MEDICAID HOME CARE IN NYS

by

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ROADMAP OF PRESENTATION

- **PART 1 - Slides 3 – 40** – **What is MLTC** and the new landscape of plans?
  - How does MLTC relate to Medicare? What are choices of plans?
  - Process for Applying for Medicaid and enrolling in MLTC.
  - Basics on Member Rights
- **PART 2 - Slides 41 – End** – **Navigating MLTC** –
  - Transition rights,
  - Requesting services and increases,
  - Fair Hearings and Aid Continuing rights
  - What happens if you need nursing home care

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NYS Medicaid Redesign

- Big changes since 2012 in the way seniors and people with disabilities access Medicaid home care and other long term care services in NYS
- Shift from:
  - "**Fee for service**" – Provider bills Medicaid program directly for services. To counter provider's incentive to bill more, get paid more, for expensive services like Personal Care, State required **prior approval** from local Medicaid program/DSS.
  - **Shift to "managed care" model** – Medicaid pays insurance plan fixed monthly "capitation," and plan contracts with and pays providers in its network for services plan approves. Hallmarks:
    - Must be in network
    - Plan reduces costs by negotiating rates with network providers AND by denying services..
    - Approval can be required for many services

Some Acronyms, Resources

- **LTC** = Long Term Care
- **MRT 90 -** Medicaid Redesign Team # 90 is the state initiative to "redesign" Medicaid home care into mandatory MLTC. Webpage has key documents https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm including:
  - **Contract** – the model contract between the State Dept. of Health and the MLTC plans.
  - **FAQ's** and **Policy directives** cited in this presentation
- **PCA/PCS** – Personal Care.
- **CDPAP** – Consumer Directed Personal Assistance
- **ADL** – Activity of Daily Living (tasks that aide assists with)

Why Are We Talking About Managed Long Term Care?

- **Medicare** DOES NOT pay for long-term care services
- **Medicaid** DOES pay for long term care services – including home care
- Most **Dual Eligibles age 21+** (adults on Medicaid and Medicare), must now enroll in a Managed Long Term Care (MLTC) plan to get long term care services – home care or nursing home care

What is Managed Long Term Care (MLTC)?

- Insurance plans for dual eligible adults who need more than 120 days of long term care
- Long term care (and other Medicaid services) provided through health insurance plans
  - Medicaid pays the MLTC plans to provide services (monthly capitation rate)
  - Includes care management component
- **Mandatory in all counties statewide** (gradually rolled out starting in NYC in 2012, last upstate counties became mandatory summer 2015)
  - Each county must have at least two MLTCs

MLTC Benefit Package

These Medicaid services MUST be accessed through MLTC Plan Network

Long Term Care

- Personal Care
- Visiting nurse or Private Duty Nursing Services at home
- Physical, Occupational, Respiratory Therapy in the home or clinic
- Home Health Aides
- Adult Day Health Care
  - Medical model &
  - Social adult day care
- Consumer Directed Personal Assistance
- **Nursing home – changes in 2015 described below**

Additional Services

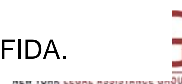
- Home Modifications
- Medical Equipment & Supplies (wheelchairs, incontinent pads, orthotics, ensure)
- Non-Emergency Medical Transportation (ambulette to MD)
- Personal Emergency Response System
- Home Delivered Meals
- 4 medical specialties:
  - Podiatry
  - Optometry (& eyeglasses)
  - Audiology (& hearing aids)
  - Dental

What Medicaid services NOT provided by MLTC?

- Primary and acute medical care (to extent not covered by Medicare, i.e. hospital deductible) other than the 4 specialties in MLTC.
- Emergency medical transportation, dialysis
- Lab tests, radiology, over the counter drugs not covered by Medicare – Medicaid pays
- Mental health, substance abuse
- Assisted Living Program (but this WILL be in MLTC soon)
- Still use regular Medicaid card for the above services. Use MLTC plan card for all MLTC services.

Does MLTC Affect Client's Choice of MD? Partial vs. Full Capitation

- It depends on whether client chose a PARTIAL or FULL Capitation Plan. Does the Capitation rate (monthly premium paid to a managed care plan) cover only **some** Medicaid services or **all** Medicare & Medicaid services?
- "**Partial Capitation**" –
  - MLTC plan is paid to provide only PART of services a Dual Eligible receives – primarily Medicaid long-term care services
  - Most MLTC plans & enrollees are partial capitation.
- "**FULL CAPITATION** – Plan paid to provide ALL Medicare & Medicaid services.
  - Plans are "MEDICAID ADVANTAGE PLUS, PACE, or FIDA.



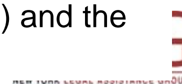
Partial Capitation MLTC – How does client get Medicare services?

For MEDICARE services, client in MLTC partial capitation plan has choice of:

1. **Original Medicare** (must also enroll in Part D plan and may purchase Medigap supplement)
2. **Or Medicare Advantage** – Managed care model for Medicare services only.

Either way, **for Medicaid services client uses TWO CARDS:**

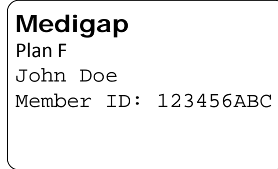
1. **MLTC card** for MLTC package of services plus
2. **Regular Medicaid card** to pay Medicare deductibles and coinsurance (hospital deductible, etc.) and the few Medicaid services not in MLTC plan

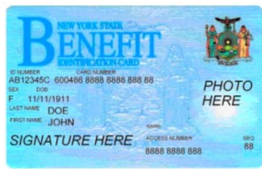


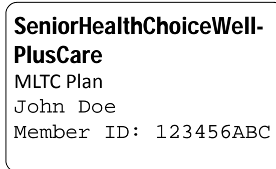
11

Combination 1 – Partial Capitation MLTC with Original Medicare

- Dual Eligible with Original Medicare Part D and MLTC







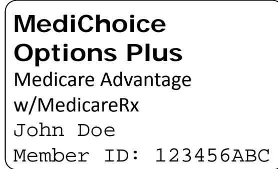
NOTE: Extra Help - Part D subsidy is automatic.

Medigap is optional

12

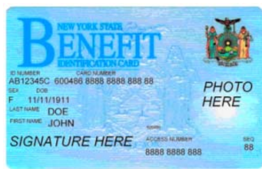
Combination 2 – Partial Capitation MLTC with Medicare Advantage

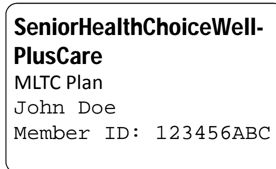
- Dual Eligible with Medicare Advantage and MLTC



NOTE: Extra Help - Part D subsidy is automatic.

NO Medigap allowed.





13

OPTION 3 – FULL CAPITATION

- **MEDICAID ADVANTAGE PLUS, PACE, or FIDA -**
- In ONE plan, combines all MLTC, Medicaid and Medicare services.
  - Like a Medicare Advantage + MLTC plan all in one.
- All doctors, hospitals, home care providers. dentist. etc. must be "in network."

NOTE: Extra Help - Part D subsidy is automatic.

NO Medigap allowed.

MediChoice Options Plus
Medicaid Advantage Plus w/MedicareRx
John Doe
Member ID: 123456ABC

3 Full Capitation Models – All provide all Medicaid & Medicare services

1. **Medicaid Advantage Plus (MAP):**

- Additional eligibility requirement: Need Nursing Home level of care
  - Use plan's provider network for all services
  - CAUTION: **Medicaid Advantage Plus** (MAP) is not the same as **Medicaid Advantage** (MA). Both include all Medicare services, but:
    - MA provides Medicaid without LTC – long-term care
    - MAP provides Medicaid with LTC

2. **Program for All-Inclusive Care for the Elderly (PACE):**

- Provide services through a particular site – a medical clinic or hospital. Because all providers are linked, potentially more opportunity for coordinated care.
- Additional eligibility requirement(s): Must be age 55+ AND
    - Need Nursing Home level of care,

3. **FIDA – see next slide**

3rd Full Capitation Model – FIDA

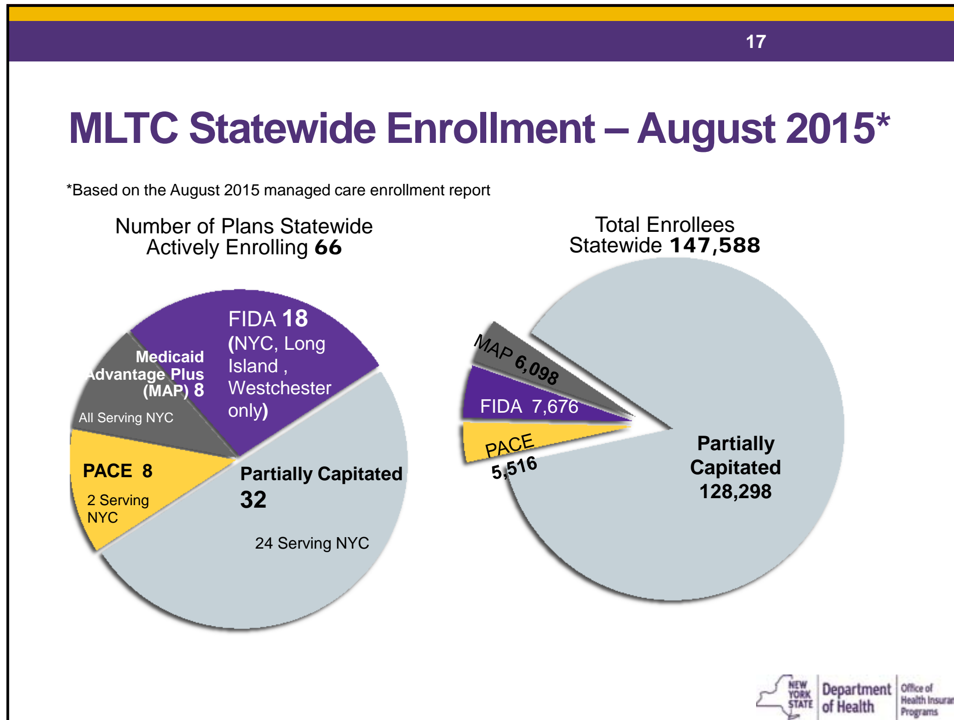
- **Fully Integrated Dual Advantage (FIDA):**
- Demonstration project to coordinate care for dual eligible population
- Person-centered care model
- Currently only in NYC & Nassau (Suffolk & Westchester rollouts delayed – DOH still planning to start there in early 2016)
- Provides most Medicare & Medicaid services
  - But not: Methadone maintenance, out of network family planning services, direct observation therapy for tuberculosis, and hospice care (these are offered through regular Medicare/Medicaid)
- Integrated Medicaid/Medicare appeals process

16

Why most people are in Partial Cap MLTC

- Most people are in MLTC plans and have separate Medicare coverage, rather than choosing Full Capitation plans (Medicaid Advantage PLUS, PACE, or FIDA). See next slide. **WHY?**

1. Many MLTC enrollees were/are being transitioned into MLTC from the old home care programs – personal care, Lombardi, CHHA, etc. They had 60 days to pick a plan and if they didn't pick, they are **randomly assigned to an MLTC** Partial Capitation plan, not to Full Capitation plans.
2. Those who do choose **prefer to keep their old Medicare coverage to keep free choice of MDs**. In Full Capitation must use provider networks.



Who Must Join MLTC?

- Dual eligibles who are age 21 or older AND
- Receiving or applying for Medicaid long term care services for >120 days in a calendar year, including:
  - Personal Care (Level II in 18 NYCRR 505.14(a)
  - Consumer Directed Personal Assistance
  - Certified Home Health Agency services
  - Adult Day Health Care (medical model)
  - Private Duty Nursing
  - Lombardi / Long Term Home Health Care Program (program now closed to new enrollees – all past enrollees transitioned to MLTC)
  - **NEW In 2015** – in a **nursing home** and determined eligible for Nursing Home Medicaid after 5-year lookback app. (for new NH admissions after 2/2015 in NYC and 7/2015 rest of state)

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Who May Join MLTC?

- **Voluntary enrollment** for:
  - Dual eligibles -
    1. 18 through 20 years old;
    2. Need >120 days community long term care; AND
    3. Assessed as nursing home eligible.
  - Non-dual eligibles (have Medicaid only)
    1. 18 years and older;
    2. Need >120 days community long term care; AND
    3. Assessed as nursing home eligible AND
    4. Need a service not covered by "mainstream" Medicaid managed care (social adult day care, home modifications, home-delivered meals)

Who May Not Join MLTC?

1. **Those who only need Housekeeping** services – not assistance with personal needs (Activities of Daily Living) "Level I" Personal Care services – 18 NYCRR 505.14(a)).

   May still apply to local DSS for these services but capped at 8 hours/week
2. **Those who are in receipt of Hospice services**
   1. But if in MLTC and develop a need for hospice, may stay in MLTC
   2. May apply to local DSS for personal care to supplement hospice services
3. **Those who only need Social Adult Day Care**
4. **Those who need <120 days Long Term Care** – may still obtain CHHA (certified home health agency) services short-term - then transition to MLTC. (But note CHHAs often refuse high hours of care because their reimbursement was cut by State).
5. Continued next slide

Who is Currently Excluded from MLTC?

Currently in --	But - Planned Carve in – Will be required to transition to MLTC in--
Assisted Living Program	1/1/16
NHTD waiver	1/1/17
TBI waiver	1/1/17
OPWDD waiver	Late 2015 voluntary 2017-2019 mandatory

Steps to MLTC Enrollment

1. Medicaid Application
2. Assessment by Conflict Free Evaluation and Enrollment Center (CFEEC)
3. Learn about Plan Types & Options
4. Obtain MLTC Plan Assessments and Choose a Plan
5. Enroll in an MLTC Plan

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1 Medicaid Application

- Must apply for Medicaid at local DSS just as before.
- **Original rules for MLTC say DSS "Front Door Closed"** to apply for personal care/CDPAP - *unless* in home hospice or need *only* housekeeping (limited to 8 hours/week). So could only submit Medicaid application, not request for home care (M11q).
- **TIP**: Because of delays in enrolling in MLTC after Medicaid approved, try submitting a "physician's order" for personal care (M11q in NYC) per 18 NYCRR 505.14(b) along with Medicaid app and ask DSS to authorize services based on *immediate need*, either while Medicaid app pending, per Konstantinov* case, and/or after Medicaid approved, per **GIS 2015 MA/11**.

*2014 N.Y. Misc. LEXIS 1137 (2014), see http://www.wnylc.com/health/entry/203/

Where to file Medicaid Application - NYC

WHO: Dual Eligible Seeking MLTC

NYC Home Care Services Program
Central Medicaid Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238
T: 929-221-0849

What to file:

- Medicaid application
- Optional – Physician's order (M11q) if "immediate need" for home care

Dual Eligible Excluded from MLTC – Needs only Housekeeping or is enrolled in Hospice

NYC Home Care Services Program
Central Intake
109 East 16th Street, 5th Floor
New York, NY 10003
T: 212-824-0706 FAX 212-896-8814

What to file:

- Medicaid application
- Physician's order for home care (M11q)

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Tips for filing Medicaid applications if seeking MLTC

- Must complete **Supplement A** and provide current asset documentation (+ last 3 months if want retro coverage)
- Indicate on top of Application and Cover Letter that seeking MLTC
- If client will have a spend-down – take special steps:
  - May be worth having MLTC plan file app, avoids "coding" problems – but you lose control over filing
  - Wait to enroll in pooled trust until AFTER Medicaid approved and enrolled in MLTC. Faster.
  - Submit any medical bills client has paid in last 3 months, and any unpaid bills from before that – to "meet" spend-down and activate Medicaid.

Tips for Married Medicaid Applicants

- Married MLTC enrollees are entitled to same "spousal impoverishment protections" that apply in nursing homes – if one spouse, not both spouses, are in MLTC. In many cases this obviates need for pooled trust.
- But – DOH Policy allows these extra allowances for income and resources only "**post-eligibility**," after enrollment in MLTC.
- Medicaid application uses regular community Medicaid rules. A married applicant may have a high spend-down or may need to use Spousal Refusal initially. Once one spouse enrolls in MLTC, s/hecan request Spousal Impoverishment protections from LDSS.
- If still have high spend-down even with spousal allowances, applicant has option to use pooled trust, budgeting only applicant spouse's income. DOH **GIS 14 MA/025** . SEE links to State directives, forms & examples at http://www.wnylc.com/health/entry/165/

Home care for People Without Medicare

- Most people without Medicare obtain Medicaid on the Exchange (Obamacare/ "MAGI" Medicaid)
  - No asset test and higher income limits than regular Medicaid.
- Most of those without Medicare are required to enroll in a "Mainstream" Medicaid managed care plan. They must access Personal Care, CDPAP, adult day care, CHHA through their managed care plan.
  - May only switch to MLTC if client needs social adult day care, home modifications, or home delivered or congregate meals.* In that case client can stay on "MAGI" Medicaid (no resource test & other differences) but must have LDSS make "coding" changes to allow MLTC enrollment. Contact hxfacility@health.state.ny.us or fax to (518) 474-9062.

* MLTC Policy 14.01: Transfers from Medicaid Managed Care to Managed Long Term Care (posted on https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

If someone has Medicaid through Exchange – and then becomes enrolled in Medicare

- If someone enrolled in a Mainstream Medicaid Managed Care plan – with **Medicaid** obtained through **NYState of Health Exchange**
- And then becomes enrolled in **Medicare**, by turning age 65 or based on Disability, she must "reapply" for Medicaid at LDSS – should receive notices to seamlessly transition to "non-MAGI" Medicaid. Must now prove resources, which are not counted on the Exchange in MAGI eligibility.*
- Will be disenrolled from the "mainstream" plan and, if already receiving home care thru that plan, should be auto-assigned to an MLTC plan. Watch out for problems!
  - **See DOH 14 -2014 LCM-02 -** *Medicaid Recipients Transferred at Renewal from New York State of Health to Local Departments of Social Services* posted on http://www.health.ny.gov/health_care/medicaid/publications/index.htm
  - See MLTC Policy 15.02: *Transition of Medicaid Managed Care to MLTC* posted https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

2 Conflict Free Evaluation and Enrollment Center (CFEEC)

- Before you may enroll in MLTC plan, must request a Conflict-Free Assessment, which is done in-home (or hospital or nursing home) by nurse employed by State contractor, Maximus – known as **New York Medicaid Choice**
- For people newly seeking MLTC
  - No CFEEC assessment needed if transferring from plan to plan, or from a previous Medicaid long term care service
- Purpose -- CFEEC determines eligibility MLTC – do you need > 120 days of Long Term Care, as opposed to merely housekeeping or social adult day care.
- Does not determine how many hours of service – plan determines hours.

2 More on CFEEC

- This step added in 10-2014 in NYC and rolled out gradually – now statewide. State aims to end “cherry picking” – plans recruiting people who don’t need any home care OR who need high-cost home care
- **WHEN** to request CFEEC: Can obtain while Medicaid app is pending, prior to DSS Medicaid eligibility decision, but assessment only good for 60 days. Maximus must schedule visit in 7 days (warning re delays)
- Request CFEEC- Call NY Medicaid Choice **1-855-222-8350**
- **CFEEC guidance & FAQs–** posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

**http://nymedicaidchoice.com -On home page click on Do I Qualify for Long Term Care? -- Direct link http://nymedicaidchoice.com/ask/conflict-free-evaluation-and-enrollment-center

Conflict-Free Assessment (CFEEC) *con'd.*

- Nurse conducts assessment using same **Uniform Assessment Tool** as MLTC plans. Conducted in-home, hospital or nursing home.
  - TIP: MAKE SURE FAMILY, SOCIAL WORKER, or other representative/spokesperson is AT ASSESSMENT to point out functional needs.
  - TIP: Have MD letter/M11q with diagnoses, meds, functional impairments at assessment – give to assessor
- No CFEEC is needed if transferring from plan to plan, or from a previous Medicaid LTC service
  - But DOH policy in flux re whether **nursing home residents** on Medicaid must have CFEEC in order to enroll in MLTC to return home. Tho some guidance said NOT required, DOH may be changing to require. Stay tuned at https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

3 Learn about Plan Types & Options (See above)

- **Choose Which of Two Models of MLTC**
- **Partially Capitated MLTC** (MLTC with only Medicaid benefits)
- **Fully Capitated** - MLTC with Medicaid AND Medicare benefits – discussed above
  - Program for All-Inclusive Care for the Elderly (**PACE**)
  - Medicaid Advantage Plus (**MAP**)
  - Fully Integrated Dual Advantage (**FIDA**) (currently only available in NYC & Nassau)
- **Lists of plans** by county with contact info:
  - **http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm**
  - **Nymedicaidchoice.com –** on home page click on bottom on *Brochures & lists. Click on **Long Term Care plans** in your region.*

4 Obtain MLTC Plan Assessments

- Find out which plans' **network** includes preferred providers
- **Schedule plan assessment(s)**
  - Must be conducted within 30 days of request
  - Obtain assessments from multiple plans
  - Ask for proposed care plans – plan must put in writing. Plan must give **written plan of care** at time of pre-enrollment assessment – before you sign enrollment form. See FAQ #44 8/21/12* posted at https://www.health.ny.gov/health_care/medicaid/redesign/2012-08-21_mltc_faq.htm
  - Family member, care manager or advocate should be at assessment. Make clear what family can and cannot do.

5 Choose & Enroll in an MLTC Plan

- **Troubleshoot Medicaid eligibility "coding" issues** – Plan may decline enrollment saying Medicaid computer says "not eligible" – sometimes because client has not met spend-down. May need a computer coding change. Show plan Medicaid approval notice and ask it to contact DSS. In NYC plan may need to fax HRA "conversion form."
- **Choose the MLTC that best meets needs**
- **How to enroll:**
  - **Partially Capitated MLTC** (Medicaid only MLTC):
    - Must enroll through the plan – not thru NY Medicaid Choice
    - Enrollment has no impact on Medicare
  - **MAP** or **PACE**:
    - Must enroll through the plan
    - Automatically disenrolled from Medicare Advantage, Stand-alone Part D and Mainstream Medicaid Managed Care

5 Enroll in an MLTC Plan

- **FIDA (NYC, Nassau and in 2016 – Westchester, Suffolk)**:
  - Passive Enrollment
    - MLTC enrollees passively enrolled (auto assigned) to a FIDA plan after 90 day's notice
    - Passive enrollment began April 1, 2015
    - Individuals can affirmatively decline ("**opt out** of") FIDA enrollment by contacting NY Medicaid Choice
  - Voluntary Enrollment
    - Enroll through NEW YORK MEDICAID CHOICE or plan
    - Automatically disenrolled from Medicare Advantage, Part D and Mainstream Medicaid Managed Care

5 Enroll in an MLTC Plan

- Timing:
  - Must enroll by noon on the 20th of month to be effective by the first of the next month. But actually must enroll with plan EARLIER. The 20th is the PLAN's deadline to submit signed enrollment form.
  - This causes delays, since must also schedule CFEEC and in-home assessments by plans to enroll.
- No lock-in!
  - Can switch plans at any time
  - But cannot return to fee-for-service Medicaid for community based long term care

NAVIGATING MLTC

What happens once you're enrolled.

Roadmap

1. **Spend-down Tips**
2. **Transition Rights** – Rights when required to enroll in MLTC after receiving other Medicaid LTC services
3. **New Member Rights** – Rights of people new to Medicaid home care enrolling in MLTC
4. **Requesting New or Increased Services**
5. **Grievances and Appeals**
   a. Internal Appeals vs. Fair Hearings
   b. Notices and "Aid Continuing" rights
   c. Requesting Hearings, Evidence Packets & Hearing Preparation basics
6. **Disenrollment** by MLTC plans
7. **New – New Nursing Home residents** must join or stay in MLTC or managed care.

MLTC BUDGETING -Spend-down Tips

- **MLTC will bill for spend-down** – and If enrollee does not pay spend-down, **MLTC may disenroll** (following written notice with appeal rights)
- **Pooled Income Trust** is important tool to eliminate or reduce spend-down
- For married couples also remember to ask DSS for **Spousal Impoverishment Budgeting.**
- People who enroll in MLTC after being in a Nursing Home or Adult home for 30 days with Medicaid paying at least one day can get spend-down reduced by **Housing Allowance**. NYS DOH 12- ADM-05, GIS 14/MA-017 See more at at http://www.wnylc.com/health/entry/212/. Apply thru DSS.

Member Rights in MLTC – Quick Summary

- Right to **medically necessary** services, including 24/7 care – same as in old DSS fee-for-service program.
- Right to **written notice** with appeal information if MLTC denies, reduces, changes, suspends, or terminate service.
  - **TRANSITION RIGHTS**: Plan must continue former services received before enrolled in MLTC for 90 days, and give notice with Aid Continuing rights if decides to reduce services after the 90 days.
- Right to Aid Continuing if Request Fair Hearing
  - For termination, suspension, or reduction of previously authorized treatment/service
  - Must provide aid-continuing even if care plan authorization period or 90-day transition expired
- NO LONGER required to "exhaust" Internal Appeal -since 7/1/2015
- Right to **request an increase in services** and appeal denial
- Right to Complain to plan about poor treatment (grievance) and to State.
- **ICAN** program available for advice and representation.

Transition Rights -- People Transitioning from Other Medicaid LTC

- Thousands of people received personal care or other Medicaid home care through their local DSS, a Lombardi program, etc. before being required to enroll in MLTC. The plan must continue the services they received previously in the same amount for 1st **90 days** of enrollment.
- This is called Transition Rights. See DOH MLTC Policy 13.10 (5/8/2013)(This increased Transition period from 60 to 90 days).
- Applies to personal care, CDPAP, certified home health care, all Lombardi program services, private duty nursing.
- Plan must give advance notice, hearing and **aid continuing** rights before reducing those services after 90 days

MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care (posted on https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

Rights of New Enrollees who did Not Previously receive Medicaid LTC

1. You are entitled to receive covered services as of first day of enrollment in plan. Contract p. 17. Article V, Sec. C.3. But how can plan start services before you are assessed?
2. Plan has done assessment BEFORE you enrolled – after the Conflict-Free assessment found you eligible for MLTC, you call a few plans and request the in-home (or nursing home) assessment. Plan may not reject prospective enrollee who was found eligible for LTC after Conflict-Free assessment.
3. Plans must do initial assessment within 30 days of first contact by an individual requesting enrollment. MLTC Model Contract, Art. V(B)(1)(B)(i)
   - Uses Uniform Assessment Tool

Rights of New Enrollees *con'd*

1. Plan must give **written plan of care** at time of pre-enrollment assessment – before you sign enrollment form. See FAQ #44 8/21/12* posted at https://www.health.ny.gov/health_care/medicaid/redesign/2012-08-21_mltc_faq.htm
2. If no plan gives you the Plan of Care you want (amount of hours, types of services), pick the best plan and then advocate for changes.
3. Services should start as soon as enrolled in plan, using the plan of care proposed at pre-enrollment visit.
4. Can you appeal that plan of care? Unclear. Best to **request increase** and then appeal if denied. More later on requesting increases.

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ASKING PLAN FOR NEW OR INCREASE IN SERVICES

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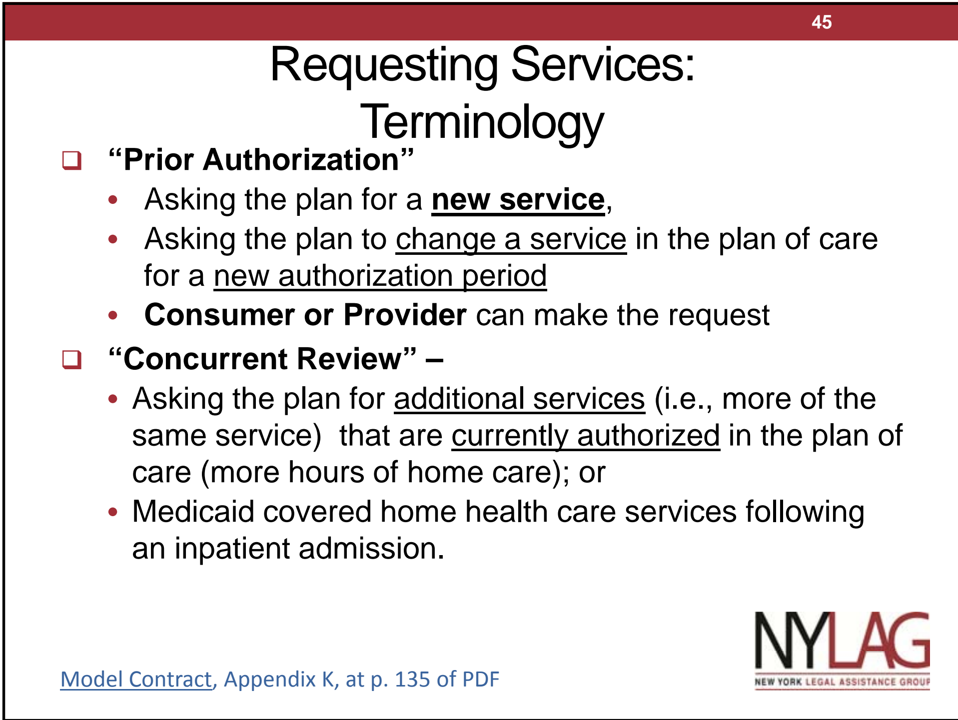

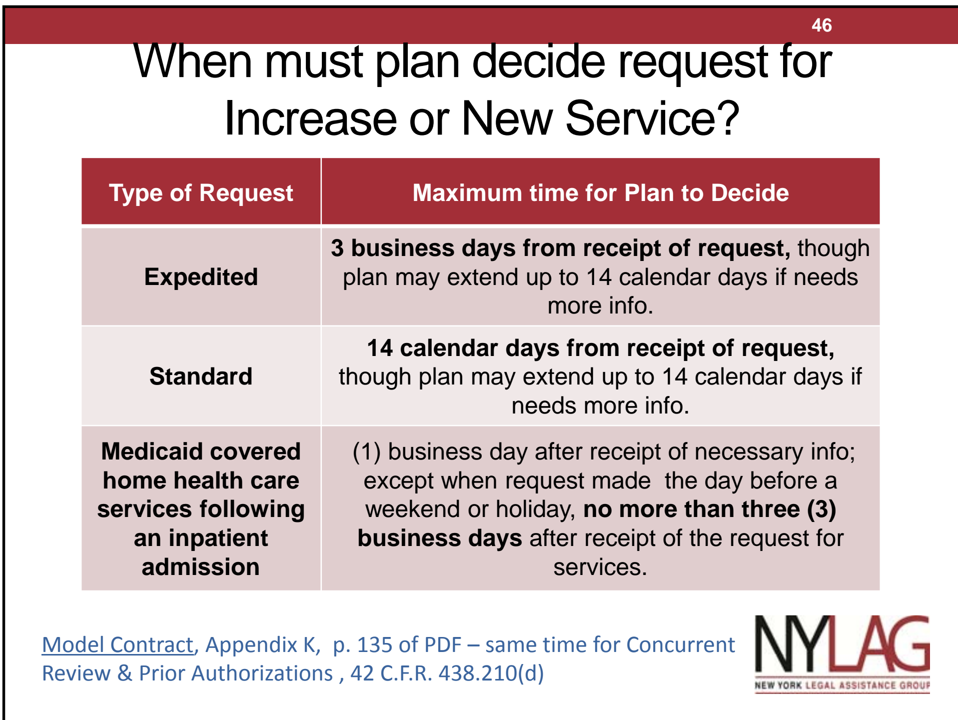

Type of Request	Maximum time for Plan to Decide
Expedited	**3 business days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Medicaid covered 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.

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.

How/ when to ask for Increased or New Services?

- **WHEN** –
  - May ask at in-home reassessment conducted every 6 months
  - 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.
  - Letter from your doctor helpful. Use detail.
  - Include request to EXPEDITE if urgent.

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).
- 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.

Advocating for more Hours – with Plan or at Fair Hearing – Medical necessity

- All managed care plans must make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a)(4)(i). The Model Contract also 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 Personal Care regulations (18 NYCRR 505.14), then should receive 24-hour care under MLTC.

24-Hour Care – Who qualifies?

- Plans sometimes apply arbitrary illegal limits, such as giving 24/hour care only if the member is bedbound.
- New state regulation redefines 24-hour care:
  - **Live-in** care if need for help during the night is **infrequent** or **can be predicted**. A live-in aide should get eight hours of sleep, including 5 consecutive hours of uninterrupted sleep. Aide must have private space – screen is OK.
  - **Continuous "split shift"** care must be given if needs "interrupted care for more than 16 hours per day and… requires total assistance with toileting, walking, transferring or feeding **at times that cannot be predicted**."

See GIS 12 MA/026 and 18 NYCRR 505.14(a).
http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma026.pdf

More on standards for authorizing PCS

Can't use "**task-based-assessment**" – a tasking tool that adds up minutes allotted for each task - when client has 24-hour needs, even if some of the care is provided by informal caregivers ("Mayer-III") 18 NYCRR 505.14(b)(5)(v)(d);

- Plans say PCS doesn't include "**safety monitoring**," but DOH policy says that time for aides to provide assistance to ensure safe performance of ADLs is part of PCS (GIS 03 MA/003)
  - Assistance may be verbal cueing, not only hands-on,
- Person who **cannot "direct" her own care**, such as someone with dementia, is eligible if family member or other can direct care; such person need not live with the consumer (92-ADM-49)
- Plans must **reinstate services after hospitalized** or in rehab – must give same amount as had before hospital/rehab (*Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996); GIS 96 MA-023

GIS messages and "ADM" directives posted at http://www.health.ny.gov/health_care/medicaid/publications/index.htm . See http://wnylc.com/health/entry/114/ & http://wnylc.com/health/entry/7/

GRIEVANCES AND APPEALS

Advocacy: Terminology

Grievance

- Complain to plan about **quality or timeliness of care** or treatment but not about amount or type of service that was approved (i.e., how the plan or its contractors are doing things) EXAMPLES:
  - Chronic lateness or no-show of aide or nurse or care manager;
  - Can't reach care coordinator or other personnel by phone;
  - Transportation delayed in taking to or from MD, day care
  - Aides not trained

Appeals

- Object to **AMOUNT or TYPE of service authorized**
  - Denial, reduction or termination of any service;
  - Failure to process or respond to request

See http://www.wnylc.com/health/entry/184/

55

APPEALS: 3 Types of appeal

1. **INTERNAL APPEALS** – Plan's own senior staff review a decision made by lower level staff
2. **FAIR HEARINGS -** a neutral third party (NYS Office of Temporary Disability Assistance) decides if the action was correct. Same state agency that hears other Medicaid & public assistance hearings.
3. **EXTERNAL APPEAL** – review of your case by health care professionals that do not work for your plan or the State. This is only available if your plan said your care was not medically necessary or was experimental. You must file an internal appeal first before requesting an external review. Call 1-800-400-8882 or see http://www.dfs.ny.gov/insurance/extapp/extappqa.htm. Fair hearing decisions always control if they come out differently than an External Review.

56

Internal Appeal or Fair Hearing?

- **RULES CHANGED July 1, 2015**
- **Before that date,** MLTC members HAD TO request an INTERNAL APPEAL before requesting a FAIR HEARING.
- **AFTER JULY 1st,** MLTC members may request a Fair Hearing without ever filing for an Internal Appeal.
  - BEWARE: If appealing a REDUCTION or TERMINATION of a service, you **MUST request a Fair Hearing** in order to get "Aid Continuing" – having your prior services continue without being reduced until the hearing is held and decided

When to Complain to NYS DOH

- MLTC members may also file a complaint with the NYS Dept. of Health and ask it to investigate – examples:
  - plan's action or failure to act causing hardship or danger
  - inadequate network of providers (upstate lack of home care aides)
  - delays in enrolling in plan – can be problems with NY Medicaid Choice or "coding" problems with LDSS/HRA
  - Client missed deadline to appeal because notices not in client's language or not in alternate format for visually impaired or obviously defective
- NEVER only file a complaint, without also requesting the appropriate appeal, grievance or hearing. Your time limit to appeal may expire.
- HOW: Call 1-866-712-7197 or e-mail mltctac@health.ny.gov

PLAN NOTICES & REDUCTIONS IN SERVICES

Best Practices for Advocacy

59

Was Written Notice of Reduction Sent?

- Ask client/family did you receive a notice?
  - If the client denies having received any notices, explore whether there are any problems with their mail
  - **If no notice, then flag this as a Defective Notice case. You can still request a Hearing even if no notice.** One of your claims is lack of proper notice.
  - Get the envelope too! The date of the postmark can be important if not mailed 10 days before effective date – it is defective and you win, or can give client Aid Continuing if she did not request hearing in time.

60

There are two Model Notices

posted at http://www.wnylc.com/health/download/579/

- Initial Adverse Determination

ZZZ Health Plan
564 First Street
New York, New York 00000

**This notice can be read to you in another language. This notice is available in other formats for special needs.
Call 1-800-555-5555 for help.**

April 1, 2014

Jane Smith
123 Main Street
New York, NY 00000

Enrollee ID: XX88888X
Health care service: request for 2 hours/day level 1 personal care, 4 days/week
Provider: Sweet Care at Home

Dear Ms. Smith:

You are getting this notice because your managed long term care plan did not approve your health care service or is changing the health care service you are getting now. This is an **initial adverse determination. You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked ZZZ Health Plan to approve the health care service described above. ZZZ Health Plan has determined that coverage for this service will be reduced. This action will take effect on 04/15/15. The plan is taking this action because the health care service is not medically necessary.

You were receiving level 1 personal care services two (2) hours per day/four (4) days per week for help with grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed on March 25, 2015. The assessment showed that your sister started living with you in March and will prepare breakfast and dinner for you. Therefore it is not medically necessary to have your aide prepare these meals for you. One (1) hour per day is enough time to complete the light housekeeping, grocery shopping and meal preparation that you need because of your arthritis condition.

- **Action Taken Notice**

LDSS-4887 (02/15) Page 1 of 3 **MANAGED LONG TERM CARE ACTION TAKEN
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)**

Notice Date: 04/01/2015	This Action will take effect on 04/15/15	Call 1-800-555-5555 for help

Case Name (c/o, if present) and Address

Jane Smith 123 Main Street New York, NY 00000	ZZZ Health Plan 564 First Street New York, NY 00000
CIN: XX88888X	Reference No.: AA999999XXX

ZZZ Health Plan has made a decision about your health care service.

On 04/15/2015 this health care service: Personal Care Level 1

- [ ] is not approved
- [ ] is partially approved
- [ ] will not be increased
- [ ] claim will not be paid. THIS IS NOT A BILL
- [XX] will be reduced
- [ ] will stop
- [ ] access will be restricted

This Action affects the health care you are getting now:

- Before this Action, from 10/15/14 to 04/14/15, the plan approved:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week = Total 208 hours
- You requested approval for:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week
- Starting 04/15/15, the plan approval <u>changes</u> to:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week, for 6 months
- This means from 04/15/15 to 10/14/15, your health care service is approved for:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week = Total 104 hours
- We will review your care again September 2015.

ZZZ Health Plan is taking this Action because:

You were receiving level 1 personal care services two (2) hours per day/four (4) days per week for help with grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed on March 25, 2015. The assessment showed that your sister started living with you in March and will prepare breakfast and dinner for you. Therefore it is not medically necessary to have your aide prepare these meals for you. One (1) hour per day is enough time to complete the light housekeeping, grocery shopping and meal preparation that you need because of your arthritis condition.

61

How to read a notice

- Here are the most important facts to look for in a notice:
  - Notice Date
    - This is the date the plan printed the notice and, hopefully, mailed it to the member (see below)
  - 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.

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

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62

How to read a notice (cont'd)

- Action[1]
  - What is the action the plan is proposing to take?
  - If the action cannot clearly be determined by a reasonable layperson, then it is a Defective Notice.
- Reason[2]
  - Whenever a plan wants to make changes in a previously authorized service, it must state the reason for the change on the notice.

(1) 42 CFR § 438.404(b)(1); 18 NYCRR § 358-2.2(a)(1).
(2) 42 CFR § 438.404(b)(2); 18 NYCRR § 358-2.2(a)(3).

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63

How to read a notice (cont'd)

- There are other things that are required to be included in a notice for it to be considered adequate.[1] For example:
  - Law and/or regulations upon which the action is based
  - Right to request a fair hearing
  - Procedure for requesting a fair hearing
  - Circumstances under which aid continuing is available
  - Right to obtain the evidence packet, and how to obtain it
  - Right to representation
  - Right to question witnesses and present evidence at the hearing
  - Liability for aid continuing
  - Availability of legal services

(1) 18 NYCRR § 358-2.2(a)(4)–(13).

64

Defective Notice

- 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.
  - Notice Date
    - If the notice date is less than 10 days before the effective date, then the notice is defective because not timely.[1]
  - Postmark Date
    - Reduction and discontinuance notices must be mailed at least 10 days before the effective date.
    - If the postmark date on the envelope is fewer than 10 days before the effective date, the notice is defective because not timely.

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

Defective Notice (cont'd)

- **Reason**
  - For reductions and discontinuances of personal care assistance, both the reason and the language used to describe it must be "appropriate." [1]
  - Plan notices have a section for the reason or rationale, but that section is often populated with conclusory language (e.g., "we have conducted a comprehensive reassessment and concluded that your needs can be adequately met with fewer hours than they were previously").
  - A notice that either gives no reason, or gives an "inappropriate" reason, would be considered a Defective Notice.

[1] 18 NYCRR § 358-2.2(a)(3) & 505.14(b)(5)(v)(c).

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Mayer v. Wing – reasons for reductions

- Mayer v. Wing was a landmark class action whose settlement provided, among other things, that the Medicaid program must provide an appropriate reason for reducing or discontinuing personal care services.
- The following slides provide the 10 reasons given as examples in the Medicaid regulations. 18 NYRR 505.14(b)(5)(c).
- Some fair hearings have held that this list is exhaustive.[1]
- Notice can't just state general ground for reduction – must state FACTS. EX: Not just "we made a mistake before" but what WAS the mistake!

(1) See Fair Hearing # 5230170H (November 10, 2010), available http://otda.ny.gov/fair%20hearing%20images/2010-11/Redacted_5230170H.pdf.

Mayer Reasons 1-5

1. the client's **medical, mental, economic or social circumstances have changed** and the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
   - NOTICE MUST STATE EXACTLY WHAT CHANGED! Did client get better?
2. a **mistake** occurred in the previous PCS authorization;
3. the client refused to cooperate with the required assessment;
4. a **technological development** renders certain services unnecessary or less time consuming
   - NOTE - may not use PERS emergency alert to reduce hours if needs aide assistance with ADLs
5. the client **can be more appropriately and cost-effectively served** through other Medicaid programs and services;
   - NOTE: MLTC plan must assess for and authorize other services, including private duty nursing, adult day care, CDPAP, etc.

(1) 18 NYCRR § 505.14(b)(5)(v)(c).

Mayer Reasons 6-10

6. the client's **health and safety** cannot be assured with the provision of personal care services;
   - NOTE health and safety need not be GUARANTEED – just reasonably expected to be maintained. Should explain what changed from past.
7. the client's medical condition is not **stable**;
   - NOTE: Client may not be eligible for PCS if condition not stable, but MLTC plan must determine if eligible for private duty nursing or CHHA services
8. the client is **not self-directing** and has no one to assume those responsibilities;
9. the services the client needs exceed the **personal care aide's scope of practice;**
   - NOTE – again, plan should assess for private duty nursing or CHHA
10. the client resides in a facility or services which are responsible for the provision of needed personal care services.
    - NOTE – with MLTC now responsible for Nursing Home Care & other LTC services, this is no longer a basis for termination

(1) 18 NYCRR § 505.14(b)(5)(v)(c).

Defective Notice (cont'd)

- Appeal Rights, Aid Continuing, Right to Representation, etc.
  - These notices are required to include a great deal of information about appeal rights, which are usually handled through several pages of boilerplate.
  - Because plans are now required to use DOH-issued model notices, it is unlikely that a notice will lack these things. But if it does, that renders the notice defective.
- **Giving NO WRITTEN NOTICE is DEFECTIVE NOTICE!**
  - You may request a hearing if you did not receive any written notice, just verbal. You should win based on lack of written notice.

Let's Make a Deal – If Member "agrees" to less services – plan must still give notice!

- When a member requests INCREASED hours of home care, or appeals the plan's proposed REDUCED hours of home care, the MLTC plan will sometimes offer a compromise to the member or her family.
- Plan must still give **written advance notice** of the change unless it has a clear written statement signed by the member that:
  - s/he no longer wants services or
  - gives information that **requires** termination or reduction of services and
  - indicates that s/he understands that this must be the result of supplying that information. 42 CFR § 431.213
- This protects client if felt pressured to agree. But plans don't comply with this!

71

Notice & Aid Continuing Required - Plan Must Reinstate PCS after Hospital stay

- If plan delays or denies request to reinstate the prior plan of care when ready for discharge home, ask plan in writing for:
  - Expedited Concurrent Review/Prior Authorization for reinstatement of personal care services.
  - Advocacy tip: Include a letter from the doctor indicating the need for services.
  - Plan should provide a written notice denying or granting services. You have right to appeal.
- Federal court held that Medicaid recipients are entitled to immediate reinstatement of their previously authorized PCS services upon discharge from a hospital stay. *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996); NYS DSS 99 OCC-LCM-2 (1999), http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/96ma023.pdf.

72

GET AID CONTINUING

The Right to Continue the Previous Amount of Services Unchanged until the Hearing is Held and Decided

Reduction CANNOT go into Effect

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Time is of the essence!

- The effect**ive date** of a reduction or discontinuance is the most important date.
- This is the deadline by which the member must request a fair hearing in order to get **aid continuing**.
- The **notice must be mailed 10 days before the "effective date" of the reduction**. But this includes mailing time and weekends! So in practice, there may be just a few weekdays to request a hearing.
- If the effective date has already passed, see if member has **postmarked envelope** the notice was mailed in. If postmark is later than the date of the notice, then it is not too late to request a hearing and get Aid Continuing.

Warning about internal appeals

- After July 1, 2015, you may request a Fair Hearing right away, without first requesting an Internal Appeal.
- However, the Notices will still tell member they have the **right** to request an Internal Appeal.
- **If plan is REDUCING care** - member will only get AID CONTINUING if she requests a FAIR HEARING before the EFFECTIVE DATE of the notice. She will NOT get Aid Continuing if first requesting an Internal Appeal.
  - Once she requests the hearing, she can request an internal appeal and see if she wins that while hearing is pending. If she does, she can withdraw the hearing request.
- **If plan is DENYING an increase** – then there is no aid continuing anyway. No harm in requesting internal appeal except some delay. Can't hurt to get 2 bites of the apple.

Expedited Internal Appeals / Grievances

- If you are requesting an increase in hours or new services, so you are not entitled to Aid Continuing, you might try requesting an Expedited Internal Appeal. The plan must decide an expedited appeal within **3 days** instead of **30 days**. Plan must agree that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function; or
- The plan may deny a request for an expedited review – best practice is to have doctor explain in writing jeopardy to health or ability to function without services.

42 CFR § 438.410;
Model Contract, Appendix K, ¶¶ (1)(A) & (B)
[pp.103, 106 of PDF]

Aid Continuing Required Even if "Authorization Period" Expired

- MLTC plans authorize services for periods of up to six months. They must do a reassessment at least every six months. What if the MLTC plan decides, at the reassessment, to reduce the number of hours below the number previously authorized?
- Before April 1, 2014, the plan had to give notice of the reduction, and the right to appeal. But Aid Continuing was required only if the original "authorization period" for the service had not expired.
- After April 1, 2014, under a change in state law enacted in the 2014-15 budget, Aid Continuing must be provided while the hearing is pending even if the authorization period expired.

42 CFR 438.420; NY Soc. Serv. L. 365-a(8); N.Y. Dep't of Health, MLTC Policy 14.05 (August 6, 2014) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_authorization.pdf

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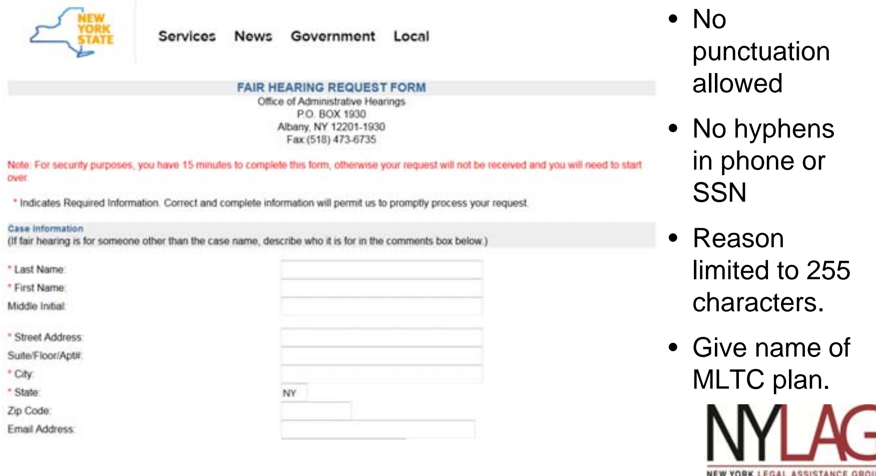
Example of Authorization Period Issue

- Jan. 1 – June 30th - Tracy was authorized to receive 12 hours x 7 days PCS.
- June 20th -- the plan did a reassessment and sent Tracy a Notice of Reduction that would reduce services to 6 hours x 5 days **effective July 1st.**
- June 25th - Tracy requests a Fair Hearing before the effective Date of July 1st, so entitled to Aid Continuing.
- Under the OLD RULE, Tracy would get Aid Continuing initially, keeping 12x7 but **it would be reduced on July 1st,** after the old authorization lapsed, even though the hearing was still pending.
- Under the NEW RULE, Tracy gets Aid Continuing that continues until the hearing is held and decided.

Requesting a fair hearing

- Website shows 3 ways to request – phone 1-800-342-3334, fax, or online http://otda.ny.gov/hearings/request/ . That link has a form you can fax. Attach copy of notice if you have it.



NEW YORK STATE

Services News Government Local

FAIR HEARING REQUEST FORM
Office of Administrative Hearings
P.O. BOX 1930
Albany, NY 12201-1930
Fax (518) 473-6735

Note: For security purposes, you have 15 minutes to complete this form, otherwise your request will not be received and you will need to start over.

* Indicates Required Information. Correct and complete information will permit us to promptly process your request.

Case Information
(If fair hearing is for someone other than the case name, describe who it is for in the comments box below.)

* Last Name:
* First Name:
Middle Initial:

* Street Address:
Suite/Floor/Apt#:
* City:
* State: NY
Zip Code:
Email Address:

- No punctuation allowed
- No hyphens in phone or SSN
- Reason limited to 255 characters.
- Give name of MLTC plan.

79

Save/print confirmation of online request

FAIR HEARING REQUEST - CONFIRMATION PAGE
Office of Administrative Hearings
P.O. BOX 1930
Albany, NY 12201-1930
(877) 209-1134

Print this page for your records

Once the fair hearing request is processed, you will receive notification (OAH-4420 Acknowledgement of Fair Hearing Request) via US mail.

Fair Hearing Record - 6/9/2015 4:53:55 PM	
Appellant Information	
Name:	
Street Address:	
Suite/Floor/Apt#:	
City, State, Zip:	
Phone:	
Email:	
DOB:	

- Date/timestamp is key for establishing entitlement to aid continuing
- Print this to a PDF file (with appropriate software) and/or print a hard copy for your file

80

Aid continuing (ATC) disputes

- If you have requested ATC but the date of your FH request is after the effective date, OTDA may not grant ATC, or they may call you.
- Be ready to argue why ATC still required (e.g., plan delay in mailing notice per postmark, no notice given, etc.)
- If OTDA orders ATC but plan does not provide, contact ICAN or call OTDA.
  - OTDA 1-800-342-3334
  - For New York City emergency Fair Hearings ONLY: 1-800-205-0110

Get signed releases

- NYS OCA 960 HIPAA Release – use for MLTC plan, doctors and other health providers
  - 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
- MAP-751D
  - This is the HIPAA authorization used by NYC HRA. You will need this to talk to HRA about any Medicaid-related issues. Download at http://www.wnylc.com/health/download/63/
- 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.

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).

REQUEST EVIDENCE PACKET

Documents in Client's File with Plan Used in Assessment.

18 N.Y.C.R.R. § 358-3.7(b)(1), (2); 18 N.Y.C.R.R. § 358-4.3(b)

What is the evidence packet?

- The documents that the plan intends to submit at the Fair Hearing in support of its decision
- The member (and his/her rep) is entitled to a copy of the evidence packet **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.

85

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.

86

Requesting Evidence Packet (con’d)

- 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.
- If you request packet on the phone, confirm your request in writing so you can show Judge at hearing, in case plan does not provide the documents requested.

87

Documents to Obtain Outside of Plan

- 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
- Medical records – hospital, clinic – may be helpful
- Work with treating physician to write statement describing client's needs.

88

What if plan wants to settle appeal?

1. If hearing is about a threatened reduction of services, you want plan to WITHDRAW threatened action. This must be **in writing**. If they withdraw the reduction in writing, you can withdraw the hearing request - http://otda.ny.gov/hearings/cancel/
2. If the hearing is about a denial of an INCREASE, if plan agrees to full amount requested **in writing**, for a reasonable authorization period (ie not just for a month), you can withdraw the hearing request. If they offer a compromise, member can decide whether to accept or to go to the hearing.

DISENROLLMENT FROM MLTC

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When MLTC Plan MUST Disenroll You

Involuntary Disenrollment -- plan **must** disenroll you if:

1. you no longer reside in the plan's service area
2. you have been absent from the service area for more than 30+ consecutive days (beware of travel!)
3. you are hospitalized or enter an OMH, OPWDD or OASAS residential program for 45+ consecutive days;
4. you clinically require nursing home care but are not eligible under the Medicaid institutional rules (you transferred assets);
5. You are incarcerated;
6. You no longer need community-based LTC.

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91

When MAY MLTC Plan Disenroll Me? #1 – Enrollee Behavior

The plan MAY disenroll you if –

1. An Enrollee or her family member or other person in the home engages in behavior that seriously impairs MLTC's ability to furnish services.
   1. Plan must document reasonable efforts to resolve the problem.
   2. MLTC plan may not request disenrollment because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs. 42 CFR 438.56(b).

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92

When MAY MLTC Plan Disenroll Me? #2 Spend-down, etc.

2. **SPEND-DOWN –** MLTC plan may disenroll member for not paying Spend-down**.**
   - **TIP: Use a Pooled Income Trust!** See materials from other presentation by Empire Justice Center.
   - See http://www.wnylc.com/health/entry/44/
3. An Enrollee knowingly fails to complete and submit any necessary consent or release.
4. Enrollee gives false information or deceives plan.

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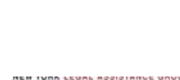
93

Disenrollment when Medicaid not "Renewed"

- If Medicaid eligibility is discontinued –most commonly for a problem in annual Medicaid renewal process, member is AUTOMATICALLY disenrolled from plan – and home care stops! Some plans continue services even without payment while renewal glitch is resolved. But others don't!
- **TIP**: Ask if client received Notice of Discontinuance for failure to submit renewal from DSS/HRA. IF no notice received, or notice is defective or still timely, request **fair hearing** against local **DSS/HRA** for discontinuance of Medicaid without proper notice (if that's the case).
  - Client may learn of discontinuance from plan or home care agency, but the hearing is against DSS/HRA action terminating Medicaid.
- Hearing request can also be against MLTC since they are supposed to "assist enrollees with renewal of their Medicaid benefits". Contract p. 28. Article V. I.1.(h)



94

Your rights if plan disenrolls you

- Plan cannot unilaterally disenroll you.
- An involuntary disenrollment requires approval by the entity designated by the Department, which is New York Medicaid Choice (Maximus). The MLTC plan must transmit information about the disenrollment request to NY Medicaid Choice, which reviews the request.
- if Maximus agrees, it sends the member Notice of disenrollment with right to request **fair hearing** and **aid continuing.** 42 CFR 438.56 (e)(1)." (Article V Section D.3. of Model Contract).

Can Member Disenroll?

- Since MLTC is mandatory statewide for adult Dual Eligibles who need LTC, with few exceptions, member cannot disenroll and switch to regular PCS or CDPAP. Can still switch to NHTDW or TBI waivers (but not for long! Those are being folded into MLTC in 2016).
- But.. Member can switch to a different plan effective the 1st of the next month.
- It can be tempting to switch plans rather than go through a difficult appeal. But – make sure you ask a new plan come assess you, and give you a written plan of care BEFORE you switch. No point changing if care plan not better.

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NURSING HOME CARE "CARVED IN" TO MLTC AND MAINSTREAM MANAGED CARE - 2015

New Permanent nursing home residents are required to enroll in an MLTC or Mainstream MMC plan

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97

Another “Medicaid Redesign Team” initiative

- Another step in NYS’ move to expand Managed Care for all Medicaid services and populations.
- MRT 1458 – State policies posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm - scroll down to near last section:

February 1, 2015 (*) Population Transition – Nursing Home ("New" Duals and Non-Duals) (FIDA Region Adults) (NYC, Nassau, Suffolk & Westchester)

- Link to DOH Webinars on transition (July 2015 - – most recent webinar & Powerpoint)
- http://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-07-29_nh_transition.pdf
- DOH Policy on Transition of NH Population to Managed Care (Feb 2015), http://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf
- FAQs Jan , Mar & June 2015 - all on same MRT 1458 page

98

Nursing Homes and Managed Care

- Big Changes Starting **STATEWIDE** in 2015 for NEW permanent residents in nursing homes --
  - Dual Eligibles -- will be required to stay enrolled in – or stay in -- an MLTC plan when they need permanent nursing home care; and
  - People with Medicaid only – not Medicare- will be required to enroll in or stay in a “mainstream” Medicaid managed care plan if they need long-term nursing home care
- WHEN
  - February 2015 – NYC
  - April 1, 2015 - Long Island, Westchester
  - July 1, 2015 – Rest of State

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99

Until now – nursing home was "fee for service" – not through managed care

1. MLTC ***was*** mandatory only for duals who need ***home care***
   - Once an MLTC member needed NH placement, she would typically "voluntarily disenroll," even though NH is in MLTC benefit package
     - Would disenroll if didn't like choice of nursing homes in MLTC plan's network, and receive nursing home FFS.
2. Mainstream Medicaid managed care (MMC) – for those with Medicaid only and not Medicare –
   - Before, members *were disenrolled* from the plans if they were in a nursing home for more than 60 days. NH was paid "fee for service."

- **Now, all adult Medicaid recipients – when they become *permanent* nursing home residents -- will be required to enroll in or stay in a managed care plan** (MLTC for duals, MMC for Medicaid-onlies).

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100

Current NH Residents Grandfathered in!

- NO ONE WILL BE FORCED TO MOVE - **Permanent NH residents** are grandfathered in – **No one is required to enroll in a plan if they were in a nursing home and approved for institutional Medicaid BEFORE**:
  - Feb. 1, 2015, and in NYC
  - April 1, 2015 - Long Island, Westchester
  - July 1 , 2015 (rest of state)
  - But – after six months, "voluntary enrollment" begins for these NH residents, when they MAY enroll in MLTC plans.
  - Caution: Various Medicare Advantage plans – not FIDA – are marketing to enroll residents. May happen in FIDA too.
  - In NYC/L.I./Westchester, almost all companies with MLTC plans will also have a FIDA plans and want to increase market share.

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When must new NH residents enroll in a managed care plan?

- Depends on whether they enter NH before or after start date in their region:
  - If went into nursing home before Feb. 1, 2015 – NYC)(July 1 – statewide) - NOT required to enroll in any plan. They are "grandfathered in."
  - Enter a NH after Feb. 1, 2015 (NYC) or after July 1st statewide – then it depends on if they were or were not already in an MLTC or mainstream MMC plan at the time of NH placement (see more on this later)
- **Merely going into NH for short-term rehab does not require enrollment in any plan.** Must enroll when it's a permanent placement, which is still unclear.
  - We thought it was only after Institutional Medicaid is approved (with the 5-year lookback), but
  - Now it seems that NH is required to file a "DOH-3559" with local DSS for change of status to long-term care – within 48 hours of decision to make it "permanent placement." That could be within days of admission.
  - Either way, resident would first receive notice from NY Medicaid Choice or LDSS giving **60 days to select and enroll in a plan**. If doesn't enroll, would be assigned to a plan that contracts with that NH.

Process for new nursing home admissions

- **Consumers NOT already enrolled in MLTC/MMC**
  - Select and enter any **nursing home of their choice**
  - When Medicare coverage ends, must apply for **Institutional Medicaid** (Includes 5-year look-back and transfer penalties)
  - They will receive **notice giving 60 days to pick a plan** (pick one that includes their nursing home in the network)
  - If don't pick a plan, will be **auto-assigned** to a plan that has that NH in network (MLTC for duals, MMC for non-duals)
  - Do not have to enroll until receive 60 day notice from NY Medicaid Choice
- **Possible advocacy**: If expect to return home, then appeal NYMC notice to select plan – because not a permanent placement. (untried)

Process for new nursing home admissions (cont'd)

Consumers already enrolled in mainstream Medicaid Managed Care (MMC) plan (do not have Medicare)

- **Must enter a NH in that plan's NETWORK** or Medicaid will not pay for it
- MMC plan no longer will disenroll someone because they need long term nursing home placement. Plan must pay for NH.
- Plans should assess members who are NH residents for possible discharge home and provide home care services on discharge.

MLTC: Transition from hospital to NH

Where Already Enrolled in MLTC plan --

- Rehab stays where Medicare pays primary – choice of NH is *not* limited to MLTC plan's network. MLTC plan must pay Medicare coinsurance out-of-network too. **DOH Q&A Aug. 16, 2012*** - Question 42 on page 7. (also see Mar. 2015 Q&A #26) – MRT 1458 webpage.
- **Once Medicare ends, if NH is out of network,** MLTC plan should pay for reasonable period to allow individual to change to MLTC plan that has NH in network, effective the 1st of the next month. DOH policy is not clear on this. How will member know they need to change plans? That the NH is not in their MLTC plan's network?
- Upon discharge from NH, MLTC provides home care services
  - Might have Medicare episode of CHHA arranged by MLTC, supplemented with Medicaid MLTC hours
- No LOCK-IN – In both MLTC & MMC, may change in

*http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_faq2_final.pdf

105

Minimum Network Size = # NHs required

	# of NHs	Network minimum
Manhattan	16	5
Brooklyn	42	8
Queens	55	8
Bronx, Suffolk	43	8
Staten Island	10	5
Nassau	35	8
Monroe, Erie	43	8
Westchester	38	8
Oneida, Dutchess, Onondaga, Albany		4
Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster		3
All other counties		2 unless only 1 exists
Specialty NHs (AIDS/ vent/ behavior)		2 unless fewer exist
Veteran's - must contract with 1 in area, if any. If none, plan must pay for member to go out of network while changes plans to one with VA NH.		

106

What Is ICAN?

- ICAN is the Independent Consumer Advocacy Network
- Network includes a toll free helpline **1-844-614-8800** ican@cssny.org
- Educates and advocates for people who want or get Medicaid long-term care through managed care plans - MLTC & "mainstream" managed care
- Funded by a NYS Department of Health grant

- **ICAN services are free, confidential and independent from all health insurance companies**

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Contact numbers & Other Info

- **New York Medicaid Choice** (Enrollment Broker)
  - **To request a Conflict-Free Assessment 1-855-222-8350**
  - **For information about MLTC 1-888-401-6582**
  - **FIDA** – for information or to OPT OUT **1-855-600-3432**
  - Website http://nymedicaidchoice.com/
  - http://www.nymedicaidchoice.com/program-materials - Scroll down to *Long Term Care plans*
- **NYS Dept. of Health MLTC/FIDA Complaint Hotline 1-866-712-7197** mltctac@health.ny.gov
- **NYS DOH Mainstream managed care complaint hotline 1-800-206-8125** managedcarecomplaint@health.state.ny.us
- **ICAN - Consumer MLTC/FIDA Ombudsprogram – 1-844-614-8800** **http://icannys.org** **ican@cssny.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/
- **NYLAG EFLRP** 1-212-613-7310 eflrp@nylag.org

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Evelyn Frank Legal Resources Program

Medicaid Home Care

Services Provided by Managed Care and Managed Long-Term Care in NYS

Updated Oct. 7, 2015

NY Health access

NYHealthAccess.org is a joint venture of Selfhelp, Empire Justice Center, the Legal Aid Society, and Western New York Law Center. Visit **http://nyhealthaccess.org** for up-to-date articles on Medicaid, SNTs, home care, and other public health insurance topics.

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Table of Contents

Overview 5
What is home care? 5
Types of Home Care Services 6
Medicaid Programs Providing Community-Based Care 8

Managed Long-Term Care (MLTC)......................................11
Fully capitated plans – PACE, MAP and FIDA 11
Partially Capitated – Managed Long Term Care Plans (MLTC) 17
Who Must Enroll in MLTC? 18
Exemptions and Exclusions..18
Mandatory Enrollment into MLTC of People Previously Receiving other Home Care Services 20
Obtaining MLTC for People Who Did Not Previously Receive Medicaid Home Care Services 22
Special Financial Budgeting Protections in MLTC (Housing Disregard, Spousal Impoverishment Protections 24
Requests to MLTC Plan for New or Increased Services.....................31
Nursing Homes and MLTC..33

PART II -- Definitions and Criteria for Particular Services Provided by Managed Care Plans and/or Fee For Service in NYS

INTRO TO PART II. Managed Care Plans Must Comply with Apply Definition of Scope of "State Plan" services....................................35

Personal Care Assistance (PCA) 37
Law & Regs 37
How Services Accessed 37
Eligibility Requirements...38
How to Apply and How Are Needs Assessed? 40
Assessment Procedure where MLTC not Mandatory in County or not mandatory for Individual..40
Standards for Assessment – How Much Care is Client Entitled to? 45
Reductions in Personal Care Services – Mayer v Wing 54

Consumer Directed Personal Assistance Program (CDPAP) 57
CDPAP and Managed Long Term Care 57
CDPAP aides may perform "skilled" medical or nursing tasks 58
Select Your Own Aide 59
To Apply For CDPAP..60

Certified Home Health Agency (CHHA) 61
Medicare Criteria 61

How To Obtain CHHA Services 63
Medicaid Pending and CHHAs...63
Appeal Rights Of CHHA Recipients 64

Private Duty Nursing 73

How To Apply 73
Appeal Rights 74
Nursing Payment Rates 74

Home and Community-Based Services (HCBS) Waiver Programs 77

Waiver Programs in New York State...77
Financial Eligibility for HCBS Waiver Programs 81
Hearing Rights in LTHHCP 82
Complaint Process in Waivers 82

Appeals.. 83

Notice..83
Time Limits To Request Hearing and Aid Continuing 85
How To Request A Hearing 86
Phone Or Home Hearings 87
Right To Obtain Case Record 89
Other Evidence To Submit At Hearing 90
Relief Granted In Hearing 92

Glossary... 97

Table of Figures

Figure 1: Community-Based Long-Term Care Services... Error! Bookmark not defined.

Figure 2 Medicaid Programs Providing Community-Based Care .... Error! Bookmark not defined.

Figure 3: Matrix of Services and Programs 9

Overview

In its Medicaid program,[1] New York has opted to include extensive coverage for a variety of community-based long-term care services.[2] New York has long tried to reverse the trend of putting people in nursing homes who could remain in their own homes and communities given the proper supports. Although private Long-Term Care Insurance (LTCI) policies are available, most people do not consider these until they are too ill to qualify, and could not afford the premiums anyway. As a result, New York's Medicaid program serves not only as health insurance for the poor, but also as the primary coverage for the long-term care services that allow people with disabilities, particularly those of advanced age, to remain in their own homes.

What is home care?

This publication does not encompass every type of community-based long-term care service available in New York. Instead, we will focus on home care services, which is itself a broad term. Generally, **home care** can be defined as assistance of another person to perform activities of daily living. **Activities of daily living (ADLs)** are the routine tasks people perform every day in caring for and using their bodies. Examples include bathing, dressing, grooming, walking, transferring, and toileting. Home care also encompasses **Instrumental Activities of Daily Living (IADLs)**, which include house-cleaning, grocery shopping, paying the bills, and doing laundry. Assistance with ADLs and IADLs is sometimes referred to as **custodial care**, because it does not require medical expertise. Some health care services, such as skilled nursing, physical therapy, occupational therapy, and speech therapy, may also be provided in the home. Home care services can be provided by family members, friends, certified paraprofessionals, or uncertified aides ("gray market aides"), though Medicaid programs restrict who may qualify as an aide.

This outline does not discuss Managed Long Term care or "mainstream" Managed Care generally. Rather, it describes those home care services under the New York State Medicaid plan that are part of the benefit package for MLTC and mainstream plans.

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1 Social Security Act tit. 19, 42 U.S.C. § 1396 *et seq.* (2013).

2 UNITED HOSPITAL FUND, AN OVERVIEW OF MEDICAID LONG-TERM CARE PROGRAMS IN NEW YORK iii (2009), *at* http://www.uhfnyc.org/publications/880507.

Types of Home Care Services

There are a few different types of home care services, as defined by the scope of tasks with which the home care worker may assist. In addition, different training and certifications are required of the paraprofessionals who provide those different services. Confusingly, the same service may be provided through many different programs. Thus, it is important to distinguish the type of **service** from the **program** through which that service is provided.

The following is a rough break-down of some of the myriad community-based services (home care and others) available through New York's Medicaid program.

Which Programs?

On the next chart, the column labeled "WHICH PROGRAMS" gives the acronyms for which programs the service is available through. Individuals may be required to use one of the listed programs, as follows:

- **Individuals with Medicaid but not Medicare** – With few exceptions, most throughout NYS are now required to join a "mainstream" Medicaid **managed care plan [MMC**]. NY S.S.L. 364-j, 18 NYCRR 360-10. If so, one must access these long-term care services, along with most primary and acute medical care through the MMC plan:
  - Personal care, including Level I and Level II
  - Consumer-Directed Personal Assistance (CDPAP)
  - Home health aide care & other Certified Home Health Agency services (visiting nurse, visiting physical/occupational therapist)
  - Private Duty Nursing

- **Adults over age 21 with both Medicare and Medicaid (Dual Eligibles)** – In all counties as of mid-2015, with just a few exceptions, all community-based long term care services including home care must be accessed through a **Managed Long Term Care (MLTC)** plan, or at their option a **PACE or Medicaid Advantage Plus (MAP)** plan. The latter two types of plans cover and control not only Medicaid long term care services but all of their Medicare primary and acute medical services as well. In 2015 the new **FIDA** option is added in the Demo area – NYC, Long Island and Westchester.
- Individuals of any age who are not in a mainstream Medicaid Managed Care plan (MMC) access most services on the following chart on a **Fee For Service** basis. Depending on the service, may be through the Local Dept. of Social Services (LDSS)(PCA, CDPAP), through the State Dept. of Health(private duty nursing), or directly through the provider (adult day care, CHHA). Very few people remain in the fee for service system.

Figure 1: Community-Based Long-Term Care Services

Service	Acronym	Which Programs?	Description
Home Care			
Personal Care[1] (formerly known as "home attendant" in NYC)	PCA or PCS	MMC MLTC/FIDA PACE/MAP FFS	Assistance with ambulation, toileting, transferring, personal hygiene, dressing and feeding and nutritional and environmental support functions. Includes both ADLs and IADLs. Sometimes referred to as Level 2 from 18 NYCRR 505.14(a). May be up to 24/hours/day "continuous" care.
Housekeeping	HSK	MMC MLTC/FIDA PACE/MAP FFS	Technically a subset of PCA services, sometimes referred to as Level 1 from 18 NYCRR 505.14(a). Limited to assistance with IADLs: shopping, light housecleaning, laundry, meal preparation. STATE LAW recently limited t 8 hours/week.
Home Health Aide[2] & other Certified Home Health services	HHA	CHHA (FFS) MMC MLTC/FIDA PACE/MAP MA	Home health aide services include all personal care and housekeeping tasks (see above), plus certain additional semi-skilled tasks. Certified Home Health Agencies (CHHAs) provide HHA along with visiting nurse on a part-time or intermittent basis; physical therapy, occupational therapy, or speech pathology and audiology.
Consumer Directed Personal Assistance Program[3]	CDPAP	MMC MLTC/FIDA PACE/MAP FFS	Assistance with personal care services, home health aide services and *skilled* nursing tasks by an adult selected, trained, and supervised by the consumer or his/her designated representative. May be a relative other than a spouse, and parent may not be aide for a child or any age.
Private Duty Nursing[4]		MMC MLTC/FIDA PACE/MAP MA FFS	Service of a registered professional nurse (RN) or licensed practical nurse (LPN) in the home when needs more than part-time or intermittent nursing services available through a CHHA and when the patient is in need of individual and continuous nursing care.
Home and Community Support Services[5]	HCSS	TBI NHTD/FIDA	The same as PCA, but also includes oversight and supervision ("safety monitoring") to prevent an individual from harmful activities.
Other Than Home Care			
Adult Day Health Care, aka Medical Model Adult Day Care[6]	ADHC	MLTC/FIDA PACE/MAP FFS	Health care services and activities provided at a hospital or nursing home, to people who are functionally impaired but who are neither residents of a facility nor homebound.
Social Adult Day Care[7]	SADC	MLTC, PACE, FIDA	Structured program providing functionally impaired persons socialization, supervision, monitoring, personal care, & nutrition in protective setting less than 24 hours/day
Assisted Living Program[8]	ALP	FFS	Adult care facility providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services.

Which Programs: MMC = Mainstream Medicaid Managed Care
MLTC = Managed Long-Term Care (partially-capitated)
PACE = Program of All-inclusive Care for the Elderly
MAP = Medicaid Advantage Plus
MA = Medicaid Advantage
FFS = Fee For Service Medicaid (may require Prior Approval)
FIDA = Fully Integrated Dual Advantage

Medicaid Programs Providing Community-Based Care

Many of the above listed services can be accessed through a variety of different programs offered under New York's Medicaid program. Some are "§1915 waiver programs," meaning that the State had to obtain waivers of certain requirements of the Federal Medicaid statute in order to target certain populations.[9] Others are "§1115 demonstration projects" allowing the State to require certain populations to receive their Medicaid services through private managed care plans.[10]

Program	Acronym	Type	Agency	Description
Long Term Home Health Care Program, aka Lombardi[11]	LTHHCP	1915	DOH	Invalid, infirm or disabled persons who are medically eligible for placement for an extended period of time in a hospital or nursing home. MOST programs for adults discontinued with MLTC in 2013-2014.
Traumatic Brain Injury waiver[12]	TBI	1915	DOH	Persons age 18 and over who have experienced a traumatic brain injury and who require nursing facility level of care.
Nursing Home Transition and Diversion waiver[13]	NHTD	1915	DOH	Persons age 18 and over who require nursing home level of care and wish either to transition from a nursing home to the community, or to remain in the community.
Office for People With Developmental Disabilities waiver[14]	OPWDD	1915	OPWDD DOH	Adults and children who are developmentally disabled and who require Intermediate Care Facility level of care.
Care At Home I & II waiver	CAH	1915	DOH	Children <18 who are physically disabled and who have had 30-day inpatient stay but ineligible for Medicaid due to parental income and resources.
Care At Home III-VI waiver	CAH	1915	OPWDD DOH	Children <18 who are developmentally disabled, have complex health care needs, and require Intermediate Care Facility level of care but ineligible for Medicaid due to parental income and resources.
Waiver for Children and Adolescents with Serious Emotional Disturbance	OMH	1915	OMH DOH	Children and adolescents who are seriously emotionally disturbed and who require psychiatric-hospital level of care.
Bridges To Health	B2H	1915	OCFS DOH	Children in foster care, including after leaving foster care up to age 21, with Serious Emotional Disturbances, Developmental Disabilities, or who are Medically Fragile.
Managed Long-Term Care	MLTC	1115	DOH	An entity approved by DOH to provide, or arrange for, health and long term care services, on a capitated basis for a population age 18 and over.
Mainstream Medicaid Managed Care[15]	MMC	1115	DOH	
Medicaid Advantage	MA	1115	DOH CMS	
Medicaid Advantage Plus & FIDA	MAP/FIDA	1115	DOH CMS	

Agency: DOH = N.Y. State Department of Health
OPWDD = N.Y. State Office for People with Developmental Disabilities
OMH = N.Y. State Office of Mental Health
OCFS = N.Y. State Office of Children and Family Services
CMS = Federal Centers for Medicare and Medicaid Services

Figure 2: Matrix of Services and Programs

Service → / Program ↓	PCA	HHA	CDPAP	Private Duty Nurs-ing	HCSS	Other HCBS	ADHC	Social-Model Adult Day	ALP
Fee-For-Service	*	*	*	*			*		●
Managed Care									
MMC	●	●	●	●					
MLTC	●	●	●	●			●	●	
MAP	●	●	●	●			●	●	
PACE	●	●	●	●			●	●	
MA		●		●					
FIDA	●	●	●	●	●	●	●	●	●
Waivers									
LTHHCP (Lombardi)	●	●		●	●	●	†	●	
TBI	†	†	†	†	●	●	†		
OPWDD	†	†	†	†		●	†		
NHTD	†	†	†	†	●	●	†	●	
CAH I-VI	†	†	†	†		●			
OMH	†	†	†	†		●			
B2H	†	†	†	†		●			

* These services may still be accessed under fee-for-service Medicaid only for a small subset of individuals who are exempt from managed care.

† Participants in this program may access this service via fee-for-service Medicaid (i.e., it is “carved out”).

Managed Long-Term Care (MLTC)

Managed Long-Term Care (MLTC)

These are programs that use new financing mechanisms, using "managed care" concepts of "capitating" payment to an insurance plan that then contracts with providers of home care and some other medical services.[16] A fixed monthly amount is paid to the managed care plan, with the expectation that the plan will save money on clients who need few services, and spend more on high-need individuals. This is known as spreading the risk.

New York has had managed long term care plans for many years. Before, however, enrollment was voluntary, and MLTC was just one option of several types of Medicaid home care one could choose. On Sept. 4, 2012, the federal government Medicaid agency CMS approved the state's request for an "1115 waiver"[17] that allows NYS to require that all *dually eligible* (those who have Medicare and Medicaid) adults age 21+ now receiving -- or who will apply for -- community-based long-term care services -- particularly personal care/home attendant services, long-term Certified Home Health Agency services, Consumer-Directed Personal Assistance program services (CDPAP), private duty nursing and medical adult day care -- to enroll in a Managed Long-Term Care (MLTC) plan. The MLTC plan now controls access to, approve, and pay for all Medicaid home care services and other long-term care services in the MLTC service package. This is the only way to obtain these services for adults who are dually eligible, unless they are exempt or excluded from MLTC.

If they do not choose a MLTC plan then they will be auto-assigned to a plan. The requirement to enroll in an MLTC plan was rolled out gradually throughout the State, starting in NYC in Sept. 2012, then in Long Island and Westchester in January 2013, and then to other counties, with the last becoming mandatory in summer 2015. The status of implementation and all policy guidance is posted in the MRT 90 webpage at https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm.

There are two models of MLTC – the fully capitated PACE, Medicaid Advantage Plus, and FIDA programs and partially capitated managed long term care (MLTC) plans.

Fully capitated plans – PACE, MAP and FIDA

In a fully capitated plan, the member essentially gives up her Medicare and Medicaid cards and agrees to use one insurance plan for all Medicare and Medicaid services. All services must be in the plan's network. The plan is

responsible for not only long term care but also primary and acute and emergency medical care.

Program for All-Inclusive Care for the Elderly (PACE)

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis).

PACE members are required to use PACE physicians & providers (they cannot go "out of plan") and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member. Most participants are dually eligible for Medicare and Medicaid, with a small number in only one or the other.

Some social and environmental services not normally reimbursed by Medicaid and Medicare may be included.

Enrollees must attend medical adult day care, supplemented by other services. NYS has the highest PACE enrollment of any state.

Lists of PACE plans:
http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm (official DOH list); http://www.wnylc.com/health/afile/114/371/ (Compiled by NYLAG). To see current enrollment by county and plan, see http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

Also see http://www.nymedicaidchoice.com/program-materials - Scroll down to *Long Term Care plans*

Spousal impoverishment protections apply.[18]

Medicaid Advantage Plus (MAP)

Like PACE, fully capitated. Unlike PACE, this is more of a pure insurance model, not based on any particular provider network. The individual joins a "Medicare Advantage Plan" and then joins the connected Medicaid Advantage Plus plan operated by the same company, thus combining both Medicare and Medicaid services.

Lists of plans – same lists as above for PACE. Model MAP contract posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm.

Fully Integrated Dual Advantage (FIDA)

FIDA is one of the demonstration programs initiated by one of the provisions of the Afforable Care Act, which established a new as Medicare-Medicaid Coordination Office (MMCO), which is housed in the CMS Center for Medicare & Medicaid Innovation (CMMI). This office was charged with more effectively integrating benefits under Medicare and Medicaid, and promoting better coordination between the Federal and State governments. One of the main vehicles through which the MMCO has advanced this mission is the Financial Alignment Initiative, whereby MMCO partners with State Medicaid programs to create demonstration projects to experiment with combining the Medicare and Medicaid programs into a single integrated benefit for dual eligibles. The Integrated Care Resource Center webpage includes all state proposals, statistical research and other information.

Seventeen states, including New York, have obtained Federal approval to create "duals demonstration projects," or "duals demos." New York's duals demo is also a product of the Medicaid Redesign Team (MRT), a State-based health reform initiative with similar goals to the ACA, but specifically for New York's enormous Medicaid program. FIDA is MRT #101 - to develop initiatives to integrate and manage care for eligible duals - with all documents posted at this link. New York has opted for a capitated model, meaning that the Medicare and Medicaid benefits will be integrated within the coverage of a private managed care plan. The demonstration project and the plans participating in it are called **Fully Integrated Dual Advantage (FIDA)**.

Click here for official NYS FIDA demo information.

FIDA starts with Medicare Advantage

The starting point for FIDA is Medicare Advantage, a type of private managed care plan available to Medicare recipients. Medicare Advantage is an optional way for older adults and people with disabilities to receive their Medicare health insurance. Instead of going to any doctor they want using their red, white & blue "Original Medicare" card, and having the Federal government pay the doctor directly, Medicare Advantage participants must generally limit themselves to providers in their plan's network. These plans must cover all of the same medical care and services that are covered under Original Medicare, but they may require prior approval for some services and they may charge different amounts of cost-sharing. The Federal government pays the Medicare Advantage plan a fixed monthly amount for each member, regardless of how costly their medical care is. Then the plan pays its participating medical providers fee-for-service. This system provides financial incentives for the Medicare Advantage plan to find more cost-effective ways of caring for its members.

All FIDA plans are also Medicare Advantage plans. The basic structure of how they work and the rights of members are based on Medicare Advantage.

Under Federal law, Medicare recipients must have freedom of choice as to whether to enroll in a Medicare Advantage plan or stay with Original Medicare. Thus, a Medicare recipient can never be forced to enroll in any type of managed care plan that includes Medicare benefits.

However, the Medicaid program does not contain such a right. Thus, Medicaid recipients (i.e., the poor) have long been required to enroll in private managed care plans in order to get State-funded Medicaid coverage. These are known as "mainstream" Medicaid managed care plans. However, until recently, dual eligibles were exempt from Medicaid managed care as well. Therefore, dual eligibles are one of the last groups in the country who have never been required to enroll in managed care.

A FIDA plan is like a Medicare Advantage plan combined with an MLTC plan. The FIDA benefit package includes everything covered by Medicare, plus everything covered by Medicaid (including long-term care). Thus, FIDA plans are considered "fully-capitated." Beginning in February 2015, New York statel started enrolling MLTC participants in NYC and Nassau County into FIDA plans offered by the same company as their MLTC plan.

FIDA members must receive all Medicare and Medicaid services through their FIDA plan. FIDA participants must only go to providers in their plan's network (as with Medicare Advantage). And the FIDA plan is responsible for both authorizing any medically necessary care, and coordinating among its members various providers.

COMPARE: Medicaid Advantage and Medicaid Advantage Plus vs. FIDA

FIDA plans are not totally new. Even up til now, Dual Eligibles have had an option of enrolling in a single plan that combines all of their Medicare and Medicaid services in one managed care plans. These are called **MEDICAID ADVANTAGE** Plans (as opposed to MEDICARE Advantage plans) and PACE plans. The name is misleading because these plans cover MEDICARE as well as MEDICAID services.

TO make it more confusing, only some MEDICAID ADVANTAGE plans include Medicaid personal care and other long term care services. These are called **MEDICAID ADVANTAGE PLUS** Plans. PACE plans also cover Medicaid long term care services as well as all Medicare services.

People in Medicaid Advantage Plus plans, but NOT PACE plans, in the Demo area, will be subject to FIDA passive enrollment.

Click here for a chart showing which of these many types of plans are offered by each insurance company in NYS, posted at http://www.wnylc.com/health/download/429. This chart shows plans in the FIDA demonstration area.

On August 26, 2013, CMS approved a "Memorandum of Understanding" (MOU) between NYS and DOH to launch this demonstration program. The demonstration is scheduled for three years – Jan 2015 through Dec. 2017. In September 2015 New York requested CMS to approve a three-year extension, an option CMS gave all of the state demonstrations. This is pending as of this writing.

Where is FIDA Demo Area?

FIDA is a demonstration solely covering downstate areas. New York City and Nassau County started in January 2015. Expansion to include Westchester and Suffolk counties was scheduled to follow in mid-2015 but has been delayed and is now scheduled for early 2016.

Who is eligible for FIDA?

To enroll in FIDA, either voluntarily or passively, you must be:

- Age 21 or older; and
- Entitled to Medicare Part A and enrolled in Parts B and D; and
- Receiving full Medicaid benefits; and
- Reside in: NYC, Nassau, Suffolk or Westchester; and either:
  - be enrolled or eligible to enroll in a Managed Long Term Care plan OR a Medicaid Advantage Plus plan because you need long term care for more than 120 days, OR be
  - Newly permanently residing in a nursing home; or
  - Are eligible for the Nursing Home Transition and Diversion Waiver (NHTD).

People excluded from FIDA include people in the OPWDD and TBI waivers, those who are receiving hospice services or who live in Medicaid Assisted Living Program.

What is "Passive Enrollment" and the enrollment process?

Unlike MLTC, enrollment in a FIDA plan is not "mandatory." MLTC members may choose to stay in an MLTC plan and use their Original Medicare or Medicare Advantage cards for their primary medical care.

However, FIDA uses a "passive enrollment" process with the right to "opt-out." FIDA is rolling out with different schedules in two regions.

All MLTC enrollees in a county that is slated for "passive enrollment" receive a series of notices from the State Dept. of Health and its contractor, Maximus, known as New York Medicaid Choice. There is a 90-day, 60-day and 30-day notice. These notices explain FIDA and give the opportunity to either select a FIDA plan and enroll, or to OPT OUT of FIDA by calling New York Medicaid Choice. If they do not opt out, or select their own plan by a deadline 90 days after their first enrollment notice, they will be "passively enrolled" into a FIDA plan selected for them by NY Medicaid Choice. The enrollment will be into the FIDA plan operated by the same company that operates the individual's MLTC plan. This selection of an affiliated plan is intended to preserve the client's home care providers, which likely contract with both a company's MLTC and FIDA plans. However, the client's preferred doctors and other providers may well not contract with the FIDA plan. After an initial 90-day Transition Period, the FIDA plan – and Medicare --will not pay for doctors who are not in the FIDA plan's network.

TO OPT OUT - CALL **1-855-600-FIDA (1-800-855-3432**) Monday to Friday 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm.

TTY: 1-888-329-1541

FIDA Features and Member Rights

- Right to change plans or disenroll from FIDA any time, effective the first of the next month.

- Continuity of care / Transition Period– Plan must approve out-of-network providers and prescription drugs that are not on the plan's formulary for the first 90 days of enrollment. However this is only for providers and prescriptions member recently used (last six months).

- Integrated Appeal Process – Appeals are not through the regular state Medicaid hearing process. There is a new procedure that integrates appeals for Medicaid and Medicare services, except for prescription drugs which continue to use the Part D appeals procedure.

- No deductibles, premiums or copayments

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYProviderFAQ.pdf

Partially Capitated – Managed Long Term Care Plans (MLTC)

"Managed long-term care" plans are the most familiar and have the most people enrolled – 128,000 in NYS as of August 2015. They provide Medicaid long-term care services (like home health, adult day care, and nursing home care) and ancillary and ambulatory services (including dentistry, optometry, audiology, podiatry, eyeglasses, and durable medical equipment and supplies), and receive *Medicaid payment only*, with NO Medicare coverage.

These plans DO NOT cover most primary and acute medical care. Members continue to use their original Medicare cards or Medicare Advantage plan, and regular Medicaid card for primary care, inpatient hospital care, and other services. The MLTC plan does not control or provide any Medicare services, and does not control or provide most primary MEDICAID care. Managed long-term care plan enrollees must be at least age 18, but some require a minimum age of 21. See state's chart with age limits. http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm. Regional lists of plans are posted at http://Nymedicaidchoice.com – on home page click on bottom on Brochures & lists. Click on Long Term Care plans in your region.

Partially capitated MLTC plans are now mandatory for adults age 21+ who need Medicaid home care and other community-based long-term care services. But consumers have the option of enrolling in "fully capitated" plans as well -- so it's important to know the differences.

The following services are included in capitation[19] – clients must use all IN-NETWORK providers affiliated with plan. WARNING: Medicaid will not pay for these services if provider is not in plan or referral not obtained.

- **Home Care**, including:
    - Personal Care (Home attendant or Housekeeping)
    - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
    - Private Duty Nursing
    - Consumer Directed Personal Assistance Program
- **Adult Day Health Care** (**medical model and social adult day care**)
- Personal Emergency Response System (**PERS**),
- **Nutrition** -- Home-delivered meals or congregate meals
- Home modifications
- **Medical equipment** such as wheelchairs, medical supplies such as incontinent pads, prostheses, orthotics, respiratory therapy

- **Physical, speech, and occupational therapy** outside the home
- **Hearing Aids and Eyeglasses**
- Four Medical Specialties:
  - **Podiatry**
  - **Audiology** + hearing aides and batteries
  - **Dental**
  - **Optometry** + eyeglasses
- Non-emergency **medical transportation** to doctor offices, clinics (ambulette)
- **Nursing home** care

Who Must Enroll in MLTC?

Medicaid recipients who:

- Are dually eligible - they have Medicare AND Medicaid, AND
- Are age 21 or older, AND
- Need or receive community-based long-term care services for over 120 days in a calendar year:
  - Personal care (but not if only housekeeping)
  - CDPAP
  - Home health aide
  - Private duty nursing
  - Adult day health care (medical model)
  - Long Term Home Health Care Program (Lombardi waiver)
- And is not "exempt" or "excluded" from enrolling in an MLTC plan.

Phased In Enrollment -

- Mandatory enrollment began in New York City in 9/2012 – and gradually rolled out until all counties in the state were mandatory by August 2015.

Exemptions and Exclusions

Who is EXCLUDED from MLTC?

- Individuals in certain HCBS waiver programs. These include: Nursing Home Transition & Diversion waiver, Traumatic Brain Injury waiver – but planned to be phased into MLTC January 2017.

- People in Office for People with Developmental Disabilities waiver, and individuals with complex mental health needs receiving services through ICF and HCBS waiver.

- Medicaid Assisted Living Program residents – But scheduled to be phased in 2016;

- Persons receiving **hospice** services (they may still apply to CASA/DSS for persona care services to supplement hospice);[20]

- Residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Alcohol & Substance Abuse Long Term Care Residental Program, adult Foster Care Home, or psychiatric facilities.

- Children under age 18

Existing MLTC members requiring hospice care are no longer required to disenroll from their plan to access hospice care.

SOURCE: CMS Special Terms & Conditions, Amended Sept. 2012), pp 14 -15. http://www.health.ny.gov/health_care/medicaid/redesign/docs/partnership_amendment_stc.pdf

Who may enroll in MLTC but is not required to? (Who is exempt?)

- Native Americans;

- Dual eligible individuals age 18- 21 who require home care or other long-term care services, and require a "nursing home level of care," meaning they could be admitted to a nursing home based on their medical and functional condition;

- Adults over age 21 who have Medicaid but not Medicare (If they require a "nursing home level of care") -- However, they are likely required to enroll in a mainstream Medicaid managed care plan anyway - unless they qualify for VERY narrow exceptions, and those plans now control personal care, so enrollment in MLTC may be a preferable option. They *may enroll* in MLTC as an alternative to mainstream Medicaid managed care if they would be functionally eligible for nursing home care AND if they need services not available from their mainstream plan – social adult day care, home modifications, or home-delivered meals or congregational meals. MLTC Policy 14.01: Transfers from Medicaid Managed Care to Managed Long Term Care (posted on https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

- Working Medicaid recipients under age 65 in the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program (If they require a "nursing home level of care").

SOURCE: CMS Special Terms & Conditions, Amended Sept. 2012), at p. 14

Mandatory Enrollment into MLTC of People Previously Receiving other Home Care Services

Current recipients of PCA, CDPAP, CHHA, and Adult Day Care in Mandatory counties still rolling out receive a series of letters by mail giving them 60 days to select an MLTC plan on their own, or they will be automatically assigned to an MLTC plan. **See**
MANDATORY ENROLLMENT PACKET - Sent by a company under contract with the State to serve as enrollment broker, called MAXIMUS or NY Medicaid Choice. 60- day notices stating recipient has 60 days to select a plan OR will be assigned to an MLTC plan. See form Letter -- http://wnylc.com/health/download/318/ It also includes the toll-free number of the enrollment broker, NY Medicaid Choice, for consumers to call with questions about MLTC and help picking a plan..: **888-401-6582**. Packet also includes Managed Long Term Care Brochure -- Official Guide to Managed Long Term Care, written and published by NY Medicaid Choice (Maximus). Download here - . http://www.nymedicaidchoice.com/program-materials and List of plans in County, organized by type (MLTC/PACE, MAP). Download lists for each mandatory county here (look under Long Term Care Plans. http://www.nymedicaidchoice.com/program-materials

CHOOSING & ENROLLING IN A PLAN -
See TOOLS FOR CHOOSING AN MLTC PLAN. http://www.wnylc.com/health/entry/169/

For people transitioning from another Medicaid home care service, if they don't select and enroll in a plan, midway through the 60-day period to select a plan, you will receive a letter with the name of the MLTC plan to which you will be randomly assigned if you do not select a plan. You will still have til the third Friday of that month to select his/her own plan.

ONCE you select a plan, you can enroll either directly with the Plan, by signing their enrollment form, OR if you are selecting an MLTC Partially Capitated plan, you can enroll with NY Medicaid Choice. If you are selecting a Medicaid Advantage Plus (MAP) or PACE plan, you must enroll directly with the plan.

WHEN IS MY ENROLLMENT IN AN MLTC PLAN EFFECTIVE?

Enrollment in MLTC, MAP and PACE plans is always effective on the 1st of the month. The plan is paid its "capitation" rate or premium on a monthly basis, so enrollment is effective on the 1st of the month.

If you enrolled late in the month (after the third Friday of the month), the enrollment will not be effective -- and the new plan will not take charge of your care -- until the first of the *second* month after you enroll.

Transition Period

MLTC plan must provide the same services and the same number of hours as CASA/DSS/CHHA had authorized for 90 days (it was previously only approved for 60 days). The CMS Special Terms & Conditions at Par. 28(d), amended.[21]

- By Day 30, the plan must assess the new members needs in her home. CMS Special Terms & Conditions 9/2012 sec. 17(d)(ii)(1)(c)(p. 19).[22] The plan's nurse will decide how much care the plan will approve for after the 90-day transition period.
- **NOTICE OF A REDUCTION IN SERVICES AFTER TRANSITION PERIOD** If the plan wants to reduce or end the services you previously received from CASA/DSS, CHHA, Adult Day Care, or CDPAP< the plan must give a WRITTEN NOTICE stating the amount of home care and other services they will give you effective on Day 91 of your enrollment. The notice will explain your right to appeal.
- On Feb. 6, 2013 DOH issued MLTC Policy 13.01 REVISED: Transition of Care for Fee for Services Participants in Mandatory Counties posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.01_revised.pdf/

This directive requires MLTC plans to continue previously authorized long-term care services unchanged for 60 (later increased to 90) days when a consumer initially transfers into MLTC plans. This is called the Transition Period, required in the CMS Special Terms and Conditions p. 17 par. 28(d) cited above. These directives remind plans of their obligation to provide notice before reducing services at the end of the 90-day transition period. They must continue services unchanged during the internal appeal and until a hearing is decided, known as "Aid Continuing," when a member appeals the plan's proposed reduction e or terminate a service.

The directive states, "This means that, for any individual receiving fee for service Medicaid community based long term services and supports and enrolling under any circumstance, the plan must provide 60 [now 90] days of continuity of care. Further, if there is an appeal or fair hearing as a result of

any proposed Plan reduction, suspension, denial or termination of previously authorized services, the Plan must comply with the aid to continue requirement identified above. In particular, if the enrollee requests a State fair hearing to review a Plan adverse determination, aid-to-continue is to be provided until the fair hearing decision is issued."

The revised directive of Feb. 6th clarifies that the requirement to continue past services unchanged for the first 60 days of MLTC enrollment applies to these services:

- Personal care (home attendant and housekeeping in NYC)
- Consumer-Directed personal assistance (CDPAP)
- Home Health (CHHA) services
- Adult Day health Care
- Private Duty Nursing

See this article re Appeals and Grievances in Managed Long Term Care -- http://www.wnylc.com/health/entry/184/ - for more information on your right to appeal.

Note that you must first request an Internal Appeal within the plan, and then, if you lose, you will receive a notice from the plan explaining you have the right to request a Fair Hearing.

Obtaining MLTC for People Who Did Not Previously Receive Medicaid Home Care Services

Adult dual eligible must first apply for Medicaid at their local DSS. They must demonstrate financial eligibility for income and assets. No lookback is required, other than three months prior to the application if retroactive coverage is desired.

Conflict-Free Eligibility & Enrollment Center Assessment (CFEEC)

Under MLTC Policy 14.06: Implementation of the Conflict-Free Evaluation and Enrollment Center (CFEEC), anyone who is seeking Managed Long Term Care will need to first contact NEW YORK MEDICAID CHOICE (Maximus) and request a CFEEC assessment. The assessment is supposed to be scheduled within seven days, but advocates are seeing delays. If the assessment finds the person eligible for MLTC, then the person can enroll in an MLTC plan. To schedule an evaluation, call

1-855-222-8350. SEE NEW YORK MEDICAID CHOICE WEBSITE ON CFEEC - http://nymedicaidchoice.com/ask/conflict-free-evaluation-and-enrollment-center

See NYLAG's Guide and Explanation on the CFEEC and MLTC Evaluation Process . http://www.wnylc.com/health/download/573/.

This is being implemented pursuant to #28 of the Special Terms and Conditions, which is CMS's approval of the State's 1115 waiver to implement mandatory MLTC, DOH has established a conflict-free assessment system for all voluntary enrollments into MLTC, MAP and PACE effective October 1, 2014.
http://www.health.ny.gov/health_care/managed_care/appextension/docs/2014-07-07_waiver_authority_stcs.pdf

Before, private MLTC plans were responsible for determining eligibility for Medicaid-covered long-term services and supports (LTSS). This creates an intrinsic conflict of interest, because plans have a financial stake in avoiding high-cost members and attracting low-cost members. The CFEEC reduces this conflict by having New York Medicaid Choice (aka Maximus), rather than the MLTC plans, determine eligibility for MLTC.

The Conflict-Free Evaluation and Enrollment Center (CFEEC) schedules and conducts initial assessment visits in the home or facility by a nurse (employed by or under contract with the CFEEC). Using the Uniform Assessment Tool, the CFEEC makes the determination of eligibility for Medicaid LTSS. If the CFEEC determines that the applicant is ineligible for Medicaid LTSS, it will send a written notice with appeal rights. If the CFEEC approves the applicant, then any MLTC, MAP, PACE or FIDA plan must accept the applicant's enrollment. If the plan disagrees with the CFEEC's determination of eligibility, it may pursue a dispute adjudication procedure via Maximus and DOH.

The assessment may be scheduled before Medicaid eligibility has been approved, but the CFEEC determination is only good for 60 days. Since a Medicaid application may be delayed, it must be timed carefully and you may have to repeat the CFEEC.

All guidance on CFEEC – Q& A etc posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm.

Special Financial Budgeting Protections in MLTC

MLTC Housing Disregard

MLTC Policy 13.02: MLTC Housing Disregard --
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.02.pdf -- A policy issued January 24, 2013, but effective October 15, 2012, creates a special income standard to help pay for housing expenses is available for certain nursing home residents who are Medicaid eligible recipients and can safely transition back to the community. To be eligible for this special income standard, the nursing home resident must:

- be age 18+,
- must have been in a nursing home for 30 days or more,
- must have had Medicaid pay toward the nursing home care, and
- must NEWLY enroll in a Managed Long Term Care (MLTC) plan (presumably new since 10/15/2012)
- must have a housing expense

See **NYS DOH 12- ADM-05** - Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program

See Chart on Next Page

Housing Allowance for MLTC Members who were Discharged from Nursing Home or Adult Home

Region	Counties	Deduction (2015)
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$382
Long Island	Nassau, Suffolk	$1,147
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1,001
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$440
North Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$791
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$388
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$336

2015 rates listed above have not been officially published in Department of Health guidance documents, but have been updated in WMS**.** The most recent guidance on how the standardized amount of the disregard is calculated is found in **NYS DOH 12- ADM-05**

2014 rates listed in NYS Dept. of Health GIS 14/MA-017 (Aug. 5, 2014)

Spousal Impoverishment Protections

Since 1998, a spouse of a nursing home resident on Medicaid is allowed to keep a reasonable level of income and resources to live on, while still permitting Medicaid payment for the nursing home resident's care. Congress enacted the "spousal impoverishment protections" in 1988 in response to stories of elderly “community” spouses -- mostly women -- whose husbands were in nursing homes. Medicaid required all of the husband's income to be paid to contribute to the cost of care. Some were practically starving. Others sought divorces in order to escape the crushing financial burden. An important sidelight of this legislation was that it permitted states to budget couples on home-and-community-based services (HCBS) "waiver" programs under these same income and asset rules, giving these couples a much-needed financial cushion.

Expansion of Spousal Impoverishment Protections to MLTC in 2014

Since the 1980's, spouses of New Yorkers receiving services through the **Lombardi** long term home health care program and other waivers were entitled to spousal impoverishment protections. When the Lombardi program was phased out between 2012 -2014, and all of its members were required to join **Managed Long Term Care** plans, the State agreed to give spousal impoverishment protections not just to married persons transitioning to MLTC from Lombardi, but to ALL married couples where one spouse receives MLTC services.

The expansion of spousal impoverishment protections to all couples where one spouse was enrolled in an MLTC plan was in part required by part of the Affordable Care Act called the PPACA, which, effective January 1, 2014, required all States to expand spousal impoverishment protections for all married couples with a spouse receiving Managed Long Term Care (MLTC) or other Home-and-Community-Based Services under a waiver --**Traumatic Brain Injury (TBI), Nursing Home Transition and Diversion (NHTD), and OPWDD** waivers. Click here for the exact language of the ACA -PPACE law on spousal impoverishment. Section 2404.

What are the Spousal Impoverishment Protections for INCOME?

The spouse receiving the MLTC or other waiver services may deduct from his/her income these allowances and deductions:

1. **SPOUSE -**an amount to bring his or her spouse's income up to the "Minimum Monthly Maintenance Needs Allowance" (MMMNA). In 2015, this is **$2,980.50**. The allowance provided to non-applying spouse is called a "community spouse monthly income allowance" (CSMIA). The CSMIA is calculated by subtracting the non-applying spouse's own income and the monthly cost of his/her health insurance premiums from the MMMNA.

2. **Family member allowance** (FMA), if applicable, is an allowance of $664 per dependent family member up to a maximum of $1992 (2015). This is for minor children, dependent children of any age, or dependent parents (defined as having over 50% of their needs met by either spouse)

3. **Personal needs allowance** (PNA) for the waiver participant - This is $384 in 2015 (the difference between the regular Medicaid level for ONE PERSON and TWO PERSON households).

4. **Health insurance premium** - may deduct the cost of his/her own Medigap and other insurance premiums.

The remainder after taking all of these deductions is the MLTC/waiver recipient's spend-down.

EXAMPLE: MLTC Spouse Sam Gross Income = $2,264.50
Community Spouse Chris Gross Income = $1500.00
Both have Medigap policies that cost $200/month each.

LTC Spouse Sam's Gross income		$2,264.50
-- Sam’s Personal Needs Allowance **PNA**		--$384.00
-- Sam's Medigap Medigap policy Premium		-- $200.00
Minimum Monthly Maintenance Needs Allowance **MMMNA**	$2,980.50	
-- Community Spouse Chris' Own Income	-$1,500.00	
-- Community Spouse Monthly Income Allowance **CSMIA**	$1,480.50	--$1,480.50
-- Chris' Own Medigap Medigap policy Premium		-- $200.00
Sam's Net Income = Spend-down		$0

What are the Spousal Impoverishment Protections for ASSETS or RESOURCES?

The MLTC spouse may keep $14,850 in his/her own name (2015).

PLUS the Community Spouse may have up to the greater of $74,820 (2014-15) or one-half of the couple's total combined assets up to $115,920 (2014-15). This total includes the Community Spouse's own resources in his/her own name, plus any of the MLTC Spouse's own resources that exceed $14,850, plus any of their joint resources. The MLTC applicant spouse must actually transfer his/her own individual and their joint resources that exceed the individual resource limit ($14,850 in 2015) to the Community Spouse.

PLUS both spouses may have a burial fund, pre-paid funeral agreement, and an IRA or other retirement funds, provided that distributions are being taken, even if they are under age 70.5. The balance is deemed available to MLTC spouse for cost of care. Rules are in NYS DOH MRG Resources Chapter at pp. 331 -335.

Do These Spousal Impoverishment Income and Resource levels Apply when an individual applies for Medicaid and is seeking to enroll in MLTC?

NO. For people first applying for Medicaid in order to get MLTC, unfortunately, state policy requires the local Medicaid program to first determine eligibility using regular Community Medicaid rules for income and assets, without the spousal protections. The spousal impoverishment protections are only used "post-eligibility." This means that initially, an applicant may have a large spend-down, even though he will not have a spend-down once he enrolls in an MLTC plan and requests spousal impoverishment budgeting. On the initial Medicaid application, here are some tips for navigating the spend-down.

- **Community Spouse not applying for MLTC may consider submitting a "Spousal Refusal."** This means his or her income and assets will not be counted for the MLTC applicant's eligibility. Beware that the county has the right to sue a "refusing spouse" for support - to recover the Medicaid funds paid for services when the refusing spouse refused. However, if the MLTC applicant immediately enrolls in an MLTC plan and requests rebudgeting with spousal protections, there would be no Medicaid expenses for the county to recover in a support suit. Download the Spousal Refusal form used in NYC   http://www.wnylc.com/health/download/66/ . Other counties may have their own forms, or this form can be adapted.
    - A spousal refusal can be used for the spouse's income and assets/resources. At the time of application, the MLTC applicant spouse's countable resources must be brought down to the individual Medicaid asset level ($14,850 in 2015). Any excess resources must be transferred to the community spouse during the month prior to the application.
- **If the MLTC applicant has a spend-down or "excess income"** just counting his or her own income, even with the community spouse doing a "spousal refusal," be sure to **make clear that the Medicaid applicant is seeking to enroll in MLTC and ask for eligibility CODE 06.** This should ensure that the application for Medicaid is not DENIED because they have not "met" the spend-down, by incurring medical bills equal to the spend-down. Medicaid applicants who would have a spend-down must request **CODE 06** so that an MLTC plan will see in the eligibility system that they are eligible. See *NYS DOH GIS 2014 MA/10 -- 06 to 30 Conversion for MLTC Enrollees.* *(May 5, 2014)* Otherwise, their Medicaid coverage does not

become effective until they submit medical bills that meet the spend-down. See http://www.wnylc.com/health/entry/46/ and on the State's website at http://nyhealth.gov/health_care/medicaid/excess_income.htm . Many people applying for Medicaid to pay for long-term care services can't activate their Medicaid coverage until they actually begin receiving the services, because they don't have enough other medical bills that meet their spend-down. This creates a catch-22, because they cannot start receiving MLTC services until Medicaid is activated. Until their Medicaid is activated, the Medicaid computer is coded to show they are not eligible. As a result, an MLTC plan could refuse to enroll them -- because they do not have active Medicaid. Eligibility CODE 06 gives them "Provisional Medicaid" eligibility so that an MLTC plan sees they have Medicaid and will enroll them. See **Medicaid Alert dated July 12, 2012.** At http://www.wnylc.com/health/download/329/.

- In New York City and some other counties, MLTC plans are required to fax HRA a "conversion form and package" to activate Medicaid when the consumer has a spend-down. Download Conversion cover sheet here.- FORM HCSP-3022 Despite extensive education by HRA, many plans still fail to do this.
    - HRA FAQ - procedures for MLTC plans to enroll members who have a spend-down.
    - In May 2014, this new GIS explains that as long as CODE 06 was used on the application, the code will automatically change to CODE 30 full eligibility when the MLTC plan enrolls the individual. So.. no "conversion" form should be necessary.
- **AFTER the Medicaid application is accepted and the individual has enrolled in an MLTC plan, request rebudgeting with Spousal Protections.** You or the Plan can use the new "Request for Assessment" form to request spousal budgeting (page 9 of this link) at http://www.health.ny.gov/health_care/medicaid/program/update/2014/mar14_mu.pdf

In NYC, submit the form or a letter requested spousal impoverishment budgeting to:

HRA--HCSP Central Medicaid Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238 T: 929-221-0849

What if the Spousal Impoverishment Protections Don't Help? May a Married MLTC Recipient Still Use a Pooled Trust to Eliminate His/Her Spend-down?

The State Dept. of Health has changed the answer to this question several times in the last few years. Currently, since a new directive issued November 3, 2014, the answer is YES. A married person may CHOOSE to use EITHER Spousal Impoverishment budgeting OR regular Community Budgeting, which allows a pooled trust. The most recent directive is **GIS 14 MA/025 -** Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act (PDF), dated Nov. 3, 2014. It states, "Spousal impoverishment budgeting with post-eligibility rules is **not mandated** for married individuals receiving home and community-based services (HCBS) pursuant to a waiver under Section 1915(c) of the Social Security Act or through enrollment in a managed long term care (MLTC) plan..."

This directive was the result of advocacy by the NYS Bar Association Elder Law Section. The new directive rescinds an earlier **NYS DOH GIS 14 MA/015,** issued August 5, 2014, and reinstates two even earlier directives, Pending further clarification from the federal CMS, "districts are to resume applying the policy provided in GIS 12 MA/013**,** "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program" and NYS DOH GIS 13 MA/018, "Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care." These GIS messages provide for spousal impoverishment budgeting with post-eligibility rules only when it is *more advantageous* to the applicant.

These spousal impoverishment protections are generally -- but not always -- favorable. The August 2014 directive **NYS DOH GIS 14 MA/015** that is now rescinded had required use of the spousal impoverishment protections even when they were unfavorable. Spousal protections can be *unfavorable* if the individual still has a high spend-down even after the spousal impoverishment allowances are allocated. Such an individual would normally want to use a supplemental needs trust in order to reduce his or her spend-down. But under the State's interpretation from August 2014, these married individuals were not allowed to use a supplemental needs trust. The State's view was that the spousal impoverishment protections are used in "post-eligibility budgeting" which is the same budgeting used in nursing homes. Just as one cannot reduce one's NAMI in a nursing home by depositing excess income into a pooled trust, the State's view was that married individuals in an MLTC plan cannot reduce their spend-down by using a pooled trust. ("NAMI" is Net Available Monthly Income - the name for "spenddown" for people in nursing homes on Medicaid).

Suffolk County was the only county, to our knowledge, that had already rebudgeted married MLTC recipients. Couples with combined gross income exceeding about $3300/ month were impacted. If the MLTC recipient was using a pooled trust, Suffolk DSS had told them they were no longer allowed to use the trust and budgeted them with a high spend-down that must be paid to the MLTC plan. All of these individuals should now be rebudgeted and allowed to use the pooled trusts.

The new directive reinstates two previous GIS directives -- NYS DOH GIS 13 MA/018 and GIS 12 MA/013 to the extent that they gave married individuals receiving MLTC or other HCBS waiver services an OPTION of choosing NOT to use the spousal impoverishment protections, if it was more favorable for the couple not to use them. It could be more favorable NOT to use the protections if a married MLTC recipient instead used a pooled trust to eliminate his or her Medicaid spend-down. Even if s/he would otherwise have a very high spend-down, by using a pooled trust, she qualifies for Medicaid and MLTC without any spend-down. Even though the spousal impoverishment protections may reduce the spend-down, they may not eliminate it altogether if the individual's or spouse's income is high enough.

Example of optional budgeting to use when spousal protections are NOT favorable. If the EXAMPLE above was changed so that community spouse Chris' income was not $1500 but was $3000? Then Chris would not be entitled to any Community Spouse Monthly Income Allowance (CSMIA) because Chris' own income would be equal to or more than the Minimum Monthly Maintenance Needs Allowance (MMNA). In that case, the MLTC Spouse Sam would have the option of using community budgeting based just on his own income as follows. Community Spouse Chris' Income Does Not Count.

Requests to MLTC Plan for New or Increased Services

If I need new services, or request an increase in services from the MLTC plan, when does the plan need to decide my request?

Both federal regulations at 42 CFR 438.210 and the NYS DOH Model Contract for MLTC Plans[23] (Appendix K - section 3. "Service Authorizations) dictate the deadlines for the plan to give you a decision when you request new services or an increase in existing services, such as home care.

The contract uses these terms to explain these requests:

A **Prior Authorization** is a request by the Enrollee or provider on Enrollee's behalf for a **new service** (whether for a new authorization period or within an existing authorization period) **or a request to change a service** as determined in the plan of care for a new authorization period.

A **Concurrent Review i**s a request by an Enrollee or provider on Enrollee's behalf for **additional services (i.e., more of the same) that are currently authorized** in the plan of care **or for Medicaid covered home health care services following an inpatient admission.**

EXPEDITED REQUEST -- In either of the above two types of requests, the member or provider may request that it be **expedited** - 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. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

DEADLINES FOR PLAN TO PROCESS -- Contract and 42 CFR 438.210 provide that Plan must decide and notify Enrollee of decision by phone and in writing as fast as the Enrollee's condition requires but no more than:

a. **Prior authorization**

- **Expedited** - 3 business days from request for service, subject to extension described below.
- **Standard** – within 3 business days of receipt of necessary information, but no more than 14 calendar days of receipt of request for services, subject to extension described below.

b. **Concurrent review**

- **Expedited** – within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services, subject to extension described below.
- **Standard** – within 1 business day of receipt of necessary information, but no more than 14 calendar days of receipt of request for services, subject to extension described below.
- In a request for Medicaid covered **home health care services following an inpatient admission**, one (1) business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the request for services.

EXTENSION OF ABOVE DEADLINES including Expedited Requests -- Up to 14 calendar day extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

- The plan must give the enrollee **written notice of the reason for the decision to extend the timeframe** and inform the enrollee of the **right to file a grievance** if he or she disagrees with that decision; and Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c).

If the plan does not issue a decision on a request for services within the timeframes specified in § 438.210(d) described 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). See article on Appeal & Grievances in MLTC

Nursing Homes and MLTC

Adults age 21+ newly becoming permanent nursing home residents in NYC after February 1, 2015 are required to enroll in managed care plans starting in Feb. 2015 in NYC, in Long Island and Westchester in April 2015. Upstate mandatory enrollment began in July 2015 on a rolling basis. The State has issued a series of FAQs and policy guidance describing these changes, which are constantly evolving. These are posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm. Scroll all the way down to the last section, titled "**February 1, 2015 (*) Population Transition – Nursing Home ("New" Duals and Non-Duals).**"

Also see NYS DOH 15ADM-01 - Transition of Long Term Nursing Home Benefit into Medicaid Managed Care.

The type of managed care plan in which the individual must enroll depends on whether or not they receive Medicare.

Those with Medicare (dual eligibles) will have to enroll in a Managed Long Term Care (MLTC) plan, unless otherwise exempt.

Those without Medicare will have to enroll in a "mainstream" Medicaid managed care plan.

Current nursing home residents are "grandfathered in" - do not have to enroll in managed care plans. Anyone already in a nursing home before Feb. 1, 2015 (and later outside of the NYC metro area) will not have to enroll in a managed care plan, and will continue to have Medicaid pay for their nursing home care on a "fee for service" basis. The State says that no one already in a nursing home should have to change nursing homes because the nursing home is not in the plan's network.

Those who are already enrolled in an MLTC or mainstream Medicaid managed care plan in the community, who come to need long-term nursing home placement after Feb. 1, 2015 (if in NYC, or April 1, 2015 in Long Island and Westchester) or in other areas when they become mandatory, will no longer be disenrolled from the plan when they need nursing home care. They will need to choose a nursing home within the plan's network (or may sometimes change plans) and the plan will still manage their care in the nursing home.

MLTC members who only need short-term rehabilitation care, however, may go to any rehab facility of their choice, and are not restricted to facilities in their MLTC plan's network. The MLTC plan must pay the Medicare coinsurance for the skilled nursing facility (rehab) stay. SEE DOH Q&A Aug. 16, 2012 - Question 42 on page 7. However, once the Medicare-covered stay is over, they must switch to an MLTC plan that includes their preferred nursing home in its network.

People who were NOT enrolled in an MLTC plan or mainstream plan who come to need nursing home care after Feb. 1st, 2015 (in NYC - see above for dates outside NYC) may enter any nursing home of their choice. They do not have to join an MLTC or managed care plan until after they are admitted to the home, apply for and are accepted for institutional Medicaid (which includes the lookback period that screens for transfers of assets).

As this is a new system, many procedures and rules are rapidly changing and still not known.

INTRO TO PART II. Managed Care Plans Must Comply with Apply Definition of Scope of "State Plan" services

The following sections explain in detail how the amount, duration and scope of the "State Plan" services have been defined in NYS – personal care, CHHA, etc. Now that many of these services will be accessed through mainstream Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC) plans, there is a question as to whether these plans can simply make up their own definition of medical necessity, or whether they must follow existing regulations and guidance for the state plan services.

Even though an MLTC or MMC plan is designated to approve or deny services, the federal Medicaid statute requires that all managed care plans make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a) (4)(i). The NYS DOH Model Contract for MLTC Plans also includes this clause: "Managed care organizations may not define covered services more restrictively than the Medicaid Program." http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf

NYS DOH has issued guidance to mainstream Medicaid managed care plans that directs them to follow much of the following policy and practices for Personal Care services. See NYSDOH Guidelines to Personal Care Services in Medicaid Managed Care, February 2012, posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_personal_care_guidelines.pdf. This guidance may not capture all of the requirements that advocates believe should apply in managed care and MLTC. Standards that should apply are both substantive (criteria of eligibility and for determining amount of service) and procedural (due process required).

As mandatory MLTC continues to roll out across the state, and more long term care services may only be access through managed care and MLTC plans, it will be essential to hold plans accountable to provide services in the legally required amount and according to required due process procedures.

Personal Care Assistance (PCA)

Law & Regs

42 USC § 1396d(a)(24); 42 CFR § 440.170(f), NY Soc. Serv. L. ["SSL"] 365-a, 367-p, 365-f (Consumer directed personal assistance program) Main state regulation is 18 NYCRR 505.14 (excerpt in App. 76). Numerous State directives. Much information on NYS PCA program is posted in the web article at http://www.wnylc.com/health/entry/7/.

Formerly known as "home attendant" in NYC. Services include[3]:

- LEVEL I -- HOUSEKEEPING (Nutritional and environmental support functions, including meal preparation) - maximum 8 hours/week, and
- LEVEL II -- PERSONAL CARE (LEVEL II) with up to 24 hour assistance with the Level I tasks plus "unskilled" or "custodial" personal care tasks such as bathing, grooming, feeding, transferring in and out of bed, toileting, turning, walking or wheelchair assistance, accompanying to medical appointments.

How Services Accessed

- Dual Eligibles Over Age 21 – As of 1/1/13, in NYC, Westchester, Nassau and Suffolk Counties, can only obtain PCA through a Managed Long Term Care Plan, PACE, or Medicaid Advantage Plus. With limited exceptions, they may no longer apply to the Local Dept. of Social Services (LDSS)/ CASA offices in these counties.
- Medicaid-only recipients without Medicare – If they are in a mainstream Medicaid Managed Care (MMC) plan, must obtain PCA through the plan.
- Everyone else – Obtains PCA through their LDSS through an assessment procedure prescribed in 18 NYCRR 505.14(b). This includes adult dual eligibles living in counties that do not yet have mandatory MLTC enrollment, and those exempt from MLTC (hospice recipients, e.g.).

[3] 18 NYCRR 505.14(a)(6)

Eligibility Requirements

18 NYCRR 505.14(a) contains two basic eligibility requirements.

1. Self-Directing – or having another direct care

Client must be "self-directing" OR have another individual direct care and make choices about activities of daily living (ADL). According to State Directive 92-ADM-49, posted at http://onlineresources.wnylc.net/pb/docs/92_adm-49.pdf, that person need not live with the client or "be physically present in the home for a specified amount of time." This "ADM" states that if the person does not live with the client, the frequency of contact needed to assure a safe situation and provide discretionary direction is determined on a case-by-case basis. Generally, "substantial daily contact" is required -- but does not require daily physical presence - can be by phone.

The personal care aide ("PCA") is not supposed to run the client's life, manage finances, pay bills, decide when to go to the doctor.

Make sure family members understand they must participate in supervising and directing care. NYC HRA uses a "2131" Agreement to Participate in Plan of Care for family or friends to specify their agreed involvement. Copy at http://www.wnylc.com/health/afile/7/145/. Try using the same form in your county or with an MLTC plan. Many MLTC plans require a "backup" agreement which is similar.

Agencies may also provide direction and supervision, but must have 24-hour emergency availability. A Community Guardian agency won a hearing showing the agency could direct care. (FH dec. No. 2544974K, dated 10/9/96)

WARNING: HIGHER LEVEL OF CARE – LDSS offices, and now MLTC plans may use lack of someone to direct care as a pretext to deny services, claiming the client needs a "higher level of care" such as a nursing home. Many favorable hearing decisions on this issue. See "HL" decisions listed in Fair Hearing digest at http://www.wnylc.com/health/download/106/ and at http://www.otda.ny.gov/oah/FHArchive.asp. See eg. **TWO-PERSON TRANSFERS** are sometimes a ground for denying care. Often you can show one person can transfer client, using hoyer lift or with training (occupational therapy) for client. See FH digest "HL-26 FH# 3738933H; Matter of Hedy L. (Nassau)(ALJ Biggs) (Herbert Harris, Nassau/Suffolk Law Services) (10/31/02)"

TIP: Make sure you indicate in writing to LDSS or MLTC plan who will "direct" care, explains the nature of their contact with the client and 24-hour

availability in emergencies (e.g. lives 10 minutes away, has a cell phone, visits 1-2x/week, calls daily, etc.).

MLTC TIP: Early in MLTC, advocates alerted DOH that MLTC plans were insisting that families agree to provide overnight care or other assistance beyond simply "directing" care. DOH responded by issuing MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care (May 8, 2013), which states in part that the "plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party." (All MLTC policies posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm.)

2. Medical condition must be "stable"

"is not expected to exhibit sudden deterioration ... and... does not require frequent medical or nursing judgment to determine changes in the ... plan of care..." and client does not need aide to perform "PROFESSIONAL CARE." 18 NYCRR 505.14(a)(4)(i)(c)(App. p. 76). This section generally prohibits a personal care aide from performing "skilled" tasks. For which tasks are "skilled" you must consult the "scope of tasks" documents.[4]

- "Skilled" tasks must usually be performed by a VISITING NURSE or a FAMILY MEMBER, and not by personal care aides, e.g. suctioning a tracheotomy, inserting or irrigating catheters, tube feeding, IV's, ventilators. Home health aides ("HHA") are permitted to perform some semi-skilled tasks, particularly for clients who are self-directing, and for some consumers who are not. This is because HHA's are regularly supervised by a nurse. Aides in the CDPAP program, described later, *may perform skilled tasks* – a highlight of the CDPAP program.
- Rule on medications: PCA MAY assist with "self-administration" by reminding the patient as to time, identifying the medication and reading the label for the client, bringing it and liquids to the patient, opening the container and positioning the patient for administration. 18 NYCRR

[4] NYS Dept of Health Scope of Tasks for Home Health Aides http://tinyurl.com/3AMHBZ (Jan. 2007); Scope of Tasks for Personal care Aides (NYS 1994) at http://www.wnylc.com/health/download/46/, and Q-TIPS leaflet at http://www.wnylc.com/health/afile/7/32/ --lists which tasks PCAs and HHAs may and may not do, 18 NYCRR 505.14(a) . Links to these documents can be found in the article on Personal Care at http://www.wnylc.com/health/entry/7/.

505.14(1)(6)(ii)(9). If client has dementia and does not know what the pill is or how many to take, family or a nurse must pre-package the pills in a weekly medication box. Then aide may give those pre-counted pills to the client at the proper time.

PCA *may not* put the pill in the client's mouth or eyedrops in the eye, give injections, or apply prescription or non-prescription medication to a stable or unstable wound. PCAs may pour pre-measured medication into bath water.

HHAs *may* put pill in client's mouth, administer eyedrops or suppositories, apply prescription topical medications to stable skin, *but only if client is self-directing*

How to Apply and How Are Needs Assessed?

- **If enrolled in or required to enroll in an MLTC plan, mainstream MMC (Medicaid managed care) plan**, PACE, or Medicaid Advantage Plus –
  - After one applies for Medicaid through LDSS and Medicaid approved, one chooses an MLTC, PACE or MAP plan and enrolls. A nurse employed by or under contract with the MLTC or other managed care plan assesses client's needs and determines eligibility and the hours of care.
  - Since federal regulations define PCS as services "prescribed by a physician," plan should be consulting with member's physician, but the practice appears to be not to do this. Recommended to submit a physician's statement describing diagnoses, functional needs anyway.
- **If applying with LDSS because not required to enroll in MLTC in your county**, or client does not have Medicare and is not in an MMC plan, assessment is prescribed by 18 NYCRR 505.14(b).

Assessment Procedure where MLTC not Mandatory in County or not mandatory for Individual

State regulations specify a series of assessments that HRA/County DSS must do – with 30 days of receiving the physician's order. 18 NYCRR 505.14(b).[5]

[5] *Miller v. Bernstein*, Sup. Ct. N. Y. Co. Ind. No. 623/78, Stipulation and Settlement of Discontinuance, filed May 11, 1978, par. 7(a), posted at http://www.wnylc.com/health/download/50/
(cont'd)

1. Physician's Order

The treating physician's order (Form M11q or "Medical Request for Home Care" in NYC - http://www.wnylc.com/health/download/30/ (updated 12/2014) is completed by the client's doctor. Even though the M11q is signed by the physician (or nurse practitioner), the family member, lawyer or advocate should closely work with the physician to be sure that the form clearly portrays the client's needs. SEE the Q-TIPS leaflet http://www.wnylc.com/health/download/32/ . Forms for some other counties posted at http://www.wnylc.com/health/entry/39/.

Doctor should sign comment page as well as page 3.

30-day rule – must be signed by doctor and submitted within 30 days of last patient exam. 505.14(b). NOTE: If filed timely, LDSS/ CASA may not insist on new M11q if it becomes "stale" – more than 30 days old - AFTER filed with CASA. *See* Memorandum of Lenore Schlossberg, Acting Director, NYC Home Care Services Program Field Operations, to CASA staff dated May 26, 1995, posted at http://www.wnylc.com/health/download/107/.

In NYC, if not subject to mandatory MLTC, send M11q return receipt requested, with "INTAKE" written across top, to

NYC HRA Home Care Services Program CENTRAL INTAKE
109 East 16th Street, 5th Floor
New York, NY 10003
Phone: 212-824-0607
Fax: 212-896-8814

Include a cover letter explaining any helpful facts – who will direct care, meet skilled needs, pre-pour medications, asking to be notified to be present at assessment, etc.

Gag Rule

A 1992 amendment of 18 NYCRR 505.14(b)(3)(i)(3) PROHIBITS a physician from stating the number of hours of care the patient needs in the physician's order. This "Gag rule" was upheld in *Kuppersmith v. Perales*, 688 N.Y.S.2d 96 (1999), affirming 668 N.Y.S.2d 381 (App. Div. 1st Dept. 1998). However, the settlements in *Mayer and Rodriguez* about Task-Based Assessment, described below, require local districts to take into account the "span of time" during which needs arise. Therefore, the doctor should state that client cannot safely be alone, that she needs one-on-one assistance throughout the night, etc. and the medical reason why, for example – that client has sleep disorder that

cannot be controlled by medication, needs contact guarding and assistance with ambulation at night to prevent falling, that client prone to falling because of unsteady gait, arthritis, poor balance, fracture, cardiac or pulmonary impairment, must be turned and positioned every 2 hours to prevent bedsores, requires frequent toileting because of high fluid intake or diuretic).

2. Social Assessment by CASA case worker in home

LDSS must assess "potential contribution of informal caregivers, such as family and friends… and shall consider the following: … ability and motivation of informal caregivers to assist, …extent of informal caregivers' potential involvement; … acceptability to the patient of the informal caregivers' involvement…." 505.14(b)(3)(ii)

See FH SS-44 No. 3385956J 12/22/00 (ALJ Traum) (reverses and orders split-shift care where daughter testified she works at least eleven hours daily x 5 days and part time on weekends and is not willing to provide informal support...."The agency on this case appears to, in effect, be coercing or requiring Appellant's daughter into providing informal support, something specifically prohibited by mandatory policy. This policy had previously been laid out in Local Commissioner's Memorandum 95 LCM-76."[6]

Local district reversed where social assessment not fully completed. **SS-66** Alice B. No. 3438362L (ALJ Vass) (June 21, 200_)

3. Nursing Assessment

505.14(b)(3)(iii) (sample used by HRA to train nurses is at http://www.wnylc.com/health/download/48/.[7]

- MUST BE DONE within 5 days after M11q received.
- MUST EXPLICITLY "REVIEW and INTERPRET" M11q (so must be done AFTER, not before, M11q)(some fair hearing decisions have reversed local determination on this ground).

[6] The cited directive, 95 LCM-76 is posted at http://onlineresources.wnylc.net/pb/docs/95_lcm-076.pdf . While some the directive is moot because it implements the fiscal assessment law, which has since expired under a sunset clause, the section on "statements of understanding" and voluntary help of informal caregivers remains valid.

[7] Accompanying HRA instructions for nurse assessment are posted at http://www.wnylc.com/health/afile/7/49/ , which were adopted pursuant to an agreement with NYC in *Rodriguez Stipulation of Settlement and Order of Dismissal*, dated January 9, 2003, in which NYC agreed to consider unscheduled and recurring needs and the span of time during which they occur.

- MUST DEVELOP "a plan of care in collaboration with the patient or his/her rep" - you can request to be present to develop plan of care with nurse
- MUST EXPLICITLY recommend an authorization for service – **NOTE:** they often do not – another defect that is grounds for reversal
- If 24-hr continuous care (split-shift) requested, must document why needed
- Nurses employed by contract vendors or CHHAs do the assessments. They are under pressure to recommend fewer hours (or else their employer may lose their contract with HRA). This means it is even more important for M11q to be very detailed and thorough.
- Effective April 2003, the nurse assessment used in NYC was revised to incorporate the final NYC-only stipulation in *Rodriguez v. DeBuono.*

On page four, the "comments" section states **that if the nurse identifies a need for assistance with any of the three key activities of ambulating, transferring or toileting, she must "indicate the span of time** over which the assistance of a home attendant is required" in the space provided, or explain why assistance is not needed over a span of time. The separate instructions further clarify that the nurse should specifically explain the type of assistance needed with these tasks, and, if the need for assistance is unscheduled, to identify the span of time on the form and in the form's "comments" section.

On page one, the nurse is asked for his or her final "recommendation for authorization of services (in hours)," replacing the more limited request for a "recommendation for authorization of total weekly time to complete tasks." The instructions now clarify that the nurse's recommendation will no longer be a simple tally of hours, but must be sufficient to cover the required span of time over which the client needs the attendant's assistance with unscheduled tasks.

4. Independent Medical Review – Local Medical Director

24-hour cases and others with a conflict between the assessments must be referred to the "Local Medical Director" or LMD. 18 NYCRR 505.14(b)(4)(i). The failure to refer to the "LMD" is grounds for reversing the decision. The LMD is a physician employed by or under contract with DSS/HRA, who does only a paper review. One of NYC's LMDs brought a False Claims Act suit in January 2011, claiming that HRA authorized 24-hour care without his approval. *US ex rel Gabriel Feldman vs. City of NY*, S.D.N.Y. 09 Civ. 8381. This case was settled in November 2011. See pleadings, amicus brief, and news

clips posted at http://wnylc.com/health/entry/148/ and settlement at http://www.wnylc.com/health/news/12/.

"Affiliation referral form" -- The "Local Medical Director" or LMD may send an HRA-contractor "affiliation" physician to make a home visit to assess patient. Usually these reports are not favorable or thorough, and must be refuted by the treating physician at a hearing by a letter or affidavit. See FH decision #3482960P (ALJ Heukerott) (August 29, 2001)(too much weight was given to this assessment compared to M11q and nurse assessment, reverses and orders interim split-shift)

5. Fiscal Assessment – REPEALED

Until the law expired under a sunset clause on June 30, 1999, people for whom the cost of home care exceeded the average local Medicaid cost of nursing home care were denied care, unless the client met one of several narrow exceptions. Social Serv. L. 367-k. In New York City, this law affected only split-shift 24-hour care. Fortunately, the sunset of this law means there is NO COST CAP on home care, and the only limit should be medical necessity. The law and its exceptions were complex, but are omitted from this outline.

In three companion cases, a state court ruled that the fiscal assessment law may violate the Americans with Disabilities Act requirement that Medicaid services be provided in the most appropriate "integrated setting," which is in the community rather than a nursing home.[8] The State court required Medicaid to consider whether the cost of this home care is an "undue burden" for the government under ADA standards set forth in *Olmstead v. L.C.*, 527 U.S. 581 (1999), which the State court held superseded *Egan v. DeBuono*, 688 N.Y.S.2d 18 (1st Dept. 1999), an earlier unsuccessful challenge to fiscal assessment.

6. Medical Review Team (MRT) Plan of Care & Home Care Reviewer's Decision

The MRT Task Sheet - Plan of Care is usually a task-based assessment that adopts the nurse's assessment TBA times, sometimes giving more or less hours. The Reviewer's Decision is usually a rubberstamp of the LMD report.

The MRT guidelines for New York City were revised in 8/02 effective April 2003 under the final *Rodriguez* stipulation. The guidelines explain the

[8] *Sanon v Wing, Jackson v Wing, and Rubin v. Wing*, 2000 N.Y. Misc. LEXIS 139, Ind No. 403296/98 and 402855/98 (Sup. Ct. N. Y. Co., Moskowitz, J.) (N.Y.L.J. Mar. 3, 2000 p. 27 col. 2).

method for completing the Task Sheet-MRT plan of care when an individual has **unscheduled needs** for assistance. First, **if the client needs assistance with ambulating, transferring and/or toileting, the reviewer must either identify the span of time** in the comments section **or explain why a span of time is not needed**. Next, the reviewer must add all the task times identified on the task sheet. If the times are not sufficient to cover the needed span, the reviewer must add additional time to the "unscheduled needs" line of the task sheet so that the total tally of task times is adequate to cover the necessary span. For example, if the task times add up to 35 hours per week, but the span of time for assistance with toileting is twelve hours per day, the MRT reviewer must add 37 hours to the "unscheduled needs" line to total the 72 hours necessary to cover the span.

Also, the guidelines reiterate the "Mayer-3" exception -- local districts may NOT use TBA for clients requiring 24-hour assistance, even if some care provided informally by family. They must receive traditional care plans, in a block of time rather than TBA hours. The hours must be sufficient for coverage when informal supports are not available. See amended § 505.14(b)(5)(v)(d).

Standards for Assessment – How Much Care is Client Entitled to?

Personal care is supposed to be authorized in the amount medically necessary. 18 NYCRR § 505.14(a)(4). Through litigation and policy some standards have evolved defining medical necessity. The requirements applicable to personal care services as a service under the Medicaid State Plan continue to apply now that authorization for these services has been delegated to managed long term care (MLTC) plans. 42 CFR §438.210(a)(3)(1).[9]

The Big 3 ADL's: Ambulation, Toileting, & Transfer (AT&T)

Most clients who need higher hours of home care need it because of one or more of these 3 ADLs. The M11q and physician's orders used in other counties are not drafted to elicit comprehensive information on these 3 needs. See the Q-Tips for tips on making sure this information is included http://www.wnylc.com/health/download/32/.

[9] Model Managed Long Term Care Contract, available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf ; see Article II and Appendices G and K.

NOTE: Under the *Rodriguez* settlement, NYC HRA must assess whether the client needs assistance with "AT&T" at unscheduled or frequent times during the day and night, and if so, must assess the span of time during which these needs arise. See Nurse's assessment form and instructions. http://www.wnylc.com/health/download/48/ and http://www.wnylc.com/health/download/49/. The treating physician MUST address these questions in the M11q.

Indicate times of day when assistance is crucial (bedtime, to give dinner because client can't reheat or prepare meal, to give evening/night meds, to assist with toileting & ambulating through bedtime)

Avoid general language such as needs "safety monitoring" - specify ways client needs help with ADLs, even if help is verbal cueing and prompting rather than hands-on – see "TBA" section below.

Doctor should specify type of care needed, why, and the span of time in which the care is needed.

Twenty-Four Hour Care – Changing Criteria

Two Types of 24-hour Care

- Sleep-in Care -- 24-hour per day care provided by ONE aide who sleeps at client's home but is "off duty" at night. Generally the aide is paid for 12 hours plus a per diem of $17/night.
- Split-Shift care --24-hour per day care is provided in two 12-hour shifts, essentially costing twice as much as sleep-in care.

Change in Regulatory Criteria for 24-hour care

In 2011, the Social Services Law sec. 365-a, subd. 2(e) was amended to add (e)(ii), authoring DOH to "…adopt standards, pursuant to emergency regulation, for the provision and management of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner."

Under this statute, DOH issued emergency regulations which change the standards for authorizing 24-hour care, both sleep-in care and split-shift "continuous" care in 18 NYCRR 505.14. Because they are issued as emergency regulations, they have been reissued every 60 days, most recently on March 6, 2015 - Personal Care Services Program (PCSP) and Consumer Directed Personal Assistance Program (CDPAP) (PDF) http://www.health.ny.gov/regulations/emergency/docs/pcsp_and_cdpap.pdf Current regulation in App. P. 76-80.

For the first time, the amendment added a **new definition of live-in or sleep-in care**, as a new 505.14(a)(5), as "... the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted."

- Additionally, the regulation adds, "When live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide. 505.14(b)(3)(ii)(c).

The **definition of "continuous personal care services,"** in 505.14(a)(3) also known as "split shift" was changed to mean --

- NEW "... the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted." (Appendix pp 76-80)
- OLD definition was "... the provision of uninterrupted care, by more than one person, for a patient who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding [at unscheduled times during the day and night]"

The restriction of split-shift services to those whose needs cannot be predicted, as well as a widespread pattern of reductions in 24-hour cases in New York City, were challenged in *Strouchler vs. Shah*, S.D.N.Y. Docket No. No. 12 CV 3216 – SAS, filed in April 2012. A preliminary injunction was issued in September 2012, posted at http://wnylc.com/health/download/340/. (2012 U.S. Dist. LEXIS 125339). The case was settled in May 2014 (Final Stipulation and Order on file with NYLAG).

In the preliminary injunction, the Court found irreparable harm and a likelihood to succeed on the merits that the City failed to use "reasonable standards" for determining eligibility and the extent of services, and to provide the same services to everyone who is eligible for them, as required by federal Medicaid law. In particular, the Court found these standards unreasonable:

- "**Total**" **vs.** "**Some**" **Assistance.** State regulation 50514(a) limit split-shift services to those who need "total" assistance with a task.[10] The Court found that the City wrongly treated many people as needing only "some" assistance -- even though they could not perform a task without help.

- **Limiting Split-Shift to Those who need Help at Times that cannot be predicted.** Though the regulation was amended limiting split-shift care to those whose needs cannot be "predicted," "… the State's witness testified that a patient who needed diaper changes and turning and positioning throughout the night would not be ineligible for split-shift services simply because the need was regular and could be predicted." (p. 42). The Court faulted the State for not clarifying the language of this regulation, leaving the City and hearing judges to apply inconsistent standards.

- **Turning and Positioning** -- "Plaintiffs have established a substantial likelihood that they will prevail on their claim regarding the availability of home care for patients who have a medical need for turning and positioning during the night." The State's regulation, again, was unclear because it omits this task from needs that qualify one for split-shift care -- such as toileting and transferring. Again, the court faulted the State for failing to establish reasonable, clear standards.

On October 3, 2012, the NYS Dept. of Health issued **GIS 12 MA/026**, which is guidance to all local Medicaid programs (and MLTC plans) in NYS that clarifies the amendments to the state regulation defining eligibility for split-shift or "continuous 24-hour" personal care. 18 NYCRR 505.14(a). Posted at http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma026.pdf, the guidance states, in part,

"The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep."

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[10] "Total Assistance" means "a specific function or task is performed and completed for the patient." Contrast with "some assistance" where "a specific function or task is performed and completed by the patient with help from another individual." 18 NYCRR 505.14(a)(2).

This guidance is issued because the decision found that plaintiffs have a likelihood of success in showing that the regulatory amendment restricting split-shift care violates federal Medicaid law.

For more on Strouchler case, including download of pleadings, see http://wnylc.com/health/news/40/.

Even before the Strouchler injunction, years of fair hearing precedent has established good standards for authorizing 24-hour care:[11]

- "…A sleep-in aide is on duty for the 12 hours for which she is paid, and off duty for the other 12 hours of the day. She is therefore entitled to sleep the 12 hours she is off duty, and may be awoken 2 or 3 times during that period for assistance with toileting and other needs. In this case, if she is awoken twice nightly as recommended by the affiliation physician, the Appellant will be changed and repositioned only every four hours, will not be observed for signs of saliva buildup [and lifted to prevent choking as prescribed by doctor]...Moreover, the sleep-in aide will have to manage to wake up periodically on her own since the Appellant will not be able to call out to her." FH No.3117732J, 9/29/99 "SS-21", FH No. 3297631Y,6/20/00 "SS-25", FH No. 3409752M "SS-40"
- Size of client's home – lack of room for aide to sleep.
  - No. 3309046L, 9/26/00, No. 3312956Q, 10/26/00, No. 3183571N 10/16/00, No. 3361673Y 1/8/01, No. 3407840Y 2/20/01 , No. 3461307K 2/28/01, No. 3592481J 12/19/01, No. 3916747R 7/14/03
- Impossibility of aide being so efficient as to multi-task toileting with repositioning needs at night – each task takes time No. 3456693Q, 3/6/01
- Inability of client to call out to aide at night (for physical or mental reasons) FH. 3481741R, 7/27/02, FH No.3117732J, 9/29/99
- Need for turning and positioning, toileting
  - FH 3382866K; Oct. 6, 2000, ALJ cites DOH pamphlet on turning and positioning,), SS-40 No. 3409752M 12/5/00), No. 2662458Y 6/3/97, No. 3421439R (ALJ Heukerott) (February 27, 2001)
- Attempts by client who wanders to transfer out of bed and ambulate at unscheduled times at night, with high risk of falling, merits split shift.

[11] Fair hearing decisions are posted since 2011 at http://www.otda.ny.gov/oah/FHArchive.asp. and prior to that on the on the WNYLC Online Resource Center – registration required but free.

- FH No. 4951038L (Vassilakis, ALJ, 9/15/08)(Specifically says *Rodriguez* does not preclude safety monitoring, which is secondary to assistance with ADLs).
- FH. #4297287M (Mahl, ALJ, 9/12/2006, Robert Gruenwald, Bronx Legal Services, Rep)(reverses and orders increase to split shift care for 100-year-old woman with dementia, who attempts to get up and ambulate, go to the bathroom and prepare food without assistance at night, with high risk of falls due to dizziness, arthritis and poor version. Daughter's testimony corroborates MD orders and statement.

The "28 Hour Per Week" Limit On Initial Cases

In June 1996, a federal court permanently enjoined the state regulation that limited "initial authorizations" of personal care services to 28 hours per week, unless the applicant needed "total assistance." 18 NYCRR 505.14(a)(6)(ii)(b). *Deluca v. Hammons*, 927 F. Supp. 132 (S.D.N.Y. 1996). Hours for applicants should not be limited to 4 per day.

Task-Based Assessment (TBA) & Mayer-3 Exception

In TBA each "task," including toileting and ambulating, is allotted a fixed amount of time (60 minutes/day for toileting, 20 minutes/day for indoor ambulation).

Mayer-3 Exception to TBA. Under a third stipulation in *Mayer v. Wing*, known as "Mayer Three," which applies statewide, TBA may not be used for anyone requiring 24-hour care, including cases where family or other non-Medicaid care provides part of the care. The Mayer provisions are now incorporated in 18 NYCRR 505.14(b)(5)(v), effective 11/1/01 (COPY in appendix p. 81). See DOH GIS 01 MA/044. Advocate with LDSS or MLTC NOT to use TBA in cases where client can't be left alone. See TBA-8 FH #335605Q (NYC 9/29/00 – client can't safely be left alone); SS-62 Ida O. No. 3465961L (ALJ Vass) (pro se) (March 16, 2001)(family members testify they can no longer stay with client every night)

Safety Monitoring and GIS 03-MA/003

The TBA form DOES NOT HAVE a "task" of safety monitoring persons who are not self-directing, who wander or who need supervision to prevent them

from leaving on the stove, etc. However, in *Rodriguez v. City of New York*,[12] the 2nd Circuit upheld the State policy of not including "safety monitoring" as a "task." However, a State directive issued 1/24/03 (**GIS 03 MA/003**) http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/03ma003.pdf (copy App. 74) controls some of the damage of this decision, stating in part:

> ". . . [D]istricts are reminded that a clear and legitimate distinction exists between 'safety monitoring' as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed."

COPY APP. P. 74. This GIS clarifies that districts MUST assess time needed for an aide to assist a cognitively impaired person with recognized "tasks" – such as toileting or ambulation – even if the assistance is verbal cueing and prompting rather than hands-on care. Also, assisting someone in ambulation to prevent falling, while it does indeed enhance "safety," is not forbidden "safety monitoring" but is rather assistance with ambulation, so must be provided.

Advocacy tip: The term "safety monitoring" is a term that has traditionally described the general 24-hour supervision needed for persons with dementia. But the term actually encompasses types of ADL assistance that the State does include in personal care. If the client has a sleep disorder because of Alzheimer's disease, and needs help during the night because she cannot find the bathroom, forgets to go, or will wander, then these are recognized ADLs of TOILETING & AMBULATING and should be covered. Make sure the M11q describes these needs as cueing. prompting and/or guarding assistance with these ADLs rather than using the catchword "safety monitoring." See Q-Tips for ideas; http://wnylc.com/health/download/32/

See FH SS-88 Dvorah G. No. 3569406M (ALJ Vass) (Nina Keilin, Esq. Legal Services for the Elderly) (January 29, 2002)(criticizes HRA's mis-interpretation of Rodriguez with regard to safety monitoring).

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[12] 197 F.3d 611 (2d Cir. Oct. 6, 1999), *rehearing den'd*, January 2000, reversing *Rodriguez v. DeBuono*, 44 F. Supp.2d 601 (S.D.N.Y.1999), *on remand from* 162 F.3d 56 (2d Cir. 1998), reversing 177 F.R.D. 143 (S.D.N.Y. 1997)

See FH No. 4951038L (Vassilakis, ALJ, 9/15/08)(cites this GIS in finding that "safety monitoring" by aide is legitimate task where appellant with dementia attempts to get out of bed, transfer and ambulate at unscheduled times of day and night without assistance, despite high risk of falling and need for assistance)

2003 Settlement in *Rodriguez*

The *Rodriguez* case was finally settled in late 2002 and 2003 on the remaining challenges to TBA. Statewide settlement: Stipulation and Order of Settlement, dated December 19, 2002 (statewide), and GIS 03 MA/003, 1/24/03.[13]

In addition to clarifying the safety monitoring issue, GIS 03 MA/003 clarifies that "The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night." In addition, the GIS provides that ". . .a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs."

New York City only – Stipulation of Settlement and Order of Dismissal, dated January 9, 2003

The City explicitly recognizes its obligation to authorize personal care assistance with identified unscheduled and recurring needs through an appropriate plan of care. Revises nurse's assessment form, MRT form and instructions to identify the span of time during which client needs unscheduled and/or recurring assistance with toileting, ambulation and transferring.

Under both settlements, the nurse making the assessment has discretion to recommend more time than the fixed pre-set times to perform the tasks. Indeed, the State GIS MANDATES that the district consider "whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night." In NYC, the revised forms explicitly ask the nurse to state the span of time during which need for assistance arises and explain why- e.g. assistance needed all day or night because of unsteady gait, hip fracture, poor judgment, etc. YOU can advocate with nurse to specify unscheduled needs and more time needed for tasks.

Nassau County

Settlement was approved in Rodriguez after a class hearing held in March 2004. County agreed to revise certain assessment forms and instructions "to

[13] http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/03ma003.pdf

identify clients with unscheduled needs (such as toileting, transferring, and/or ambulating) and/or recurring needs (such as feeding, assistance with medication, etc.) to ensure a plan of care that will meet these needs." (Departmental Memo to all assessing and reviewing nurses and medical directors from Rita Nolan, Dir, Medical Services, dated ________ , 2004).

The Task-Oriented Plan of Care now says that the recommended hours and days "must allow for unscheduled and/or recurring needs." If assistance with toileting, ambulation, transferring, feeding, meal prep or assistance with meds is needed, the reviewing nurse must explain in a memorandum to the Medical Director how the total task time is sufficient to meet those needs when they occur.

- See FH No. 3577972J (ALJ Bush) (January 30, 2002)(task based assessment afforded inadequate time for medical appointments for couple)
- Authorized only 5 not 7 days per week, with no evidence that client has care on the weekend. No. 3386249Q (ALJ Mahl) (January 4, 2002).

Personal Emergency Response Systems (PERS)

PERS is the medical alert button made famous by the "I've fallen and I can't get up" commercial. State law requires that personal care and home health services include PERS "where appropriate" as determined by the local DSS. By regulation, PERS can be provided only if it reduces the need for personal care. 18 NYCRR 505.33.

Under a settlement in *Deluca v. Hammons*, (April 1996) HRA is allowed to give PERS to new applicants and recipients, as long as it does not reduce hours. PERS should not be used to reduce hours of care, and should not be given to people who can't use it because of mental or physical impairments. People who are at risk of falling should receive extra hours of home care at the times they are at risk, and not be forced to rely on PERS after they fall.

Under a 2004 settlement resulting in issuance of DOH 04 GIS 29 (11/26/04), PERS will be available to HOUSEKEEPING clients as well as personal care/ home attendant clients in NYC.[14] While this is not spelled out in the GIS, the GIS states that "no threshold amount or level of personal care services is required," though PERS will not be authorized with no personal care services. Since housekeeping services are formally "Level II" personal care services, the GIS implies that housekeeping services are sufficient to trigger PERS eligibility.

[14] http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/04ma029.pdf

Reductions in Personal Care Services – Mayer v Wing

Under *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996) a local district may not reduce hours without a good reason. This holding, based on due process principles, is incorporated in state regulations at 18 NYCRR 505.14(b)(5)(v), effective 11/1/01 (copy Appendix pp 76-80). Local agency notice must state that the reason for a reduction is:

- "a change in medical, mental, economic, or social circumstances (improvement in condition, family is more available to help)
  - **BURDEN OF PROOF –** Local district has burden of proof to show change or improvement. 18 NYCRR 358-5.9. Eg. FH decision "Mayer -1" - No. 3287490P "G.B." (July 14, 2000, Jaret, ALJ, *pro se* by daughter) holds HRA failed to introduce documentation of client's PREVIOUS condition, when higher number of hours was first authorized. Without those documents, they have not proved that he has improved. TIP: DSS/ HRA can't just allege improvement, but must PROVE it. See fair hearing "Mayer" decisions holding agency to burden of proof. Before fair hearing, obtain EARLIER documents from case file showing client's needs when she was first approved for higher care. If they are helpful, submit them at the hearing and show that condition hasn't improved. See also HL-20 No. 3475656P ALJ Traum 6/5/01 (The Legal Aid Society Health Unit - Lisa Sbrana, Diane Spicer)Eg. FH decision "Mayer -1" - holds HRA failed to introduce documentation of client's PREVIOUS condition, when higher number of hours was first authorized. Without those documents, they have not proved that he has improved.
- a mistake that occurred in the previous authorization. (See FH decision Mayer-5 as example of REJECTION of claim of a "mistake") FH. No. 3515475Y 12/6/01 (Hiller, ALJ)(Nina Keilin, Legal Services for the Elderly)
- a recipient's refusal to cooperate with reassessment
- a technological development rendering certain services unnecessary or less time-consuming, such as a personal emergency response system (PERS) or cluster care
  - **NOTE:** Since April 1996, HRA can't reduce services based on giving "PERS" -- *Deluca v. Hammons* (settlement)

- a finding that the recipient can be more appropriately and cost-effectively served through other Medicaid programs
  - **NOTE:** Conversions from CHHA, LTHHCP or private duty nursing care to personal care are covered by this exception, but NOTICE of a finding that the change is appropriate, and AID CONTINUING rights should be provided. This exception originally contemplated "fiscal assessment," but that law expired under a sunset clause.
- **Task-based assessment** - HRA may NOT reduce hours based on TBA for anyone receiving 24 hour care (sleep-in or split shift), or who has been determined to need a total of 24-hour coverage, even if family provides part of the care and Medicaid provides less than 24-hour coverage. This is the "Mayer 3 Exception," which is now incorporated in revisions to 18 NYCRR 505.14(b)(5)(v), effective 11/1/01 (App. 156). TIP: If client cannot safely be left alone, she should be a "Mayer 3" and argue TBA should not be used.

The *Mayer* holding applies to MLTC and any other managed care plan. The burden of proof held by *Mayer* to apply to reductions in personal care services is consistent with long-time state regulations that have always assigned the local social services agencies with the burden of establishing that its actions resulting in reduction or termination of services were correct. 18 NYCRR § 358-5.9(a). Medicaid managed care organizations carry the same burden to establish that its actions were correct. (*See* 18 N.Y.C.R.R. § 360-10.8(a) declaring "Part 358 of this Title is incorporated by reference as if set forth fully herein and is applicable to . . . MMCOs").[15] Part 358 also includes Medicaid managed care organizations in its definition of Social Service Agency, stating "Social services agency means the State, county, city, town official or town agency, social services district, … or **other entity** responsible for making the determination or for the failure to act, which is the subject of review at the fair hearing." 18 NYCRR § 358-2.21. (emphasis added). Further, Medicaid Managed Care organizations have the responsibility to "ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished." 42 CFR §438.210(a)(3)(1).

***See section below* on Appeals and model notices MLTC and managed care plans should be using, infra pp. 59-67 and APPENDIX pp 15-73.**

[15] Managed long term care plans are a form of health management organization subject to state and federal law and regulations applicable to Medicaid managed care plans. See NY Pub. Health Law Sec. 4403-f, sub. 4 and 5; 42 CFR Part 438.

Reinstatement of Services After Hospital Discharge

Granato v. Bane, 74 F.3rd 406 (2d Cir. 1996) - After a hospital stay, the former amount of hours must be reinstated, for both personal care AND CHHA care. (State's 1999 directive 99 OCC LCM-2 clarifying *Granato* posted at http://www.wnylc.net/pb/docs/99OCCLCM2.pdf (also for Long Term Home Health Care program -- *Martin v. Wing*, 1996 WL 191974 (N.D.N.Y. 1996).

See FH decision No. 3602952Z, 1/11//02 "TBA-70" (NYC), No. 3368591N, 10/11/00 "HL-19" (Suffolk), No. 3316538M "SS-39" (NYC -CHHA), No. 34765656P, 6/5/01 "SS-70" (NYC).

The State directive permits the district to reassess the client's needs which may have changed, but the client must have advance notice with aid continuing rights of any reduction in hours or termination. The notice can't just say "we are stopping home care be because you are in the hospital or in a nursing home" – that is not a valid ground. Request hearing and aid continuing (reinstatement of services).

For CHHA cases, the *Catanzano* case established that the same principle applies. See 18 NYCRR 505.23 Appendix (distinguishing "applicant" as someone who had not received home health services prior to the hospital stay" from a "recipient" who had received services immediately prior to the hospital stay, so is entitled to advance notice and aid continuing if the district determines to terminate services after the hospital stay. HRA & other local districts often claim that they will reinstate services only if the hospital stay was 30 or 90 days. This is wrong. Under *Granato*, it should not matter how long the hospital or nursing home stay is.

Granato only gives right to SAME hours client had pre-hospital, not to INCREASED hours. If client needs more hours after hospital stay, and HRA denied increase, ask for hearing. If family can supplement "Granato" hours so client can go home pending hearing, it is better than client staying in hospital and being pressured to go to nursing home.

Consumer Directed Personal Assistance Program (CDPAP)

An alternative program permitting consumer to choose his or her own aides, and allowing aides to give "SKILLED" care otherwise prohibited. The program is often known as "CONCEPTS" – named after the main "fiscal intermediary" that contracts with HRA and other local DSS to provide CDPAP in NYC as well as in numerous other counties. In May 2004, a second vendor was added in NYC- Chinese American Planning Council Home Attendant Program (CAPCHAP). List of fiscal intermediaries in entire state posted at http://wnylc.com/health/download/43/ or http://cdpaanys.org/countymap.html.

See http://www.wnylc.com/health/entry/40/ - has links to law and guidance on CDPAP. State law REQUIRES all counties – and MLTC and managed care plans --to ensure access to a CDPAP operated under SSL 365-f to allow persons receiving personal care, certified home health care or private duty nursing to directly arrange and pay for care. Soc. Serv. L. § 367-p(c). All people receiving home care (CHHA, LTHHCP, personal care, or AIDS home care) shall be provided notice of availability of program and have opportunity to apply. THIS REQUIREMENT WAS STRENGTHENED IN THE 2009 STATE BUDGET.

Client need not be SELF-DIRECTING but may have someone else to direct care. The law requires the program to be available to people who "designated an adult to make informed choices." SSL 365-f(2)(c). Adult children can direct care of a parent with Alzheimer's disease, or a parent can direct care for a disabled child.[16]

CDPAP and Managed Long Term Care

Since November 1, 2012, MLTC plans in New York City have been required to offer CDPAP services, and to contract with the two CDPAP vendors/fiscal intermediaries in NYC. In 2013, CDPAP became mandatory in Long Island

[16] Guidance issued in 2008 clarifies how a district determines which consumers are "self-directing," and for those who are not, the level of involvement required of the "self-directing other." DOH GIS 08 LTC-005 (9/9/08)

and Westchester and now any MLTC plan in a county in which MLTC is mandatory must offer CDPAP. Consumers have concerns that the concept of CONSUMER-directed services is antithetical with the premise of "MANAGED" care, which is based on a nursing model. Consumers also have concerns about how plans will assess eligibility to direct services.

State DOH Guidance on CDPAP and MLTC is posted here – http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm scroll down to **MRT 90 – Mandatory Enrollment MLTC** then to **CDPAS Final Documents**

- Responsibilities of the Health Plan (PDF, 83KB, 3pg.)
- Policy for the Transition of Consumer Directed Personal Assistance Services into Managed Care (PDF, 77KB, 2pg.)
- Administrative Agreement for the Provision of Fiscal Intermediary Services for the Consumer Directed Personal Assistance Program

CDPAP is a required service for mainstream managed care as well. See DOH Medicaid Redesign webpage MRT 1458 http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm (Adding CDPAP to mainstream benefit package Nov. 1, 2012). Both the MRT 90 (MLTC) and MRT 1458 (mainstream MMC) webpages post numerous directives regulating CDPAP from when it was a fee for service program. (Links to all MRT pages at http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm. These include:

- CDPAP Regulations 505.28
- CDPAP Scope and Procedures-11ADM-06
- CDPAP GIS 08OLTC007-Non-Medical Transportation (
- CDPAP Questions and Answers 2006 (1)
- CDPAP Questions and Answers 2006 (2)
- Consumer Directed Personal Assistance Services (CDPAS) Final Guidelines
- CDPAP GIS 08OLTC-005 Clarification CDPAP Questions and Answers (

CDPAP aides may perform "skilled" medical or nursing tasks

"A CDPAP aide is able to provide nursing services because the Education Law specifically exempts CDPAP aides from having to be licensed under Article 139 of the Education Law, otherwise known as the Nurse Practice

Act." DOH GIS 04-MA-010, Apr. 27, 2004.[17] A client who would otherwise need a 24-hour LPN because she cannot put pills into her mouth, or needs suctioning, can train her selected CDPAP aide to perform this "nursing" function. Medicaid saves thousands of dollars paying the aide the personal care rate instead of the nursing rate. Public Health L. § 3622, subd. 10, Education Law § 6908, subd. 1(iii).

DOH guidance clarifies that aides may perform medical or "skilled" services. *See* DOH GIS 08 LTC-005 (9/9/08),[18] amending DOH 06 OMM/LCM-1 (Q & A on CDPAP).[19] The 2008 guidance clarifies that the family member or other person directing care does *not* have to be present at all times in which skilled nursing tasks are administered by a CDPAP aide to a non-self-directing recipient of CDPAP. The 2008 GIS specifically amends Question 8 of DOH 06 OMM/LCM-1.

Select Your Own Aide

The client, or family member directing her care, HIRES and TRAINS their own aides, who need not be licensed aides. The client must work out the aide's schedule, arrange for replacement aides when the aide goes on vacation or is sick. The only thing CONCEPTS or other CDPAP program does is payroll and benefits, which in NYC are the same as the union.

Most Family Members Can Be Hired As Aide

The federal Medicaid statute does not allow a "member of the individual's family" to be the aide. 42 USC 1396d(a)(24). Federal regulations define "family" as a "legally responsible relative." Arguably, this means that spouses and parents of minors may not be the aide, but that any other relative may be. 42 CFR § 440.167.[20] **State regulations amended in 2011 now allow an adult child,** son-in-law, daughter-in law to be hired as the aide, and other family members**, but not a parent or spouse.** Relatives may not reside in the client's home OR if they must reside in the home only because of the high amount of care needed. NY SSL § 365-a(2)(e), In addition to client's

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[17] http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/04ma010.pdf

[18] http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08oltc005.pdf. The GIS was issued as the result of a settlement in *Leon v. Danes, et.al.,* (CV 07-1674 E.D.N.Y, June 12, 2008)(posted on WNYLC.net Online Resource Center)

[19] http://onlineresources.wnylc.net/pb/docs/dohq_aversion2june302006.pdf

[20] Renumbered from 42 CFR § 440.170(f), as amended 62 Fed. Register 47896, 9/11/97.

child, **siblings, cousins, nieces/nephews** could become the paid home attendant ! See 18 NYCRR Part 505.28, effective April 20, 2011.

To Apply For CDPAP

Apply in same way as PCA services. In NYC and counties where MLTC is mandatory, must obtain from an MLTC plan if a dual eligible over age 21. In same counties, if one does not have Medicare and is in a mandatory Mainstream Medicaid managed care plan, must obtain through that plan.

Elsewhere, one applies at LDSS, usually in same ways as for PCS

For more info in NYC -- (not for applications)

- CONCEPTS 212-293-9999 (website has tutorials on how to manage a CDPAP case, hire and train, etc. http://www.coiny.org/
- Chinese American at 212-219-8100

For more information see http://www.wnylc.com/health/entry/40/

Certified Home Health Agency (CHHA)

Legal Authorities

42 C.F.R. § 440.70, 18 NYCRR § 505.23, 10 NYCRR §§ 761-763

Commonly known as "visiting nurse" services, CHHAs provide a "higher level" of home care that is more expensive than personal care because the federal certification requires extension supervision of the aides by a nurse. It is for people with unstable or acute medical conditions, needing close nursing supervision as opposed to solely assistance with "ADLs". CHHA services are often provided after a hospital stay for a short term, but *may also be long-term*. CHHA services can be obtained more quickly than personal care, so can be used temporarily while the personal care application is processed – either after a hospital stay or for clients at home.

Both Medicaid and Medicare pay for CHHA services, though Medicare will pay only for up to 35 hours a week of home health aide care (though rarely more than 12-20 hours/week), while Medicaid will pay for 24-hour/day sleep-in or split-shift care. However, 2011 changes in Medicaid payment methodology for CHHA services through "episodic payment" have resulted in reductions of services. See http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/index.htm/

ALERT: Medicare criteria for payment for home care are stricter than Medicaid's. CHHAs sometimes conflate the two sets of criteria, imposing Medicare criteria on Medicaid eligibility. These requirements DO NOT apply to Medicaid, though many CHHA personnel do not know this.

Medicare Criteria

Homebound Requirement

SEE HCFA Olmstead Update No. 3, letter to State Medicaid Directors, July 25, 2000 (says "The 'homebound' requirement is a Medicare requirement that does not apply to the Medicaid program.") Posted at http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf

Skilled Needs

Medicare requires that a client must have a need for part-time or intermittent skilled care by a nurse, physical or occupational therapist, as a condition for eligibility for home health aide services. There is not a specific directive

saying that Medicaid requires "skilled" needs.[21] However, many CHHAs will deny care absent a "skilled" need.

CHHA services include:

- **Skilled Nursing (RN/LPN)** on a part-time or intermittent basis NOT full-time private duty nursing) -- both Medicare and Medicaid cover.
- **Home Health Aide** services - assistance with ADLs (activities of daily living e.g. transferring, toileting, ambulating, bathing) and household chores, basically the same as personal care (home attendants) but aides may do some "health-related" tasks, though not skilled nursing tasks. See 10 NYCRR § 700.2(c)(15); NYS Dept. of Health Home Care Health Related Tasks Curriculum (Jan. 2007) posted on http://www.health.ny.gov/professionals/home_care/ (direct link is http://www.health.ny.gov/professionals/home_care/curriculum/docs/health_related_tasks_curriculum.pdf). A summary chart comparing HHAs and PCAs is in "Q-TIPS" at http://wnylc.com/health/download/32/
  - Medicare -- pays for up to 35 hours per week of home health aide services ONLY IF patient ALSO needs a skilled nursing or therapy service intermittently (as infrequently as once every 60 days) AND IF patient is HOMEBOUND. BUT federal reimbursement cuts have caused CHHAs to cut back hours sharply, even though the LAW has not changed.
  - Medicaid -- pays for up to 24-hour care (2-12-hour shifts or sleep-in). Fiscal Assessment NO LONGER limits hours, but 2011 changes in the reimbursement system have drastically reduced how much CHHAs get paid and reduced their willingness to provide 24-hour care. See http://wnylc.com/health/news/18/.
- Medical Supplies, Equipment, Physical or Occupational Therapy (PT/OT), speech, audiology services at home – both MEDICARE & MEDICAID cover.

[21] A 2009 CMS letter to the Missouri Medicaid program verifies that Medicaid has no skilled need requirement as a condition for paying for home health aide services from a CHHA. *See* Gene Coffey, *To be or not to be Homebound: The Limits of States' Discretion in Medicaid's Coverage for Home Health Services*, National Senior Citizens Law Center, December 2009. http://tinyurl.com/homebound-home-health

How To Obtain CHHA Services

Unlike personal care, CHHA services do not require "prior approval" of DSS/HRA. The treating physician orders them directly from the CHHA, which does its own assessment of the client (in the hospital or at home) and decides whether to “admit” the patient and sets the “plan of care” -- how much home care to give – up to 24 hour split-shift (since the fiscal assessment law SSL 367-j expired).

As a practical matter, a family member or advocate can make the referral to the CHHA by calling their intake number. The CHHA sends a nurse to assess, and if nurse finds services are warranted, will then contact the treating physician to sign the “plan of care.”

LIST OF CHHAs in NYS-- serving a particular city or zip code can be found at **http://homecare.nyhealth.gov/**

Each CHHA has its own **physician’s order form**, a version of the CMS "Home Health Certification and Plan of Care.” They do not use the “M11q.” An order is only good for 60 days, then must be renewed.

In counties where MLTC is now mandatory (all but a few upstate counties as of 5/1/2015), CHHA services should still be available without accessing through MLTC on a short-term basis, defined to be under 120 days. If services are needed beyond 120 days in mandatory MLTC counties, the individual receiving the HHA services will receive a letter from NY Medicaid Choice requiring her to enroll in an MLTC plan within 60 days. Once enrolled, the MLTC plan should be required to provide the same plan of care for 90 days as a transition benefit. After that, it will then be up to the MLTC plan whether to continue the same CHHA services, or use different service, subject to notice and hearing rights.

Medicaid Pending and CHHAs

A diminishing number of CHHAs will provide services to a client who does not yet have Medicaid, gambling that Medicaid will be accepted and that CHHA can then bill retroactively for Medicaid. This is possible because a CHHA is a Medicaid provider. This is a good strategy to use while the Medicaid/personal care application is pending at DSS/HRA.

CHHA vs. LHCSA

CHHAs may contract out the “home health aide” part of their service plan to a separate agency, called a Licensed Home Care Services Agency (LHCSA), licensed under Public Health Law § 3605. The CHHA nurse supervises this

aide and the plan of care. The LHCSA, in addition to serving as a contractor to a CHHA, usually also provides aides on a private pay basis. **A LHCSA may NOT bill Medicare or Medicaid for services offered in this private capacity**. Their services may be billed to Medicaid only when provided under subcontract by a CHHA, which bills Medicaid and pays the LHCSA.

If the client is purchasing private services temporarily while the Medicaid application is pending, and if she is counting on the home care agency to later back-bill Medicaid, then she must obtain the services directly from a CHHA, not from a LHCSA. However, if she (or her family) pays the LHCSA for the services, she may later request Medicaid to *reimburse* her for services back to 3 months before the application. See Reimbursement below at VIII.

Since a CHHA and LHCSA are often sponsored by the same organization, it can be confusing to know which you are hiring. Be sure to ask or *check the website*. (Don't depend on the aide to tell you who is her employer – you don't know if that's just a subcontractor). They may not use the same terminology!

Example: "Partners in Care" is the LHCSA run by VNSNY, separately from the VNSNY CHHA. VNS also has a Managed Long Term Care Program called "VNS Choice." The Natick Visiting Nurse Association is a CHHA; the same organization has a LHCSA called "New Century Home Care."

Damage Control

Your client may already be receiving private home care through a LHCSA but doesn't realize Medicaid won't pay the bill when Medicaid is approved. If the LHCSA is connected to a CHHA, try to get the CHHA to accept the case "Medicaid pending" – client should be able to keep the same aides. This way CHHA can bill for the services once Medicaid is accepted. Otherwise client/family must PAY the LHCSA and then seek reimbursement from Medicaid.

Appeal Rights Of CHHA Recipients

Certified Home Health Agencies, known as "CHHAs," may not unilaterally deny or cut hours of Medicaid "home health aides" or other Medicaid home health services.

Under an important federal court decision, called *Catanzano v. Dowling*, 60 F.3rd 113 (2nd Circuit 1995), a CHHA client is entitled to notice and fair hearing rights before her services are cut or terminated. This gives CHHA clients essentially the same rights as personal care clients -- the right to

request a hearing and continue to receive the former level of home care as "aid continuing" until the hearing is held and decided.

New applicants denied admission to the CHHA may not receive “aid continuing,” but are entitled to a hearing to contest the denial.

However, there are exceptions to the right to a hearing: if conditions in the client’s home are deemed unsafe for CHHA employees, for example, or if the client’s doctor agrees with the CHHA’s reduction of hours. Ask doctors to read orders carefully before signing them, and explain their patients’ rights to receive the care they prescribe.

The following rules are in the *Catanzano Implementation Plan*, 18 NYCRR 505.23 Appendix 156 and in 10 NYCRR 763.5).

Rights of current CHHA recipients, including those temporarily in hospital or nursing home, to continue receiving services as long as the doctor certifies that the current home care is necessary.

Before the CHHA cuts services for any of the reasons listed below, the CHHA must refer the case to the local Medicaid office (HRA in NYC), which then must send the client a Notice with the right to request a hearing to contest the proposed reduction or termination, and with the right to receive "aid continuing" -- the same services the client has been receiving -- until the hearing is held and decided. At the hearing, the client can challenge the proposed cut. The CHHA must refer the case to HRA to give notice before cutting services if the CHHA believes:

- The client's medical condition has changed or improved or therapeutic goals have been attained and client can function independently or with other support, services are no longer sufficient to meet changing needs and maintain recipients' health & safety, and client needs institutional placement or alternative care.
- Client is not self-directing and no one is available to direct care, or client, family, or informal supports are non-compliant with or interfere with plan or care to the extent that it will lead to an immediate deterioration of the patient's condition serious enough that home care will no longer be safe and appropriate, or making it impossible to attain reasonable therapeutic goals
- services can be reduced by using “efficiencies” like cluster care or PERS
- If the client requests the CHHA to stop services, the CHHA must still continue services if the client's physician believes that services should

continue. In such cases the CHHA should refer the case to HRA to send the client notice with hearing rights.

NOTE: Hospitalization of the client is NOT a reason in itself for terminating services. Upon discharge from the hospital, the CHHA must reinstate services in the same amount of hours provided before. Only if one of the reasons listed in (a) - (e) above exist may the CHHA refer the case to HRA to give notice of that reason, but meanwhile MUST reinstate the former amount of home care upon discharge while HRA issues a notice, and a hearing is requested. See Catanzano Implementation Plan, 18 NYCRR 505.23, which defines "applicant" as someone who does not receive home care, and did not receive home care immediately prior to a current application . Hospitalized persons who DID receive CHHA care prior to the hospital stay are "recipients" so are entitled to Advance notice and Aid Continuing rights. CHHAS may claim that they will reinstate services only if the hospital stay was 30 or 90 days. This is wrong. Under *Granato*, it should not matter how long the hospital or nursing home stay is.

Exceptions: Certain Conditions When the CHHA May Cut Or Deny Services Without Referring to DSS/HRA To Give Notice And Right To a Hearing:

- Treating Physician Agrees With CHHA

  Unfortunately, the Catanzano judge created an exception to the rule that CHHA clients must have a right to a hearing. If the client's doctor "agrees" with the CHHA's decision to reduce, terminate, or deny care, then the client has NO RIGHT TO APPEAL. See preface of Implementation Plan, 18 NYCRR 505.23 Appendix. P.156. [22] The doctor's "agreement" would be indicated on the orders s/he must sign every 60 days on a "Physician's Certification and Plan of Care" form prepared by the CHHA If on this form, or elsewhere, the doctor signs for reduced hours, or for termination of services, the CHHA does not have to provide notice and the right to a hearing with "aid continuing."

[22] NOTE: In the latest and last round of *Catanzano v. Wing*, 277 F.3d 99 (2nd Cir. 2001), the case was dismissed based on mootness because of the "sunset" of the fiscal assessment law. This dismissal did not affect earlier court rulings that established the notice and hearing rights described above. But the district court had ruled for the State on one issue - precluding fair hearing rights if the treating physician "agreed" with the CHHA about a reduction, denial, or termination of CHHA care. The Second Circuit vacated this part of the decision on a procedural ground - not on the merits, preserving the "treating physician exception" for later litigation. Until successfully challenged, though, State policy is to deny fair hearing rights if the treating physician has signed off on the reduction or termination.

TIP: Ask doctors to read orders carefully before signing them, and explain their patients' rights to receive the care they prescribe. Often the CHHA tells the doctor the prescribed care is "too expensive" or "Medicaid doesn't pay for it anymore," so the doctor signs orders reducing the hours. Advocates must educate physicians that Medicaid still pays for 24-hour home health care.

SEE EXAMPLE of doctor's orders and doctor's statement clarifying that he did not mean to order reduction in services by signing CHHA's plan of care.

- If conditions in the home imminently threaten the safety of CHHA personnel or jeopardize the agency's ability to provide care. EXAMPLES: physical assault likely to happen, presence of weapons, criminal activity or contraband material or continuing severe verbal threats creating a reasonable concern for safety of CHHA personnel, or
- If CHHA has valid reason to believe that CHHA personnel will be subject to continuing severe verbal abuse which will jeopardize the agency's ability to secure sufficient staff or provide care.

NOTE: Even in such "exception" cases, the CHHA must follow requirements of the Department of Health for "discharge planning," which require consultation with the client's doctor and other supports, and continuation of "services to the extent necessary to address minimally essential patient health and safety needs until such time as an alternative placement becomes available and such placement is made, or until the patient or legal representative makes an informed choice to refuse such placement." The CHHA must make a referral to APS. 10 NYCRR 763.5

Rights of new CHHA applicants

If CHHA wants to DENY home health services prescribed by the physician, in certain circumstances it must refer the case to HRA to review the CHHA's decision and give NOTICE to the client of the right to request a hearing:

DENIALS because client is appropriate for an "efficiency" such as shared aide, home attendant, PERS, etc, or because of fiscal assessment (which is no longer applicable).

CHHA MUST send case to HRA to review. If HRA agrees with CHHA, HRA must send client NOTICE of denial with right to request a hearing.

If HRA disagrees with CHHA, it must find a CHHA to take the case or DIRECT a CHHA to take case.

NOTE: Lately CHHAs have been denying care claiming that client has no "skilled" needs. In such cases, demand that CHHA refer case to HRA to give notice, because CHHA is essentially saying that client is eligible for personal care. In fact, Medicaid rules have no requirement that client must have skilled needs to receive Medicaid home health care. (Unlike Medicare). If CHHA rejects case because the services ordered by the physician "Cannot maintain the client's health and safety in the home" for one of the following reasons (1) or (2), then CHHA must follow procedures described in (3) below.

(1) Client does not meet any ONE of the following:

i. she is self-directing, OR

ii. is able to call for help to someone outside who can provide timely assistance; OR if can be left alone - does not require continuous presence to meet ongoing health and safety requirements, OR

iii. has informal supports or, if in adult home, adult home personnel, who are able, available and willing to provide care when CHHA personnel not present.

(2) Based on CHHA's previous experience with delivery of care from the agency, client or informal supports are known to repeatedly refuse to comply with plan or care or interfere with plan or care to the extent that it will lead to an immediate deterioration of the patient's condition serious enough that home care will no longer be safe and appropriate, or making it impossible to attain reasonable therapeutic goals.

(3) If CHHA believes client meets (1) or (2) above, the CHHA must consult with the physician and develop, if possible, a plan of care that would maintain health and safety. If they cannot develop a plan of care that the CHHA believes would maintain health and safety, the CHHA must follow these procedures:

- HOSPITALIZED Medicaid recipient – CHHA must refer case to discharge planner who will attempt to find another CHHA. If no CHHA can be found, discharge planner OR original CHHA must refer case to HRA, with copy of CHHA's assessment, physician's order. They must advise client case referred to HRA.
- NON-HOSPITALIZED recipient – CHHA must refer case they reject to HRA/local district.

HRA, upon referral, must have local medical director evaluate case within 10 days to decide whether CHHA services should be provided in accordance with physician's order, or denied contrary to physician.

If HRA agrees with CHHA to DENY care, HRA must send NOTICE with right to request a hearing. If HRA disagrees with CHHA and believes CHHA services can maintain health and safety, HRA must attempt to refer case to a CHHA. If HRA can't find a CHHA that will take case, HRA must DIRECT CHHA to admit recipient and provide services ordered by physician.

EXCEPTIONS – The CHHA does not have to refer the case to HRA if the reason it is rejecting the case is listed above in Section VII. A (2) (imminent threat to safety of CHHA personnel or patient's doctor AGREES with CHHA's denial). Even then, CHHA must refer to PSA.

MLTC/managed care and CHHA

CHHA services are a mandatory service of both mainstream MMC and MLTC. Because CHHA's can bill Medicaid on a fee for service basis outside of the MLTC/managed care plan, it can be difficult to find out whether a determination to deny, reduce or terminate CHHA services was made by the PLAN or made by the CHHA apart from the plan. You have to find out if the CHHA was operating as a plan contractor – in which case your appeal would be against the plan, or independently providing services outside of the plan, in which case your appeal is against the CHHA.

In MLTC, where most members are dual eligible, it is common for the client to receive CHHA services after a hospital or rehab stay paid for by Medicare – totally outside of the MLTC plan. If the CHHA acts adversely, the appeal is against the CHHA. However, the MLTC plan is required to coordinate all services including those not provided directly by the plan. See e.g. Model MLTC contract defines person centered care management to include "enlisting the involvement of community organizations that are not providing covered services, but are otherwise important to the health and well-being of Enrollees;… and providing care coordination of all services the Enrollee receives including transitions between care settings such as hospital to nursing home and nursing home to home…" Contract Article V, Sec. J.7.d.(vi) and (viii). In one case, NYLAG successfully advocated for an MLTC to restore hours reduced by a CHHA that was providing services separately from the MLTC Plan, based on the plan's responsibility for coordinating the over all plan of care.

Advocacy Tips For CHHA Clients

- MAKE SURE TREATING PHYSICIAN HAS NOT SIGNED ORDER "AGREEING" WITH CHHA's REDUCTION or DENIAL. If CHHA denies services, or threatens to cut or stop services, ask the client's doctor if he or she signed an order approving a reduction in services. If so, ask doctor to send a corrected order to the CHHA, specifying the amount of home health aide hours that are medically necessary. Keep a copy.
- If CHHA or MLTC/managed care plan authorizing the services does not obey doctor's corrected order, ASK FOR A HEARING (call 212-344-0055) and ask to talk to the CHHA's director or lawyer. Tell the director or lawyer about Catanzano and the state regulations.
- If the CHHA case has been "converted" to personal care services, but the hours have been reduced, ASK FOR A HEARING with AID CONTINUING to keep the CHHA's old amount of hours. A change in the level of service from CHHA to personal care is an adverse change that should trigger these due process protections.
- IF CHHA APPROVES LESS CARE THAN NEEDED – If the CHHA approves fewer hours of care than the client needs, the treating physician must state in writing to the CHHA the number of hours that are medically necessary. The physician's order triggers the duty of the client to refer the case to the local district (HRA), which, if it agrees with the CHHA, must send the client a notice with hearing rights.

  TIP: In practice, the doctor usually makes a referral to a CHHA orally, not in writing. After the CHHA assesses the client, the CHHA prepares the "plan of care" for the doctor to sign. So the doctor's order reflects the number of hours the CHHA believes the patient needs, rather than what the doctor believes. If the doctor "agrees" with the CHHA, under Catanzano the client has NO APPEAL RIGHTS. Therefore the doctor's view MUST be put in writing.

  If client doesn't get notice -- In reality, CHHAs still give only oral notice, and don't refer their cases to HRA to give written notice. Ask for a hearing anyway, based on:

  – failure to give written notice
  – CHHA's action is wrong in substance (e.g. hours shouldn't be reduced, stopped, admission shouldn't have been denied)
- **AID CONTINUING** -- If CHHA threatens to or does actually REDUCE hours or TERMINATE services, client is entitled to "aid continuing" -- services at the unreduced level-- until the hearing is held and decided.

TO get aid continuing, you must request the hearing on time, before the "effective date" on the notice.

If there was no notice -- it is never too late to get aid continuing.

WARNING – CHHA may maintain that aid continuing is not required because doctor "agreed" with reduction. Get the doctor to fax CHHA an "order" specifying that client needs former amount of hours.

If a CHHA client is hospitalized -- the CHHA must reinstate services when the client is discharged in the same amount of hours the CHHA provided before the hospital stay. The CHHA may not refuse to reinstate service -- must give notice with AID CONTINUING and HEARING rights before reducing or terminating services. This is in the *Catanzano* implementation plan which incorporates *Granato v. Bane*, 74 F.3d 406 (2d. Cir. 1996).

Private Duty Nursing

Clients with continuous skilled nursing needs may need a Licensed Practical Nurse (LPN) or Registered Nurse for up to 24-hours a day. Intravenous or gastro-intestinal feeding, suctioning of tracheostomies, direct administration of medications (putting a pill directly in the client's mouth), operating a ventilator are examples of tasks that aides may not perform. The exception to this restriction is if client enrolled in the Consumer-Directed Personal Assistance Program (CDPAP) or "CONCEPTS" – these aides may perform "skilled" tasks. See below.

MEDICARE does not pay for this service.

MEDICAID pays for up to 24-hour split-shift care. SSL § 365-a, subd. 2(a), 18 NYCRR § 505.8. Medicaid private duty nursing care must be authorized by the State Department of Health (DOH) Bureau of Medical Review and Evaluation in a "prior approval" process. 18 NYCRR 513.

How To Apply

Adult dual eligible not excluded from mandatory enrollment in MLTC must request these services from their MLTC, MAP , PACE, or FIDA plan. For clients with Medicaid but not Medicare, if they are enrolled in mainstream Medicaid Managed Care, they must access the services through that plan. A nursing vendor in the plan's network may assist in preparing the prior approval forms to get approval from the plan.

Sample letters of physicians available upon request.

By MLTC Policy 13.07: Private Duty Nursing Summary, issued in March 2013, DOH instructed MLTC plans to comply with an earlier directive 08-INF–5 (Aug. 18, 2008),[23] that establishes procedures for applying for nursing services. This directive was the result of a settlement in *Leon v. Danes, et.al.,* (CV 07-1674 E.D.N.Y, June 12, 2008)[24]. The directive describes private duty nursing services, informs applicants (and their representatives) as to who can

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[23] http://www.health.state.ny.us/health_care/medicaid/publications/docs/inf/08inf-5.pdf

[24] Settlement posted on the Online Resources Center of www.wnylc.net. Registration is required to access postings, but it's free.

provide the services, describes how to apply for services, and requires decisions to be made within 21 days of a fully documented application. It explains how to obtain a list of Medicaid private duty nurses in the local area by calling the Medicaid helpline at 1-800-541-2831 and online at www.homecare.nyhealth.gov. (The same directive does not appear to have been issued to mainstream plans, but it is a covered benefit so it should apply).

Fiscal Assessment Law

SSL § 367-l required denial of LPN services if they would cost more than a nursing home, BUT THIS LAW EXPIRED JUNE 30, 1999. Fiscal assessment limited LPN hours to only about 6-7 per day, but now should NOT BE LIMITED based on cost. However, language in the "prior approval" regulations still allows DOH to consider whether "other adequate and less expensive alternatives have been explored and, where appropriate and cost-effective, are approved." 18 NYCRR § 513(b). So the treating MD should explain why a cheaper form of care – like nursing home care – is harmful or not appropriate.

Appeal Rights

Fair hearing may be requested if services denied, inadequate hours authorized, or services reduced or terminated.

GET THE INTERNAL CASE RECORD FROM DOH or Plan TO PREPARE for hearing

Nursing Payment Rates

With the shortage of nurses nationwide, it is difficult to find nurses willing to work at Medicaid rates.

The Coalition for Medically Fragile Children developed legislation enacted in 2006 that created a continuous home nursing rate for medically fragile children under age 21. Medically fragile children are defined as those needing continuous home nursing services – whether provided through a CHHA, a LHCSA, or a long term home health care program. The program took effect on January 1, 2007 and will sunset in 2011. NY Soc. Serv. L. § 367-r; NY Pub. Health L. § 3614, subd. 3-a. Private duty nurses may be held responsible for submitting certification of licensing and quality. In addition, case management services began in January 2007.

The settlement in *Leon v. Danes, et. al., supra,* establishes statewide procedures for obtaining Medicaid private duty nursing services if there is difficulty finding a provider. One option is to apply at the local DSS for a DOH case-specific enhanced payment rate. The enhanced rate is applicable in *all* DSS districts in the State pursuant to the Settlement. See DOH 08- INF–5, *supra*.

Home and Community-Based Services (HCBS) Waiver Programs

Medicaid waivers give CMS, the federal Medicaid agency, broad discretion to waive Medicaid state plan requirements contained in §1902 (42 U.S.C. §1396a) of the Social Security Act. Section 1915(c) waivers, known as "Home and Community Based Care" waivers (or HCBS waivers), permit states to develop and implement community-based alternatives to placing Medicaid-eligible individuals in hospitals, nursing homes or intermediate care facilities for persons with mental retardation. Thus, the range of target groups is limited to those who would otherwise be in institutions. Services that may be provided in HCBS waiver programs include: case management, homemaker/home health aide services; personal care services; adult day health or day care; respite care; transportation services; special communication services, minor home modifications; and others.

These waivers typically target specific groups: the elderly, persons with physical disability, DD/MR, or persons with specific illnesses or conditions such as AIDS. The programs must be **cost neutral**, meaning that on an average per-capita basis, the cost of providing HCBS must not exceed cost of care for the identical population in an institution. This is why hours of aide service rarely exceed 8 hours/day in the Lombardi and other waiver programs.

Generally, the waivers are approved by CMS for three years and then renewable at five-year intervals.

Waiver Programs in New York State

Long Term Home Health Care Program (LTHHCP) aka "Lombardi"

PROGRAM HAS BEEN PHASED OUT beginning April 1, 2013.

Lombardi was the largest and most popular one among seniors. It is also known as the Long Term Home Health Care program or Nursing Home Without Walls. This waiver program provided a coordinated care plan of visiting nurse, home care, adult day care, social work by certified home

health agencies, hospitals, and nursing homes.[25] As in all waiver programs, the client must be medically eligible for nursing home care, which is done through the DSM-3.

Cost neutrality limits the cost of care to 75% of the cost of a nursing home. Because of the cost cap and range of services, there is essentially a maximum of about 8 hours/day of home care.

On April 1, 2013, the federal CMS agency approved NYS's request to require adults receiving Lombardi services in mandatory MLTC counties to nroll in managed long term care (MLTC) plans. Also, for Medicaid-only recipients of Lombardi, the transition into Mainstream Medicaid Managed Care plans *statewide* began then as well. See CMS Letter dated April 1, 2013, posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/appr_ltr_amend_partner_plan_f-shrp.pdf.

A popular feature of Lombardi was the use of Spousal Impoverishment protections. As part of the 1115 waiver establishing MLTC, these protections now apply to all married couples in MLTC. (discussed elsewehere).

AIDS Home Care Program

NY SSL §367-e; 18 NYCRR §505.21(a)(2); 92-ADM-25 (June 15, 1992)

"Katie Beckett" Waiver Program for Children

86-ADM-4 (February 12, 1986). For info in NYC call 212-360-5444 HRA, Ann Ghosh-ray

Care at Home Waiver Program for Children

NYC HRA Contact: Andrea Makdisi (212) 360-5445[26]

DOH manual for parents posted at http://www.health.state.ny.us/nysdoh/medicaid/cah/crhmgts.pdf; Arkontaky, Adrienne, *Special Needs Forum: Waivers In New York,* NYSBA Elder Law Attorney, Fall 2008, Vol. 18 No. 4, p. 25.

90-ADM-20 (May 30, 1990); 92 LCM 170; DOH manual for parents posted at http://www.health.state.ny.us/nysdoh/medicaid/cah/crhmgts.pdf;

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[25] SSL §§ 367-c, 366(6), 461-1.1(d); NY Pub Health Law § 3602.8, 3616.1; 10 NYCRR § 505.21, 78 ADM-70, 80 ADM-77, 83 ADM-74, 85-ADM-27, 89 INF-20

[26] 90-ADM-20 (May 30, 1990); 92 LCM 170 (DSS/OMRDD Home and Community Based Services Waiver").

Arkontaky, Adrienne, *Special Needs Forum: Waivers In New York,* NYSBA Elder Law Attorney, Fall 2008, Vol. 18 No. 4, p. 25.

GIS 09 OLTC/004 (April 2009) clarifies criteria – must:

- Be under the age of 18 (and not married);
- Be physically disabled, according to the SSI program criteria;
- Require the level of care provided by a skilled nursing facility or hospital, and
- Be capable of being cared for in the community safely.

Note: Applicants no longer require a 30 day inpatient stay.

Parents' income and resources not counted

OPWDD Home and Community-Based Services (HCBS) Waiver

must be developmentally disabled and be eligible for ICF/MF level of care. SSL 366(7), 92 INF-33, 92 LCM-170, 94 LCM-24, 94 LCM-147; http://www.health.state.ny.us/health_care/medicaid/program/longterm/omrdd.htm

Waiver is being totally revamped – People First Waiver – see http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/home

Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance (OMH)

http://www.health.state.ny.us/health_care/medicaid/program/longterm/omh.htm

Traumatic Brain Injury (TBI) Waiver Program

Age 18 - 64, must be injured after age 18 and enter program before 65, but may remain after 65. About 1600 participants. A Regional Resource Development Specialist (RRDS) educates the individual about the waiver program, helps the applicant select a service coordinator, and approves all service plans. Includes 11 services, and may include housing subsidies. DOH TBI Waiver Services may be accessed through the DOH Regional Resource Centers.
http://www.bianys.org/how_we_can_help_nursing.html[27]

[27] N.Y. Pub Health § 2740 et seq, 95 LCM-70, 96 INF-21; (HCBS/TBI) Program Manual (June 2006, 123 pp.), available at:
(cont'd)

GIS 12 MA/013 - reinstates Spousal Impoverishment protections in waiver.

Hallmark feature of this waiver is the *housing subsidy allowance*, which makes it possible for some people to leave nursing homes.

Nursing Home Transition and Diversion Waiver (NHTDW)

Enacted October 19, 2004 (S.7073, A11350A), adding new SSL § 366(6-a). Up to 5000 slots for nursing home-eligible persons over age 18, regardless of the type of their disability. Unlike TBI waiver, no specified housing subsidies. Uses the Money Follows the Person Act wherein the federal government will pay 100 percent of the first year of Medicaid costs for individuals who transition out of nursing homes. County pays 10% cost. Implemented 2008.

Administered through Regional Resource Development Centers (RRDC), each covering specific counties. Each RRDC has a Specialist and a Nurse Evaluator. List at http://www.health.ny.gov/facilities/long_term_care/regional_resource_development_centers.htm.

State DOH NHTDW manual posted at http://www.health.state.ny.us/facilities/long_term_care/waiver/nhtd_manual/index.htm

Cost Neutrality

Targeted aggregate average cost for all waiver participants in a region may not exceed cost of serving such individuals in an institutional setting. “Aggregate” cost is better than an individual cost cap, as is used in some waivers.

Bridges To Health (B2H)

Eff. 1/1/08, provides family and community support services to 3,305 children statewide that will supplement, not replace, the existing foster care and Medicaid State Plan programs.
http://www.ocfs.state.ny.us/main/b2h/manual.asp

DOH GIS 08 LTC-001
http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08oltc001.pdf

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http://www.health.state.ny.us/health_care/medicaid/reference/tbi/docs/tbiprovidermanual.pdf

Financial Eligibility for HCBS Waiver Programs

Transfer of assets

Under state directive dated 9/24/07, the look back and penalty no longer apply to any Waiver Services. GIS 07 MA/018 http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma018.pdf

Pooled Income Trusts

Waiver programs have historically been treated as "institutional" programs for purposes of Medicaid budgeting. In *Wong v. Doar*, 571 F.3d 247 (2d. Cir. 2009) the Second Circuit held that income placed into an SNT is countable using institutional budgeting -- the budgeting used in nursing homes. This means that the "Net Available Monthly Income" (NAMI) may not be eliminated by placing excess income into a Supplemental Trust in programs using institutional budgeting. At the time *Wong* was filed, institutional budgeting was used not only in nursing homes but also in home-and-community-based **waiver programs** such as Lombardi and TBI.

In April 2008, however, the new Nursing Home Transition & Diversion Waiver was implemented, using community budgeting rather than institutional budgeting.[28] In September 2008, the *Traumatic Brain Injury* waiver program was changed from institutional budgeting to community budgeting.[29] Since community budgeting is used in these programs, waiver participants should be able to eliminate their spend down by depositing their excess income into an SNT.

Meanwhile, as part of the Patient Protection Act enacted as part of the Affordable Care Act, since Jan. 1, 2014, all states must allow Spousal Impoverishment budgeting in 1915 waiver programs, which include both the TBI and NHTDW programs. State DOh policy has shifted a number of times, but currently waiver participants may use spousal protections if they choose, but alternately they may use regular community budgeting, which would include use of pooled trusts. **GIS 14 MA/025** - Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act **(**PDF), dated Nov. 3, 2014, rescinds an earlier NYS **DOH** GIS 14 MA/015, **issued**

[28] For the NHTDW program, see DOH 08-OLTC-ADM-1, 4/28/08 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/08oltcadm-1.pdf pp. 5-6

[29] For the TBI program, see NYS DOH Directive 08-MA–024, 8/26/08, http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08ma024.pdf

August 5, 2014, and reinstates two even earlier directives. See more at http://www.wnylc.com/health/entry/165/.

Hearing Rights in LTHHCP

Waiver (LTHHCP) clients have right to notice, hearing and aid continuing rights when LTHHCP services are denied, reduced or discontinued.[30] Local Districts such as HRA sometimes send notices to terminate LTHHCP of many clients and convert them to personal care, based on the alleged lack of need for "coordinated care." Some of these terminations are technically "denials" because the LTHHCP accepted the client pending HRA's approval. So even though HRA took months to DENY the approval, and the client received care for all those months, the client is technically an "applicant." Clients can win these hearings showing need for coordinated care.[31]

Complaint Process in Waivers

- Care at Home I/II Program Complaint Process - http://www.health.ny.gov/facilities/long_term_care/complaint_medicaid_ltc_waivers/2011-12-08_cah_complaint_process.htm
- Long Term Home Health Care (Lombardi) Program Complaint Process http://www.health.ny.gov/facilities/long_term_care/complaint_medicaid_ltc_waivers/2011-12-08_lthhcp_complaint_process.htm
- Nursing Home Transition and Diversion Program Complaint Process – http://www.health.ny.gov/facilities/long_term_care/complaint_medicaid_ltc_waivers/2011-12-08_nhtd_complaint_protocol.htm
- Traumatic Brain Injury Program Complaint Process - - http://www.health.ny.gov/facilities/long_term_care/complaint_medicaid_ltc_waivers/2011-12-08_tbi_complaint_process.htm

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[30] Bernard v. Novello (E.D.N.Y. No. 00 CV 260) – Settlement incorporated in 02 OMM/ADM-4 (May 28, 2002)(Notice and Fair Hearing Procedures for the LTHHCP).

[31] See decisions posted on WNYLC.net Online Resource Center Fair Hearing database. Must register to view decisions, but it's free. About other waiver litigation nationally, *see* *Status Report: Litigation Concerning Home and Community Services for People with Disabilities,* http://www.hsri.org/index.asp?id=news, by Human Services Research Institute (updated bi-monthly, last in June 2006).

Appeals

Every adverse action is appealable at an administrative hearing, presided over by the State Department of Health. This includes initial DENIALS of applications, DENIALS of increases, an INADEQUATE INITIAL AUTHORIZATION, and threatened REDUCTIONS or TERMINATIONS of care. Once a client is authorized to receive a service, it cannot be taken away or reduced without advance NOTICE, with the right to receive AID CONTINUING until the hearing is held and decided.[32]

Effective July 1, 2015, appeal rights in MLTC were changed so that an internal appeal within the plan is no longer required before requesting a Fair Hearing. DOH MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Plan Enrollees. (July 2, 2015). See more at http://www.wnylc.com/health/entry/184/.

Notice

Like DSS, MLTC and mainstream plans are supposed to send a written notice of every determination, but often do not send a notice. Receipt of a notice is NOT a prerequisite for requesting a hearing. EX: On initial applications, the client often learns her case was accepted from the home care vendor, and does not get written notice. If the hours are inadequate, she may nevertheless request a hearing. This is still true in MLTC and mainstream managed care.

Advance Notice

If client is already receiving Medicaid home care, the managed care plan/DSS must give ADVANCE NOTICE 10-days before reducing or terminating care.

Aid Continuing

If client requests a hearing before the "effective date" of the proposed adverse action (within the 10-day advance notice period), the proposed reduction or termination CANNOT take place until the hearing is held and decided

[32] Notice and hearing rights are governed by 18 NYRR Part 358. The regulations at 18 NYCRR 505.14(b) contain some additional particular notice requirements.

Authorization Periods and Appeals

In the MLTC program, the Department of Health originally authorized MLTC plans to reduce and terminate hours of home care services, with no right to Aid Continuing, if the plan's service reduction coincided with the end of the plan's "authorization period" for the services. Home care services have always been authorized for an "authorization period" of up to six months. This ensures that the administrator - whether the local Medicaid program or an MLTC plan -- has reassessed the individual's needs to make sure services meet changing needs. Since these are LONG-TERM care services, the end of the authorization period does not mean services should end - they should be reauthorized with no interruption. But - the State's view allowed disruption and even termination of these services without these crucial hearing rights.

The 2014 NYS Budget included an amendment that guarantees the right to receive AID CONTINUING "without regard to expiration of a prior service authorization." Soc. Services Law Sec 365-a, subd. 8. This amendment, enacted in 2014, was communicated to the MLTC plans by MLTC Policy 14.05: Aid-continuing (Aug. 6, 2014)(appendix p. 15)

Reductions Masked as Denials of Home Care

A related strategy used by managed care plans to deny Aid Continuing rights is the mischaracterization of a REDUCTION in services as a DENIAL. This practice has the effect of denying aid continuing because an individual is not entitled to aid continuing when appealing a "denial" of a new or increased amount of services, since she is not yet entitled to that increase. But an ongoing recipient is always entitled to appeal a reduction in the service they have been determined eligible for. In August 2015, DOH issued MLTC Policy 14.05(a) REVISED Proper Handling of Enrollees' Request for Fair Hearing, which prohibits this practice. (Appendix p. 16)

DOH Issues Model Notice Templates

Responding to advocates' complaints and a lawsuit about defective notices, called *Taylor v. Zucker,* DOH has issued model notices to both mainstream and MLTC plans.

Mainstream notices were sent to plans on Dec. 2, 2014, with an implementation target date of March 1, 2015.

MLTC notices were sent to plans on Mar. 15, 2015, with an implementation target date of May 15, 2015. The notices with the state directive are posted at the following link:

- **Model Initial Adverse Determination (IAD)(pp 12 -22 of this PDF)** http://www.wnylc.com/health/download/579/
    - Replaces the Plan Decision Template found in Appendix K of the Model Contract http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf
    - Provides details on all three appeals options (internal, external, and fair hearing)

- **4687 MLTC Action Taken - Denial, Reduction or Termination of Benefits ("Action Taken Notice") (pp 4-11 of this PDF)** http://www.wnylc.com/health/download/579/
    - Informs consumers of their fair hearing rights regarding the action
    - Provides consumers with a form they can submit to request a fair hearing

Time Limits To Request Hearing and Aid Continuing

You have 60 days to request a hearing from the date of the notice (or date of mailing of the notice if later), but you only get AID CONTINUING if you ask for the hearing BEFORE the effective date of the notice - less than 10 days.

- Try to get aid continuing even after 10 days, OR
- Ask for the HEARING even AFTER 60 DAYS if: (1) client didn't receive the notice, (2) notice was "inadequate" -- misleading or incomplete.

In close cases, look at the postmark of the envelope the notice was sent in – if later than the date of the notice, the time limit runs from mailing.

If you think your client needs a hearing, contact the Legal Resources Program.

If You Miss The Deadline To Appeal

Submit a new M11q requesting an increase in hours. If request is denied, or not acted upon promptly, then request a hearing.

Effect Of Notice Dates On Reimbursement

If the client will seek reimbursement for home care privately paid for, it is very important to request a hearing within the time limits. SEE REIMBURSEMENT SECTION BELOW.

How To Request A Hearing

Same for all types of home care

See complete list of FH contacts at App. p.19

Phone

212-344-0055 212-417-6550 800-342-3334 statewide toll-free

Fax 518-473-6735 –

use form http://otda.ny.gov/oah/FHReq.asp)

Mail POB 1939 Albany NY 12201-1939

REQUEST FORM and FORM adjournment request

Online

http://otda.ny.gov/oah/

FAIR HEARING REQUEST FORM
Office of Administrative Hearings
P.O. BOX 1930
Albany, NY 12201-1930
Fax: (518) 473-6735

Note: For security purposes, you have 15 minutes to complete this form, otherwise your request will not be received and you will need to start over.

*Indicates Required Information. Correct and complete information will permit us to promptly process your request.

Case Information
(If fair hearing is for someone other than the case name, describe who it is for in the comments box below.)

*Last Name
*First Name
Middle Initial
*Street Address
Suite/Floor/Apt#
*City
*State NY
Zip Code
Email Address
Phone ( ) -
Date of Birth (mm/dd/yyyy) / /
SSN - -
Male (click one)
Female
Case#
Client ID Number (CIN)
How many adults in case?
How many children in case?
Upstate County or NYC Center#
If an interpreter is needed, please enter the

Adjournments

Statewide toll free 1-877-209-1134 or http://otda.ny.gov/oah/

Phone Or Home Hearings

Under the preliminary injunction in *Varshavsky v. Perales*, 608 N.Y.S.2d 194 (App. Div. 1994) People who cannot travel to the hearing because of a disability can ask for a "home hearing," where the Administrative Law Judge comes to their home. They do not get a home hearing at first, though. FIRST, there is a PHONE HEARING or a REPRESENTATIVE hearing, in which a family member or advocate appears at the hearing for them. If they win this first hearing, that is the end of the process. If they lose the first hearing, the State must schedule a second hearing at HOME. If they had aid continuing, this aid must continue pending the home hearing. If they did not have aid continuing, they may get special interim aid while awaiting the home hearing - see below.

How To Request Home Hearing

Ask for a phone or representative hearing in the same way as any other hearing - and state that the client is homebound. For info or adjournments once a case is referred for a home hearing, call the HOME HEARING UNIT at 518-474-5415 (Pat Keayes).

If you use the online hearing request form, check the box indicating that the client is homebound:

Client ID Number (CIN)
How many adults in case?
How many children in case?
Upstate County or NYC Center#
If an interpreter is needed, please enter the language or dialect
Is client homebound? ⦿ Yes ○ No
(If yes, mail medical documentation to the above address. Do not delay submitting this fair hearing request form to obtain medical documentation.)

YOU won't receive a decision after the first hearing if you "lose" – you will simply receive a letter from the State telling you that the hearing will be rescheduled for a home hearing.

Interim Aid - Temporary Increase In Home Care

Extra benefit of home hearing -- in addition to getting a second bite at the apple by having a 2nd hearing, client can get special "interim aid" after the 1st phone or representative hearing while waiting for the 2nd home hearing. Interim aid is the amount of hours client wanted but did not get -- so it is more than standard "aid continuing." Confusingly, it is called "Aid Continuing" anyway.

Example: HRA denied request for increase from 8 hours to 24 sleep-in, which client appealed. Interim aid is 24 hours sleep-in.

If issue is denial of an initial application, there is no "interim aid" thru Varshavsky. Client must have been found eligible for Medicaid and for services to receive interim aid.

NOTE: The State hearing program (OTADA) does not send clear notices explaining that the aid is temporary. Many clients and advocates mistakenly believe the client has somehow received a permanent increase, and withdraw the fair hearing request! Of course, then the aid is cut. Before withdrawing the hearing, confirm with the CASA that the authorization has been increased officially, not just as Aid Continuing.

Client receives Interim Increase only if case is sent on for a home hearing. Often client "wins" the first phone or regular hearing, but the decision only REMANDS the case to the district and does not authorize any INCREASE pending the remand. Those cases are not given "home hearings" because client has technically "won" a reversal of the original local decision. ADVOCACY TIP: The *Varshavsky* preliminary injunction order requires any decision that is not "fully favorable" to be referred for a home hearing. A mere remand with no actual order for care is not "fully favorable." You can write Russ Hanks directly to demand under *Varshavsky* that the client either get a home hearing or an interim increase pending the remand (see Fair Hearing contact list - App.19). Or contact Nina Keilin, class counsel for *Varshavsky* (212) 302-7760.

The interim aid ENDS when a decision is issued after the home hearing. So hours may go back down if you lose.

Some Types Of Hearings Not Referred For A Home Hearing

Counsel in *Varshavsky* agreed with the State that some types of hearings need not be referred for a home hearing, so that an Unfavorable decision is issued even after a phone or representative hearing. These are hearings where there are no facts in dispute, no issue of credibility, etc. Examples are calculation of a Food Stamp or Medicaid budget. Most hearings have factual issues and should be referred for a home hearing - e.g. number of hours of home care, Durable Medical Equipment approval cases, failure to recertify where there is an issue of whether client did recertify (credibility), etc. If you received a LOSING decision without a home hearing and want a home hearing, contact PAT KEAYES at OTADA 518-474-5415 or Nina Keilin, Esq. 212-302-7760.

Advocacy tip: If you are notified that your case will be scheduled for a home hearing under *Varshavsky*, this is an opportunity to use the long period before the hearing is scheduled to submit yet another M11q to the CASA and try to win the hours you are seeking. The delays for home hearings are so long that you have time to do this and, if denied by the CASA, to request a new hearing on that new denial. If you win "hearing 2" at the regular hearing office, you can drop the home hearing. You have a better chance of winning "hearing 2" in part because you have made sure that the M11q is drafted in thorough manner, making a better hearing record.

Waiver Of Home Hearing

If, after the first hearing, you receive the letter that a home hearing will be scheduled, and you don't want the home hearing, you can waive it, and ask for a decision based on the phone or representative hearing. Keep in mind that decision is not likely to be favorable -- you will LOSE. Some people opt to waive the home hearing because they have no further evidence to submit and are prepared to file an Article 78. Consider whether client would benefit from "interim aid" pending the home hearing, see above. Contact the home hearing unit to waive the home hearing.

Right To Obtain Case Record

State regulations require DSS/HRA or the MLTC or managed care plan to provide you with copies, at no cost, of all documents HRA will introduce at the hearing, and any other documents from your client's case record you ask for to prepare for a hearing. You need client's written authorization. 18 NYCRR § 358-3.7 (amended 11/1997).

Similarly, MLTC plans are required to provide documents upon request to prepare both for the internal appeal and the fair hearing. 42 CFR 438.

What To Request

There are 2 parts of the file you want:

- THE "HEARING PACKET" - this is what HRA will submit to prove their case – the documents they used to make the decision you are appealing (e.g. why they denied request for increase). It is the easiest part to get and you can request it by phone or fax without going to the HRA office. For new applications, the hearing packet is all you need.
- OTHER DOCUMENTS FROM THE CASE RECORD -- HRA will not bring the whole case record to the hearing or give it to you by mail. It should mail you copies of specific documents you request, however. If it is an old case, caseworkers' notes and prior assessments may be useful. If

DSS is proposed to reduce or terminate hours, ask for copies of assessments from when the current hours were first authorized, so that you can show the condition has not changed.

WARNING: The MLTC plan probably WON'T submit at the hearing your cover letter and other helpful documents you or a social worker or MD may have given in support of the request – they'll just submit their own assessments. So be prepared to submit copies AND raise their failure to consider this evidence at the hearing.

How To Request Documents

Send a request with a client's HIPAA-compliant privacy release by letter or fax., specifying what documents you want. SEE SAMPLE for MLTC plan App. p. 99.

HIPAA release - should not be required for fair hearing documents, but helpful.

For HRA: NYC - HRA Medicaid Fair Hearings Rivera Unit
Fax: 718-722-7565

KEEP fax receipts and copies of your document requests for the hearing.

Documents no longer must be provided within 3 days of the request, but only in a reasonable time. 18 NYCRR 358.3-7.

HRA/MLTC plan Duty To Submit Notice And Case Record At Hearing

Even if the client or representative DO NOT request a copy of the HRA documents in advance of the hearing, HRA still has the duty to bring a copy of its NOTICE to the client and other relevant documents to the hearing. If HRA fails to, it must withdraw the adverse notice at the hearing. *Annunziata v. Blum*, 81 Civ. 302 (CSH)(Stipulation & Judgment, Apr. 4, 1983). If plan fails to produce notice, they have not met their burden of proof of the validity of a reduction or termination. This remedy only helps where the issue of the hearing is a reduction or termination of home care.

TIP: If the client is requesting an increase, it does not help for HRA to withdraw its notice denying the increase. In such cases, you MUST be prepared to submit the local district's documents even if they don't, if you want to get relief. Otherwise, you'll just get a remand.

Other Evidence To Submit At Hearing

OBTAIN records from sources other than HRA/CASA:

- **CHHA or MANAGED LONG TERM CARE program**– all plans of care, physician's orders, nursing records, etc. SAY YOUR CLIENT IS INDIGENT AND CAN'T PAY. (NOTE - these documents are useful in conversion cases, where the CHHA authorized MORE hours than HRA is now authorizing. You can argue that the CHHA and physician approved those hours because they were "medically necessary"). Use a HIPAA release.
- **VENDOR of home care** – may have records of complaints by aides that client needs more hours (e.g. needs split shift, so sleep-in aides complain about no sleep - good for showing credibility of aides)
- **Hospital records** - sometimes useful
- **SUBMIT A BETTER M11q** TO THE CASA while hearing is pending, and submit a COPY at the hearing. Maybe you'll get a better result at the CASA and can then withdraw the hearing request. Even if you don't, you can tell the ALJ the CASA had a chance to process it but did not, supporting your request for a REVERSAL rather than a REMAND to consider "new" evidence. If the new M11q is already processed by the time the hearing is scheduled, and the increase is denied, ask the State hearing office to ADD this new denial as an issue at the same hearing.
- **SUBMIT LETTER or AFFIDAVIT from treating physician**, nurse, rehab specialist. Specifically refute any contentions of HRA's assessors – nurse, LMD (eg that client is "independent" in toileting or ambulation
- **"Expert" reference materials** -- nursing and medical textbooks and even a State DOH booklet prescribe protocol for turning and positioning every 2 hours, etc. Appendix. pp 1101
- **Testimony Of Witnesses**

  Client, family, friends, informal caregivers about actual functional limitations, history of falls, unavailability of informal caregivers at all or on weekends, existence of needs at night, evening, weekends

- **Home attendant log** -- Aide is often be the best witness. May want to subpoena her to protect her job. Ask home attendant to keep a log for a week of everything s/he does, especially during hours in dispute. Eg., sleep-in aide should keep log of 12 hours at night if seeking split shift). Submit the log or put it in an affidavit.

  HRA memo clarifying that home attendants MAY testify at fair hearings but can't represent client - available upon request

- **Prior Hearing Decisions as Precedents** – Research OTDA FH archive http://otda.ny.gov/hearings/search / and www.wnylc.com (online resource center - Fair hearing database). Also see, though not updated,

NYLAG digest of home care hearing decisions
http://www.wnylc.com/health/download/106/.

Relief Granted In Hearing

The ALJ will either *reverse* or *affirm* the local agency decision. A reversal is great in a case involving reduction or termination of benefits, because then services must be restored to the previous level. If you are seeking an increase in services, though, a "reversal" might not help. The ALJ may "reverse" an improper agency assessment, but *remand* the case to the local district (HRA) for a new assessment, rather than order the increased care you want.

Ask for TWO alternate forms of relief. If your evidence establishes the need for the hours you are requesting, ask Judge to:

- Reverse and ORDER specified amount of care (example No. 3366674K, 12/22/00 ("SS-42"- copied in appendix at p 201)
- In the alternative, reverse and order INTERIM CARE pending a reassessment. (Example SS-5 --FH 2293561N 8/29/96 at App. p. 194; SS-62 Ida O. No. 3465961L (ALJ Vass) (pro se) (March 16, 2001), 3409536Q, 1/18/01 "TBA-26" at 149. This alternative is especially important where you are just now submitting new evidence at the hearing that was not submitted to the local office, or where you only recently submitted a new M11q to DSS that has not been processed yet. ALJs favor giving the CASAs first crack at new evidence.

NOTE: If a homebound appellant does not personally appear at hearing, ALJ may NOT affirm HRA's adverse decision, and must refer for a home hearing. *Varshavsky*, above.

Grounds for Reversal

Reduction based on stale Uniform Assessment Tool or other evidence not timely

- No specific evaluation of night-time needs, or of other disputed needs, by Affiliation physician or LMD. SS-92 Ella P. No. 3556963K (ALJ Mahl) (pro se) (1/4/02); SS-69 Tanya S. No. 3430870K (ALJ Vass) (pro se by Son-In-Law and Grandson) (July 20, 2001)

- "Speculative" evidence, such as that client would sleep through the night with sleeping pills or higher dosage, etc.[33]
- Reliance on stale-dated documents, such as Affiliation physician reports that pre-dated the M11q. SS-59 Yusoup G. No. 3434554J (ALJ Vass) (pro se) (February 14, 2001)
- Failure to assess whether appellant is a "Mayer-III" case, meaning needs 24-hour care though some of that care is provided by family or other informal caregivers. TBA- Mayer III – 4 FH ~~4691096k~~ 2/6/07, Heukerott, ALJ (remanded to assess whether appellant, who lives with daughter, is a Mayer –iii, gives interim care of 8 hours day from 21 hrs/week). TBA-Mayer-III- 4 No. 3574354K (ALJ Traum) (pro se by daughter) (November 27, 2001)
- Affiliation physician report given too much weight, TBA-69 Tamara I. No. 3625679J (ALJ Vass) (January 11, 2002); TBA-71 Margot S. No. 3593264L (ALJ Mahl) (pro se) (January 4, 2002), TBA-79 No. 3560664P (ALJ Mahl) (pro se) (February 8, 2002); SS-65 Nina K. No. 3456824P (ALJ Zaret) (June 29, 2001)
- Nursing assessment not given enough weight SS-69 Tanya S. No. 3430870K (ALJ Vass) (July 20, 2001)
- Social assessment -- Informal caregivers improperly presumed to be available for care – SS-44 No. 3385956J 12/22/00 (ALJ Traum) (pro se by daughter)(reverses and orders split-shift care where daughter testified she works at least eleven hours daily x 5 days and part time on weekends and is not willing to provide informal support...."The agency on this case appears to, in effect, be coercing or requiring Appellant's daughter into providing informal support, something specifically prohibited by mandatory policy. This policy had previously been laid out in Local Commissioner's Memorandum 95 LCM-76." *See* social assessment section above.

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[33] **SS-82** No. 3488023H (ALJ Mahl) (Judith Grimaldi, Esq., Freedman & Fish, Andrew Koerner, Esq.) (10/4 2001)
SS-91 No. 3469938R (ALJ Mahl) (pro se) (12/20/01)(speculative that if took medications properly, would have no sleeping problem, where no evidence that was not taking medication properly);
SS-71 No. 3495511P (ALJ Vass) (Michael Scherz, Esq., NYLAG)(May 23, 2001);
SS-103 FH# 3782252Z Rose Y. (12/30/02) (Traum, ALJ) (pro se by daughter)(sleep meds contraindicated)

- Authorized only 5 not 7 days per week, with no evidence that client has care on the weekend. TBA-75 Beyla B. No. 3386249Q (ALJ Mahl) (pro se) (January 4, 2002).

Strategies for asking the ALJ to reverse and direct an increase instead of reverse and remand:

- ASK FOR "INTERIM INCREASE" in HOURS AT HEARING - IF URGENT SITUATION and you have strong medical evidence, ask ALJ to grant "interim increase" pending re-evaluation. See, e.g. FH decisions No. 3483589R, 3/31/03 (NYC) "SS-107", No. 3539816M, 8/2/01 "HL-24" (Available on wnylc.net) Submit a sample decision to ALJ
- ALJ often remands because he or she believes the local district/HRA has the right to review new evidence you submitted at the hearing.

Arguments to oppose a remand:

Client has right to "offer evidence in opposition to the evidence presented." 18 NYCRR 358-3.4(g). Memorandum to State DSS Hearing Officers from Russell Hanks, May 1, 1991 p. 4[34] which says:

> "In some cases, an appellant will provide evidence for the first time during the hearing which was not provided to the social services district at the time the original determination was made. Where the evidence demonstrates that a determination in the appellant's favor is now appropriate, the decision should indicate that the determination of the district was 'correct when it was made' but that new evidence requires a different result."

CAUTION: If client will seek reimbursement for care privately paid, a "correct when made" decision may not be enough to warrant reimbursement, because it may be prospective only.

To prevent remands based on "new" evidence, submit any new M11q or other evidence to the CASA/local office as much before hearing as possible. Then at the hearing you can argue that local agency already has had the opportunity to review the new evidence but has failed to do so. Otherwise the hearing will definitely be remanded.

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[34] http://onlineresources.wnylc.net/FairHearingResources/showquestion.asp?faq=4&fldAuto=2

Even if you do put in new evidence, argue that the old evidence was enough, if you can. (Especially if you are looking for reimbursement for privately paid care). Say that evidence would have been available to the agency if it had done a thorough assessment.

Glossary

Activities of Daily Living .... The routine tasks people perform every day in caring for and using their bodies. Examples include bathing, dressing, grooming, walking, transferring, and toileting

ADL .... Activities of Daily Living

CASA .... 9 borough offices within HRA Home Care Services Program where applications are filed for home attendant care and Medicaid for home attendant clients

CDPAP .... Consumer Directed Personal Assistance Program (also known as "CONCEPTS" after first and largest CDPAP vendor), in which aides may perform "skilled" nursing tasks, & consumers manage their own care. Personal care, home health, and private duty nursing clients are all eligible.

CHHA .... Certified Home Health Agency -- certified to provide Medicare & Medicaid visiting nurse & "home health aide" services. NY Pub. Health Law §§ 3602(3), 3608, 3616; NY Soc. Serv. L. 365-a(2)(d), 18 NYCRR 505.23

CONCEPTS .... "Concepts of Independence" is one of two vendors in NYC, and in other counties, for persons enrolled in the Consumer-Directed Personal Assistance Program (CDPAP),

DOH .... State Department of Health, supervises Medicaid

DSS .... State Department of Social Services. It supervised Medicaid until 1996. It no longer exists. Now DOH runs Medicaid, and "OTaDA" – the Office of Temporary & Disability Assistance runs the Office of Administrative Hearings

Expedited Hospital Discharge Program ...... HRA's system for authorizing CHHA services temporarily after a hospital stay, to be "converted" to home attendant care within a few months after hospital discharge. AKA "Bridge"

FIDA .... Fully Integrated Dual Advantage program – a demonstration program using a fully-capitated managed

care model that includes both Medicare and Medicaid covered services, including Medicaid long-term care. Solely in NYC and Nassau County in 2015, expanding to Westchester and Suffolk in 2016. Not slated to expand further.

HHA .... Home Health Aide – aide provided by CHHA, or by its subcontractor LHCSA

Home attendant... same as "personal care aide," in program administered by HRA in NYC through "CASA" offices

Home care... Assistance of another person to perform activities of daily living

HRA.. New York City Human Resources Administration runs the Medicaid program in NYC, including the Home Care Services Program and the "CASA" offices

IADL... Instrumental Activities of Daily Living

Instrumental Activities of Daily Living...... Activities that do not directly involve the person's body, but which are necessary to live in the community, such as keeping the house clean, grocery shopping, paying the bills, and doing laundry

LDSS .... Local Department of Social Services (sometimes just DSS). The unit of County government (or in NYC, of City government) responsible for operating the State-funded welfare system, including temporary assistance, SNAP, HEAP, and Medicaid.

LHCSA.. Licensed home care services agency - provides home health aide services either privately or under a subcontract from a CHHA. May not bill Medicaid directly. Licensed under Public Health Law § 3605.

M11q.. "Medical Request for Home Care" - HRA's application for home attendant services, signed by treating physician. Online at http://onlineresources.wnylc.com/kbbase/afile/34/30/

MAP .... Medicaid Advantage Plus. A type of fully-capitated managed care plan that includes both Medicare and Medicaid covered services, including Medicaid long-term care.

MLTC .... Managed Long-Term Care. Sometimes used as a generic term for Medicaid-funded private health plans providing community-based long-term care services (this includes MAP and PACE), but mostly used to refer specifically to the "partial capitation" variety of MLTC.

NHTDW .... Nursing Home Transition & Diversion Waiver

OTDA .... State Office of Temporary & Disability Assistance runs the Office of Administrative Hearings (replaced State Dept. of Social Services)

PACE .... Program of All-inclusive Care for the Elderly. A type of fully-capitated managed care plan that includes both Medicare and Medicaid covered services, including Medicaid long-term care.

PCA .... Personal Care Aide or Home Attendant

PERS .... Personal Emergency Response System - "I've fallen and I can't get up" medical alert button or pendant

Personal Care .... Formal name for home attendant program

SADC .... Social Adult Day Care

Sleep-in Care .... 24-hour per day care provided by ONE aide who sleeps at client's home but is "off duty" (and not paid) at night

Split-Shift .... 24-hour per day care provided in two 12-hour shifts (or three 8-hour shifts) - may be personal care, home health care, or LPN care. Distinguished from 24-hour "sleep-in" care. Technically "continuous 24-hour personal care services" are "uninterrupted care, by more than one person, for a patient who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day and night." 18 NYCRR 505.14(a)(3). See definition "total assistance" below.

TBA .... Task Based Assessment - cost-cutting tool in home attendant program that assessed amount of hours needed by assigning pre-set times to "tasks"

TBI .... Traumatic Brain Injury

Total Assistance .... "a specific function or task is performed and completed for the patient." Contrast with "some assistance" where "a specific function or task is performed and completed by the patient with help from another individual." 18 NYCRR 505.14(a)(2).

Vendor .... agency which contracts with HRA in NYC to provide home attendant services authorized by HRA

Endnotes

[1] N.Y. SOCIAL SERVICES LAW § 365-a(2)(e) (2013) [hereinafter SSL]; N.Y. COMP. CODES R. & REGS. tit. 18, § 505.14 (2013) [hereinafter 18 NYCRR].

[2] SSL § 365-a(2)(d); 18 NYCRR § 505.23.

[3] SSL § 365-f; 18 NYCRR § 505.28.

[4] SSL § 365-a(2)(a); 18 NYCRR § 505.8.

[5] N.Y. DEP'T OF HEALTH, NURSING HOME TRANSITION AND DIVERSION WAIVER MANUAL, § VI (September 2008), *at* http://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/home_and_community_support_services.htm

[6] 10 NYCRR § 425.1 *et seq.*

[7] 9 NYCRR § 6654.20

[8] SSL § 367-h; 18 NYCRR § 505.35.

[9] Social Security Act § 1915 *et seq.*; 42 U.S.C. § §1396a(a)(10)(A)(ii)(VI), 1396n(b) - (e).

[10] Social Security Act § 1115 *et seq.*; 42 U.S.C. § 1315.

[11] SSL § 367-c; 18 NYCRR § 505.21.

[12] N.Y. PUBLIC HEALTH LAW § 2740 *et seq.* (2013) [hereinafter PHL].

[13] SSL § 366(6-a); N.Y. DEP'T OF HEALTH, ADMINISTRATIVE DIRECTIVE: NURSING HOME TRANSITION AND DIVERSION HOME AND COMMUNITY-BASED SERVICES WAIVER, 08 OLTC/ADM-1 (April 28, 2008), *at* http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/08oltcadm-1.pdf.

[14] N.Y. MENTAL HYGIENE LAW § 13.01 *et seq.* (2013) [hereinafter MHL]; 14 NYCRR, chap. 14.

[15] PHL §§ 4403, 4403-a, & 4403-c; N.Y. DEP'T OF HEALTH, MEDICAID MANAGED CARE/FAMILY HEALTH PLUS/HIV SPECIAL NEEDS PLAN MODEL CONTRACT (August 1, 2011), *at* http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

[16] The Long-Term Care Integration and Financing Act (Chapter 659 of the Laws of 1997) established a regulatory framework under Article 44 of New York Public Health Law (Section 4403-f) for the integration of long-term care service delivery and alternative financing through the development of managed long-term care

(MLTC) plans. Medicaid regulations for managed care plans apply – 42 CFR Part 438.

[17] State law authorizing the request for the waiver is NY P.H. L. 4403(f), posted at http://www.health.ny.gov/health_care/medicaid/redesign/1115_waiver_amendment_for_managed_long_term_care.htm. The actual waiver approval is in "Special Terms and Conditions," which have been amended several times since 2012. The most recent is January 2014, is available at http://www.health.ny.gov/health_care/managed_care/appextension/docs/special_terms_and_conditions.pdf. Check for updates at this webpage - http://www.health.ny.gov/health_care/managed_care/appextension/. See "Partnership Plan Revised ST&C – Jan 2014.

[18] DOH GIS 01-MA-037 http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/01ma037.pdf

[19] See model contract.. listed in Appendix http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_model.pdf

[20] PHL § 4403-f(7)(b)(v)(8); N.Y. Dep't of Health, MLTC Policy 13.18: MLTC Guidance on Hospice Coverage (June 25, 2013), at http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_18_guidance_hospice_coverage.pdf.

[21] N.Y. Dept' of Health, Managed Long Term Care Policy 13.10: MLTC Policy Guidance – Communication with Recipients Seeking Enrollment and Continuity of Care (May 8, 2013), at http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf.

[22] http://www.health.ny.gov/health_care/medicaid/redesign/docs/partnership_amendment_stc.pdf

[23] http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_model.pdf