMEDIATE NEED" FOR HOME CARE

- Solves delays in Applying for Medicaid and then Enrolling in an MLTC plan
- Immediate Needs Requests to LDSS.
- CAN USE Spousal Impoverishment Protections

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 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 & approve PCS/CDAP in 12 days. NY Soc. Serv. L. §366-a(12).
- July 2016 – new regulations effective. 18 NYCRR 505.14(b)(7) and (8) and 505.28(k);
- **DOH 16-ADM-02** - Immediate Need for PCS & CDPAP
- HRA Procedures 10/19/16 - http://www.wnylc.com/health/download/615/

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.

In above categories – may be applying from hospital or nursing home as well as from community.

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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What to Include in Application for Immediate Need Medicaid

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)**
   a. May "attest" to value of real property & assets – but better to verify
   b. May request Spousal Impoverishment budgeting if favorable
   c. Need all other documents – ID, proof IRA payout status, income, lease/utility bill, Medicare card, insurance premiums, etc.
3. **Physician's order** for personal care (M11q)- 18 NYCRR 505.14(b)
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.

DSS Initiate PCS/ CDPAP

- Once LDSS approves the Medicaid application and personal care or CDPAP services, LDSS assigns a home care agency/CDPAP agency under contract to LDSS to staff the case.
- Generally client may not choose her own agency – must use a LDSS contractor.
- If requesting CDPAP, the aides must register with the LDSS' CDPAP agency called a "Fiscal Intermediary."
- **Immediate Need PCS or CDPAP is only temporary.**
- Services will be provided for 120 days and continue through transition to MLTC. See next slide re transition.

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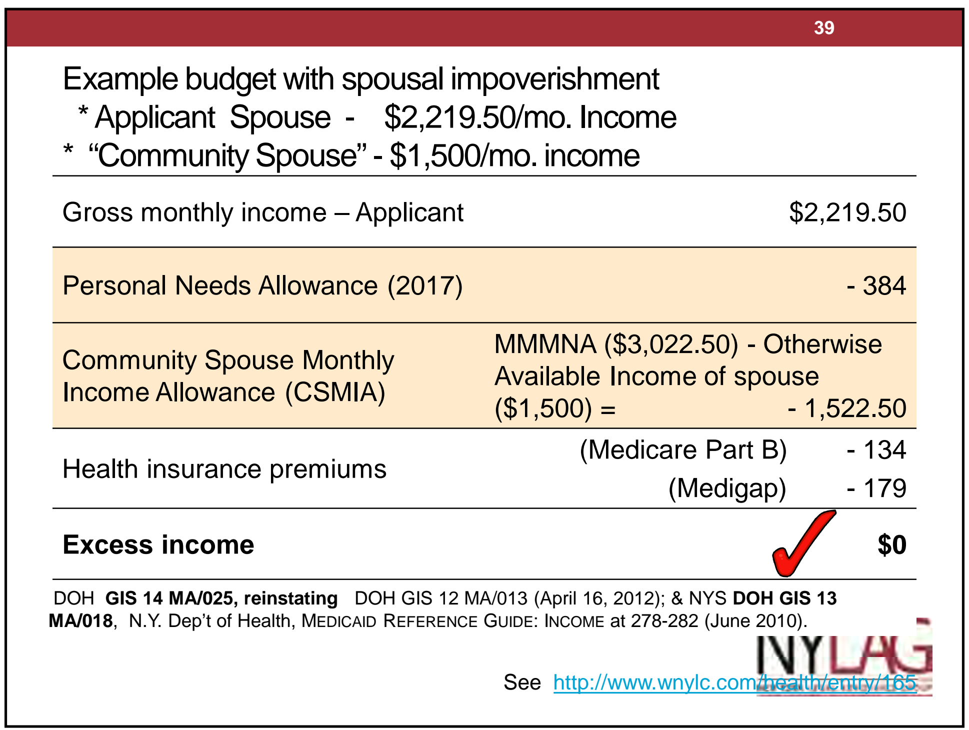
Transition from Immediate Need to MLTC

- **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 plans only, not FIDA, PACE or Medicaid Advantage Plus though client may select such plans).
  - 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

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 – counting both spouses' income using couple level of $1209/mo. or using Spousal Refusal. Soc. Serv. L. § 366.3(a). Had to do spousal refusal.
- **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 $3,364 after deducting Medigap premiums, and countable assets under $90,000. See more at http://www.wnylc.com/health/entry/165/
- Example next slide.



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Example budget with spousal impoverishment
* Applicant Spouse - $2,219.50/mo. Income
* "Community Spouse" - $1,500/mo. income

Gross monthly income – Applicant		$2,219.50
Personal Needs Allowance (2017)		- 384
Community Spouse Monthly Income Allowance (CSMIA)	MMMNA ($3,022.50) - Otherwise Available Income of spouse ($1,500) =	- 1,522.50
Health insurance premiums	(Medicare Part B) (Medigap)	- 134 - 179
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

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PLANS REDUCING HOURS OF HOME CARE

2016 Report in NY Times on Patterns of Plans Reducing Hours

- In July, 2016, Medicaid Matters NY, a statewide coalition, & NAELA released a report of all FH decisions posted online by state hearing agency OTDA for last 7 months in 2015. Showed huge increase in number of reductions. (copy in materials) https://otda.ny.gov/hearings/search/
- Found highest volume of appeals against two MLTC plans – Senior Health Partners (Healthfirst) & VNS Choice, which repeatedly reduced hours for no reason. Plans won only 1% of the 1,042 hearings but persisted in sending notices.
- The report was featured in a story in the NYTimes on July 21, 2016, "Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients." http://tinyurl.com/nytimes-FairHearing.

DOWNLOAD AT http://tinyurl.com/nytimes-FairHearing

More on MLTC reductions - CONCERNS

- Those with an advocate could win the hearing, but what happens to those without? If don't request a hearing, can't win.
- Most wins because plan didn't even send proper notice.
- 8.7 % of consumers accepted a "deal" when offered at the hearing – a reduction that was not as severe as originally threatened, but still a cut. They didn't know their rights.
- Plans lost because tried to cut hours for NO REASON – claiming they made a "mistake," or that there had been a change when there was none.
- NYLAG *Caballero* lawsuit filed against plan with most reductions – Senior Health Partners.

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Plans reducing hours - Progress

- Plan needs a REASON to reduce – a **change in medical condition or circumstances,** such as increased availability of family to help. But instead, plans just recite that their task plan says client gets x hours. Not a permissible reason under federal law precedent – **Mayer v. Wing** case - and state regulations.
- Plans must give proper WRITTEN ADVANCE NOTICE.
- Since the Medicaid Matters Report was issued and NYLAG *Caballero* case was filed, NYS DOH issued two important directives in 2016.

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DOH MLTC Policy 16.06 – Guidance on Notices to Reduce PCS or CDPAP

- Defines what changes or mistakes by plan in previous authorization may justify reduction
  - "MLTC plan must not implement a new task-based assessment tool that contains time or frequency guidelines for tasks that are lower than … previous .. [tools], and then reduce services … on the basis that a "mistake" occurred in the previous authorization.
- 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..."
- Copy in materials and in MRT 90 website

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

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Plans reducing hours - Strategies

1. Request a **hearing.** https://otda.ny.gov/hearings/
   1. Must request RIGHT AWAY to get **AID CONTINUING.** Hours will stay at old plan of care until hearing held and decided. Must request within 10 days of notice.
   2. NOTE that in 2018 will have to request INTERNAL APPEAL 1st!!
2. **Find a legal representative – ICAN** takes referrals of cases statewide. **1-844-614-8800**
3. Request **evidence packet** from plan to see what assessments say that plan relied on to reduce hours (in materials)
4. **Class action lawsuit against one plan – Senior Health Partners** –challenging systematic unjustified reductions of hours. For more information about *Cabalero* case – contact Ben Taylor at btaylor@nylag.org.

DOH MLTC Policy 16.07 – Guidance on Task Based Assessment Tools

- 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 **safety monitoring, supervision or cognitive prompting** for the performance of those particular IADLs or ADLs for those with dementia etc.....
  - *Gives 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."

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/index.htm

GETTING HELP

What is ICAN?

- ICAN stands for **Independent Consumer Advocacy Network**.
- ICAN is the New York State Ombudsprogram for people with Medicaid long term care services.
- We assist New Yorkers with understanding how to enroll in and use 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.

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), including **MLTC.**
- 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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Get help