MEDICAID TOPICS 2016

by

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Medicaid Topics 2016
NYSBA Intermediate Elder Law CLE

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Topics covered

1. What is MAGI Medicaid under the Affordable Care Act?
   A. What is MAGI and who is eligible? How is household size calculated
   B. Who has a CHOICE of MAGI or NON-MAGI and how to choose?
   C. Can a MAGI person get Long Term Care – Home care or Nursing Home?
   D. Transitions Issues – When a MAGI person becomes eligible for Medicare – What Happens? What if She was receiving Home Care?
2. Update on MLTC and FIDA – Status and issues in 2016

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AFFORDABLE CARE ACT: HOW DOES IT AFFECT YOUR PRACTICE?

- Affordable Care Act expanded Medicaid Eligibility for SOME categories, and Subsidizes Private "Qualified Health Plans" for Those with More Income – what are pros and cons and who can qualify?
- Transitions from "MAGI Medicaid" or QHPs When Clients Become Enrolled in Medicare

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Medicaid Expansion – ACA – "MAGI"

- **WHO gets MAGI Medicaid**:
  - People **under age 65** who **do not have Medicare**
  - Medicare beneficiaries of any age and people 65 + caring for children < 18 or 18 and full time secondary school student
- Everyone else who is 65+ or younger with Medicare are "**Non-MAGI**" under old rules for income and assets
- **PRO: Higher Income limit** - 138% of Federal Poverty Level. Some MAGI categories have even higher income limits – children < 18 or 19-20 living with parents, pregnant women**. See** GIS 15 MA/021
- **PRO: MAGI HAS NO Asset limit**! But interest and dividends count as income.

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Main Medicaid Categories – 3 sets of rules

	MAGI	Non-MAGI	
	"Obamacare" - Affordable Care Act	(Disabled-Aged-Blind)("DAB")	SSI (Supplemental Security Income)
Who	• **< 65 and not on Medicare** OR • any age on Medicare and caring for minor child/ grand-child	**Age 65+** OR **Disability** – any age	
Asset limit (exclusions apply)	NONE (but interest, dividends count as income)	$14,850-Single $21,750 Couple	$2,000- Single $3,000 - Couple
Income limit Monthly	**$1,367** – single $1,843 – couple 138% FPL - Higher if pregnant, young children MAGI = Modified Adjusted Gross Income	**$ 845** –Single $1,229-Couple	$ 840 – single $1,224 - Coue

More benefits of MAGI

1. **Quick online applications** – https://nystateofhealth.ny.gov/ or through Navigator (locate on same site). Quick approvals.
   - Rules complicated – best to refer to Navigator! (find online)
   - No proof needed unless reported income different than IRS database, and immigrant status documentation
2. **12 continuous months of coverage**, regardless of whether income increases.
   - Exception – People who turn 65 cannot keep MAGI Medicaid. GIS 15 MA/022 - Continuous Coverage for MAGI Individuals (more later)
3. **Covers full Medicaid benefits including home care**, and nursing home care, subject to 5 year lookback.
   - BUT requires transfer of administration of case from Marketplace to DSS for NH and MLTC!

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More MAGI benefits - some income doesn't count

- MAGI uses federal income tax rules for Adjusted Gross Income, with some modifications – hence called **MAGI Medicaid**.
- Modified Adjusted Gross Income =
  - Adjusted Gross Income (AGI) from Tax Return
  - + Untaxed foreign income
  - + Tax exempt interest
  - + Non-taxable part of Social Security benefits (means ALL of the Social Security counts)
- Some income that counts for both MAGI and Non-MAGI:
  - Earned income – though Non-MAGI has better rules – disregards > 1/2
  - Social Security
  - Alimony
  - Unemployment
  - Net Rental Income

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Some Income NOT Counted toward MAGI

Type of income	Explanation
Gift or inheritance	Not taxable, therefore not counted. Not even cash gift. Taxed to the donor of the gift, or to the Estate, not to the recipient or beneficiary.
Personal injury settlement	Not taxable - see IRC 104(a)(2). Not MAGI income even if receive as structured settlement in monthly payments. Example below. Note that some lawsuit awards are taxable – discrimination/employment, business, punitive damages. See IRS Publication 525, IRS Rev. Ruling 85-97.
Veteran's benefits	MAGI - Don't count as income – both disability and pension benefits. Non-MAGI Disabled/65+ counts VA benefits except for Aid & Attendance. Military retirement pay IS counted.
Income of child or tax dependent	Income of a child or tax dependent who is not required to file a tax return is not included in the household income. GIS 15-MA-08 (includes child's Social Security)
Workers Comp	Not Counted

See 13 ADM-04, Attachment 4 (revised 8/5/2015) for additional examples of income not counted towards MAGI.

Lump Sums and MAGI – 12 mo. continuous coverage

- **Lump sums** do not affect eligibility even if taxable (e.g. lottery or employment discrimination award), because they only count as income in the month received. Medicaid can't be cut off during the 12-month continuous eligibility period (unless client turns age 65 during the 12-month period). GIS 15 MA/022 - Continuous Coverage for MAGI Individuals
- The lump sum becomes a resource in later months – but resources are not counted in MAGI.
- Strategy tip: If lump sum is taxable, best to receive it in one payment or multiple payments payable during the 12-month continuous eligibility period. If it is not taxable, like a PI award, can receive it for years.
- WARNING: Taxable lump sums DO count for the Advance Premium Tax Credit and Cost-Sharing subsidy for Qualified Health Plans bought on the Exchange. Those use MAGI budgeting but eligibility is based on annual income, not monthly. So a lump sum, if taxable, is income (e.g. lottery).

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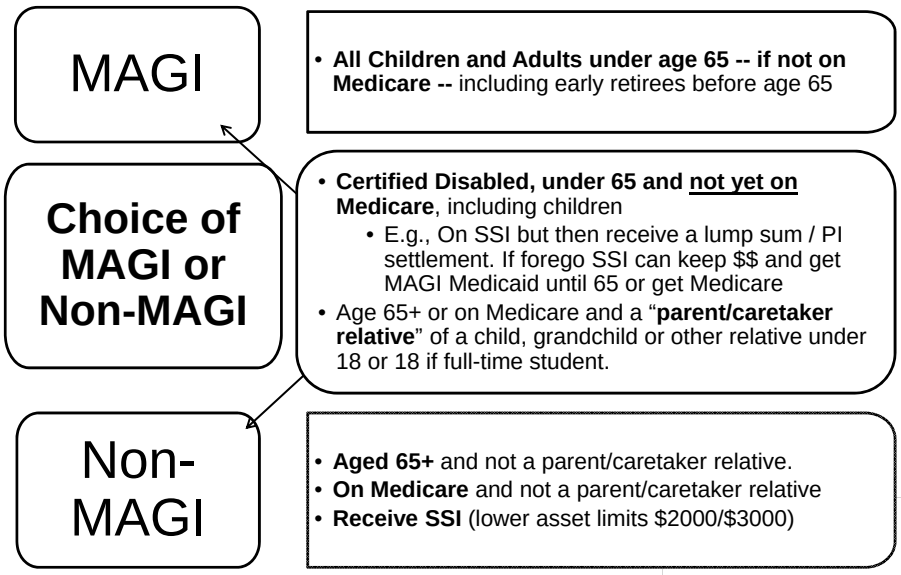
Medicaid Eligibility Categories



EXAMPLE: Mary

FACTS: Mary, age 55, lives alone and just won SSD benefits. – $1300/month. Won't have Medicare for 2 years. Has been living on some savings – has $50,000 and an IRA of $50,000.

1. What are her options for Medicaid? MAGI or Non-MAGI. MAGI is better for her:
   - Savings of $50,000 exceed non-MAGI limit of $14,850.
   - Must start taking distributions from IRA with non-MAGI.
   - She is income eligible since SSD under MAGI limit $1,367/mo., while she'd have a spend-down of $455/mo. with non-MAGI.
2. How would she apply for MAGI Medicaid? Find a navigator to help apply online through Exchange.
   http://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations

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EXAMPLE: Mary *con'd.*

FACTS: Mary, age 55, lives alone and just won SSD benefits. – $1300/month. Won't have Medicare for 2 years. Has been living on some savings – has $50,000 and an IRA of $50,000.

3. What happens when she gets Medicare in 2 years? At the end of her 12 months of continuous coverage, she will be non-MAGI. Will have to bring her assets down to $14,850, take IRA distributions, and will have a spend-down – may require pooled trust. She will receive a notice telling her how to renew Medicaid with the local DSS. Beware of problems!
4. What if she has a 14-year old child who lives with her? Mary can stay on MAGI even after Medicare starts, until child turns 18 (or 19 if in school full time). Child's social security doesn't count here.
5. What about the child? Child is MAGI and will keep MAGI Medicaid even after Mary is transitioned to non-MAGI Medicaid after child reaches 18 or 19. Mary's income may still count for the child, but they are separate cases.

EXAMPLE: Mary *con'd.* – Lump Sum

FACTS: Mary, age 55, receives SSD $1300/month. Won't have Medicare for 2 years. Has savings $50,000 and IRA of $50,000.

6. If Mary settles a lawsuit, how does this affect her MAGI Medicaid eligibility?
   - A lump sum settlement would not affect her eligibility, during her 12 months of continuous coverage. It does not matter if it is taxable or not taxable. After the 12 months, if interest or dividends bring income above MAGI limit - she would need to spend down the excess resources and transition to Non-MAGI Medicaid.
   - If she received a structured settlement:
     - If the settlement isn't taxable, i.e. personal injury [IRC 104(a)(2)], it would not be counted as income for MAGI.
     - If it is taxable, then payments after 12-month period could disqualify her for MAGI Medicaid. Once she transitions to Non-MAGI Medicaid, a structured settlement payment could be placed in a pooled trust.

Example: Sara

Sara, age 35, is disabled but lacks sufficient work quarters for SSD. She is on SSI. She receives a PI lawsuit recovery of $1,000,000. What are her options to keep Medicaid?

1. She can put it all into an SNT and keep SSI and Medicaid.
2. If she retains the money, she'd lose SSI. It will generate $20,000/year income at 2% return, or $1,667/mo. Will she be eligible for Medicaid under MAGI Medicaid if she's single? No. The income exceeds the MAGI limit of $1367.
3. If she gives away the money, will she lose MAGI Medicaid for home care benefits? No transfer penalty for home care.

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Example: Sara con'd.

What is Sara's option with a Structured Settlement of the $1 million?

- If she chooses a structured settlement:
  - $500,000 annuity that will provide $3,000/month, and a
  - $500,000 lump sum with interest $833.33/month

Will she be eligible for MAGI Medicaid?

- Yes. Her only countable income is $833.33/month in interest. The $3,000 monthly payments under the annuity set up as part of the settlement agreement are not taxable so are not MAGI income. IRS Rev. Ruling 85-97; IRS Publication 525.
- But – when she reaches 65 or obtains Medicare, whichever happens first, she will be non-MAGI and payments will count as income and the lump sum will be a resource.

Which to Choose if One has a Choice

Factors	What to do
Is MAGI income under 138% FPL?	Pick MAGI! No asset limit, easy quick application. If client will need MLTC or FFS homecare, must apply at LDSS using "MAGI-LIKE Budgeting."
Is client working?	Non-MAGI has better EARNED income disregards • 50% of gross earned income "disregarded" – while MAGI counts all gross income. • If < 65 - Medicaid-Buy-In for People with Disabilities – income limit is 250% FPL (using DAB budgeting)
Is spouse's income too high?	If Spouse's income brings income above MAGI limit, choose non-MAGI with option for **spousal refusal**
Look at types of income	Workers comp, VA benefits, child support, gifts, PI settlement, lump sums not count as income for MAGI, unlike non-MAGI. If MAGI income >138% MAGI limit, Non-MAGI can you use **spend-down** or **pooled trusts** (not available in MAGI)
Excess assets?	No Asset test for MAGI!
Age/Medicare status	If close to 65 or to receiving Medicare, must plan for transition to Non-MAGI – Medicaid planning for resources, income.

DETERMINING COUNTABLE INCOME - MAGI

- What is "household size?"
- Whose income is counted toward eligibility?

See NHELP Household Size Quick Reference - http://www.healthlaw.org/issues/health-care-reform/MAGI-quick-reference

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Income limit increases with Household Size

138% FPL for various household sizes (for adults)

1	2	3	4	5	6	7
$1,367	$1,843	$2,319	$2,795	$3,271	$3,747	$4,224

- Compare to Non-MAGI for Disabled/Age 65+/Blind (DAB), where household size can only be **ONE or TWO**.
- MAGI uses **tax rules** - Who is in the household depends on whether the applicant is a:
  A. Filing taxpayer, not claimed as a dependent by another, or
  B. Tax Dependent, or
  C. Non-tax filer and non-dependent
- **Spouses** – Spouses who live together are in each other's household, regardless of whether they file taxes jointly. **NO SPOUSAL REFUSAL**!

42 CFR 435.603(f); 13 OHIP/ADM-0

1. Tax Filers Not Claimed As A Dependent

Household =

- Taxpayer
- + Spouse (even if filing separately)
- + Tax Dependents:
  - Qualifying Children
  - Qualifying Relatives

Special rule for Pregnant Women: Always count woman + number of babies expected.

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2. Tax Dependent

- Household = Same as the Taxpayer's, BUT
- Three Exceptions → Use Non-Filer/Non-Dependents household rules for:
  1. Dependent who is not taxpayer's child or spouse (e.g., child claimed as dependent by grandmother, or grandmother claimed as dependent by her grown son)
  2. Children living with both parents, who do not expect to file taxes jointly (e.g., minor children living with unmarried parents)
  3. Children claimed as dependents by non-custodial parent

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3. Non-Filer and Non-Dependent Rule

- Household depends on person
  - Adult's Household = Individual + Spouse and Children with whom they live
  - Child's Household = Individual + Parents and Siblings with whom they live
- Step- and adoptive parents, children and siblings count
- Children/siblings count if they are under 19, or full-time students under 21

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Household Composition Example

- Joe and Mary are married and live with their 2 children, Abby and Bill, as well as Joe's Uncle Matt, who does not file taxes.
- Joe and Mary file a joint tax return, claiming the 2 children and Uncle Matt as dependents.

	Household Size	Rule
Joe	5	Tax Filer – count spouse, dependents
Mary	5	Tax Filer – count spouse, dependents
Abby	5	Dependent rule – same as Tax Filer
Bill	5	Same as Abby
Uncle Matt	1	Non-Filer – just count self (see next slide)

Multi-Generation and Not-traditional Households

If a grandparent, uncle, grandchild, niece other relative or friend living with a taxpayer is:

- **claimed as a dependent** by the taxpayer but
- **is not a child or spouse of the taxpayer**

The dependent's household is just HIM/HER and -- if they are living with him -- his spouse, and his children/siblings < 19 (or <21 if a student)

- In the prior **Household Composition Example**, because Uncle Matt is claimed as a dependent, he is counted in Joe's, Mary's and their kids' Medicaid households. But Uncle Matt's MAGI household is just him. If Uncle Matt's Spouse and children < 19 (or <21 if a student) live with him, his household includes them too.
- Note: Uncle Matt can be claimed as a dependent & counted in Joe's and other's MAGI households even if Uncle Matt is non-MAGI (e.g., 65+)
- This rule helps low-income families with multi-generations living together.

Determining Countable Household Income

To determine each applicant's household income, add up the MAGI income for each member of the household who is required to file taxes.

- Children's and other dependents' income is not counted unless the person is required to file a tax return
  - Even if voluntarily file, but not required to, income not counted
- Children's and dependents' social security benefits are not counted unless the child/dependent has an independent obligation to file taxes based on earned income and other types of unearned income.

GIS 15 MA/08

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LONG TERM CARE & MAGI

- 15 OHIP/INF-1 (10/2015) (Q&A -Long Term Care and MAGI)
- GIS 14 MA/16, (Long Term Care Eligibility Rules and Estate Recovery Provisions for MAGI Individuals)
- 13 ADM-31
- 10 OHIP/ADM-1
- Department Regulations: 360-2.3, 360-4.4,
- MLTC Policy 14.01: Transfers from Medicaid Managed Care to Managed Long Term Care – at MRT 90 policies page http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

MAGI & Home Care

- All Medicaid community-based Long Term Care services are part of the MAGI benefit package.
- Most MAGI Medicaid recipients must receive home care services from their **mainstream Medicaid managed care plan** (plan that serves 4.5 million Medicaid recipients without Medicare). These include personal care (PCS), Consumer-Directed Personal Assistance (CDPAP), certified home health agency (CHHA), & private duty nursing.
- Members of mainstream plans may switch to MLTC only if they need a service not covered by the plan: social adult day care, environmental mods, home delivered meals. **MLTC Policy 14.01** - **Transfers from Managed Care to MLTC.*** Their Medicaid case must be transferred from the Marketplace to the LDSS for input of needed eligibility codes.

* http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

MAGI & Nursing Home Care

- MAGI includes Nursing Home care if "**medically frail**." Need for NH care alone meets that definition.* Does not require a disability determination UNLESS income > 138% FPL so not MAGI 15 OHIP/INF-1 #20 - 22.
- **Transfer of Assets** – If need NH care > 29 days, must submit 5-year lookback and normal transfer penalty/ exceptions apply. **GIS 14 MA/16**,
  - A MAGI individual is "otherwise eligible" if income < 138% FPL. 15 OHIP/INF-1
- **NO LIEN** on homestead.* But **home equity** limit applies to single individuals. 15 OHIP/INF-1 Q. #11.
- Must transfer case from Exchange to LDSS just like home care .
- **MAGI income limit** in NH = 138% FPL for single person, even if married - $1,367/month. If income under that limit, eligible and **no NAMI**. If over that limit, must qualify under Non-MAGI – regular rules.
- Cannot use spousal impoverishment unless switch to Non-MAGI budgeting.

***GIS 14 MA/16**, "Long Term Care Eligibility Rules and Estate Recovery Provisions for MAGI Individuals" and l Q& A **15 OHIP/INF-01 -** 15 OHIP/INF-1 (10/29/2015)

Estate Recovery and MAGI

Estate Recovery applies to a MAGI Medicaid recipient for cost of:

- nursing home care or other home and community-based services received on or after 55th birthday,
- related hospital and prescription drug services received on or after the MAGI individual's 55th birthday
- Same exclusions apply for Non-MAGI Medicaid recipients – no recovery if there is a surviving spouse, disabled children, etc. SSL 369, GIS 14-MA/016, 15 OHIP/INF-1 Q. 12

(For non-MAGI, estate recovery of ANY Medicaid expenses after 55th birthday)

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TRANSITIONS: MARKETPLACE TO LOCAL DSS

What happens when the MAGI recipient reaches age 65, or becomes eligible for Medicare?

Or had Medicare with a dependent child who is now over 18, so parent is no longer MAGI.

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When a MAGI Medicaid recipient turns 65 or becomes eligible for Medicare

• 3 THINGS HAPPEN if no longer eligible for MAGI due to age:

1. MAGI Medicaid will be discontinued and will need to transition to "regular" Non-MAGI Medicaid, with asset limits and lower income limits. More details below.
2. The individual was likely in a Medicaid Managed Care plan that provided all Medicaid benefits. Once obtaining Medicare, client will be disenrolled from that plan and will have Medicare + Medicaid Fee For Service.
3. If client is on Medicare and received personal care or Consumer Directed Personal Assistance from the Medicaid managed care plan, needs to enroll in MLTC.
   Be alert for disruptions in care.
   Some tips below.

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Transition (1) Termination of MAGI Medicaid

1. Two populations transfer to LDSS when no longer MAGI Medicaid eligible:
   a. Under 65 and begin receiving Medicare → Continue Marketplace MAGI Medicaid until end of 12-month continuous coverage period or until turn 65, whichever comes first. Then transfer to LDSS
   b. 65+ → cannot keep MAGI Medicaid. Must immediately transition to LDSS when turn 65.
2. Marketplace will:
   a. Identify individual who is no longer eligible for MAGI Medicaid due to age or Medicare and notify them that they are no longer MAGI Medicaid eligible.
   b. Make a referral to the LDSS to start a renewal process. LDSS sends the individual a renewal Medicaid application to apply for Non-MAGI Medicaid.
   c. Continue Medicaid on the Marketplace until the LDSS puts up temporary coverage.

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Transition (1) Termination of MAGI Medicaid

3. The LDSS will put up temporary Medicaid coverage for several more months. Consumers must respond to requests for information from the LDSS to continue to receive Medicaid – proof of assets, income.
   - Should receive Notice with Aid Continuing rights if determined not eligible for Non-MAGI Medicaid GIS 15 MA/022 - Continuous Coverage for MAGI Individuals
4. Be alert for people age 65+ or on Medicare who are still entitled to MAGI Medicaid – if they are a caretaker for child/relative < 18 or < 19 in school. If MAGI is more advantageous, advocate for that option.

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Transition (2) Leaving Medicaid Managed Care

If client is now eligible for Medicare, she will be automatically disenrolled from "mainstream" Medicaid managed care plan.

- Options for Medicare:
  1. **Original Medicare + enroll in Part D plan** + Medigap plan (optional)
  2. **Medicare Advantage** plan with prescription drug coverage.
  3. May be marketed to by her mainstream Medicaid managed care plan to enroll in their **Medicaid Advantage** product – this is a combo-plan which combines a Medicare Advantage plan with a Medicaid plan - covers both Medicare and Medicaid. If client had doctors already in the Medicaid managed care plan's network it may be ok as the network is likely to be the same. And obviates the need to buy a Medigap plan.

Transition 3. What if client had home care from Medicaid managed care plan?

- People without Medicare must access personal care, CDPAP, and nursing services from their mainstream managed care plan – not from their local DSS.
- But.. When they get Medicare they are automatically disenrolled from the managed care plan! That means their home care STOPS. To prevent this disruption, DOH issued -
- **MLTC Policy 15.02*: Transition of Medicaid Managed Care to MLTC** (June 2015) - Members turning 65 who receive home care should be automatically transferred to an MLTC plan, if they don't select their own, preferably one owned by the same insurance company, which should continue the same care provided by mainstream plan. BUT no procedure if obtain Medicare based on disability, rather than on turning 65

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

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MANAGED LONG TERM CARE UPDATE

1. **FIDA UPDATE**
2. **NEW 7-Day Medicaid Application if Immediate Need for Home Care**
   - Spousal Impoverishment Budgeting available with Application
3. **Challenges for Current MLTC members**
   - Reductions in Hours of Home Care
   - Strategies to Increase hours - New 24-hour Care Definition
   - New Overtime Requirements

MLTC now mandatory statewide

- Statewide, most adult "dual eligibles" (21+) who need community-based long-term care – personal care services (PCS), Consumer Directed Personal Assistance (CDPAP), certified home health care, adult day care, or private duty nursing must enroll in an MLTC plan.
- The **last 14 upstate counties became mandatory** in mid-2015.
- **Exceptions** –MLTC not mandatory if client is in hospice, if need only 8 hrs/week of housekeeping, or if in OPWDD, NHTDW/ TBI waivers. Can still apply at LDSS for PCS.

FIDA status (Fully Integrated Dual Advantage)

- Still only a demo in NYC & Nassau County
- Expansion to Westchester and Suffolk Counties indefinitely delayed. No other expansion planned.
- FIDA = MLTC plan + Medicare Advantage Plan all in one plan – includes all Medicare and Medicaid services, including prescription drugs, home care, hospital, tests, etc. Must use all providers in-network.
  - MLTC members, in contrast, keep their own Medicare coverage, whether Original Medicare + Part D + Medigap or Medicare Advantage
- When FIDA started, MLTC members were "passively enrolled" in FIDA but had the right to opt out. In January 2017 State stopped passive enrollment.
- 8/2016 FIDA Enrollment - 5,090 vs. 160,000 MLTC

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

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

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MLTC - Delays in Enrollment

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

1. **Apply** for Medicaid at the County DSS/HRA — 45 days
2. Get a "**Conflict Free Eligibility**" assessment from Maximus (NY Medicaid Choice) — 15 days
3. **Pick a plan** - MLTC, Medicaid Advantage Plus, PACE or FIDA plan (Nassau/NYC only) –
   a. Schedule an in-home assessment with plan — 15 days
   b. Pick a plan and enroll.
   c. Enrollment paperwork must be submitted by 19th of month for enrollment to start 1st of next month. No mid-month pick-up dates. — 30-60 days

TOTAL 3-5 months

TIPS to Expedite Medicaid Approval and MLTC Enrollment

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

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

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

- April 2015 - NYS law required DOH to create procedures for local DSS to process a Medicaid application in **SEVEN DAYS** for any applicant **with an immediate need** for personal care (**PCS**) or consumer-directed personal assistance (**CDPAP**) services & approve PCS/CDAP in 12 days. NY Soc. Serv. L. §366-a(12).
- July 2016 – new regulations effective. 18 NYCRR 505.14(b)(7) and (8) and 505.28(k);
- **DOH 16-ADM-02** - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services

[1]42 USC Sec 1396a(a)(8); 42 C.F.R. Sec. 435.911; 18 NYCRR 360-2.4; NYS Medicaid Reference Guide pp. 487-488.

New Regs & ADM for Expedited 7-Day Medicaid Applications – Effective July 6, 2016

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

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

Includes people applying from hospital or nursing home.

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

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

1. DSS must determine **Medicaid eligibility within 7 calendar days** of receipt of complete Application.
   a. If application incomplete, DSS must request missing documents within 4 calendar days after receipt of physician's order & Attestation of Immediate Need.
2. Within **12 calendar days** of receiving complete Medicaid app, Attestation form and Physician's order, DSS must:
   a. Conduct social & nursing assessments
   b. Determine eligibility for & **authorize PCS/CDPAP and Number of hours**
   c. "Promptly notify" the recipient of the amount authorized
3. DSS arranges for services to be provided "as expeditiously as possible." 18 NYCRR 505.14(b)(8)(ii). (NOTE: no time limit!!)
   - DSS contracts with home care agencies to provide care or approves CDPAP

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What to Include in Application for Immediate Need Medicaid

1. **In NYC – Cover Sheet / Transmittal Form (**will be posted when available at http://www.wnylc.com/health/entry/203/)
2. **COMPLETE Medicaid application (or approval Notice if already have Medicaid)**
   a. May "attest" to value of real property & assets – but better to verify
   b. May request Spousal Impoverishment budgeting if favorable
3. **Physician's order** for personal care (M11q in NYC) per 18 NYCRR 505.14(b)
4. Signed "**Attestation of Immediate Need**" Form – posted at https://www.health.ny.gov/health_care/medicaid/docs/ohip_form-0103.pdf - - and attached to 16-ADM-2 -described on next slide.
5. **HIPPA RELEASE** - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA
6. **Cover letter** describing Immediate need circumstances

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

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New Attestation Form – Immediate Need

"Attestation of Immediate Need" Form –OHIP-0103. Attached to 16-ADM-2 & https://www.health.ny.gov/health_care/medicaid/docs/ohip_form-0103.pdf - which states you:

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

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

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

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

(NOTE – arguably, even if Medicare, hospice or private services in place, explain why they are not enough to provide "NEEDED" help, or that can't continue etc.)

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

Transition from Immediate Need to MLTC

- **Immediate Need PCS or CDPAP is only temporary.**
- **AUTO-ASSIGNMENT** - after 120 days receiving the temporary Immediate Need services, Maximus/ NY Medicaid Choice will send individual a letter that if she doesn't select & enroll in an MLTC plan in 60 days, she will be auto-assigned to a plan.
  - TIP - Use that time to select a plan – find plan that contracts with same home care agency, if client wants to keep aides.
- MLTC plan should continue the DSS Plan of Care for a **90-Day Transition Period.** MLTC Policy 13.10.* (DOH has not confirmed this but see FH **7214923Z** (Erie Co.).
  - After 90 days, plan may reassess hours but under *Mayer v. Wing*, may reduce only if alleges and proves change in circumstances. See more later re REDUCTIONs. Must give advance notice with right to request hearing with aid continuing.

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

NEW: Spousal Impoverishment available on application for IMMEDIATE NEED Medicaid

- Before DOH issued 16 ADM-02, a married person applying for Medicaid in order to enroll in MLTC had to initially apply using regular Medicaid rules – combining both spouse's income using couple level of $1209/mo. or using Spousal Refusal. Soc. Serv. L. § 366.3(a).
- This is because NYS sees Spousal Impoverishment as a "post-eligibility" budgeting methodology. GIS 14 MA/025 - Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act.
- **Under 16 ADM-02, married person may request Spousal Impoverishment budgeting with Medicaid application based on IMMEDIATE NEED for personal care or CDPAP**.

ISSUE 3: CHALLENGES FOR MLTC MEMBERS

(1) Reductions in Home Care Hours

(2) New Definition of 24-hour care and other strategies to increase or keep hours

(3) New Overtime Requirements

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Plans reducing hours of home care

- Since 2015 pattern of some MLTC plans reducing hours of personal care services and CDPAP, especially Senior Health Partners, VNS Choice, Centerlight.
- Medicaid Matters NY and NAELA NY released "**Mis-Managed Care"**
  - Report analyzed 1000+ MLTC FH decisions on reductions for 7 months June – Dec. 2015. See NYT Story July 21, 2016. Report posted at http://tinyurl.com/nytimes-FairHearing. Even DOH recognized increase in Fair Hearing requests for MLTC in 3rd quarter 2015.*
- Most people win hearings because plans fail to give any written notice or fail to give adequate notice with justification for reduction. But many lack the wherewithal to request or attend a hearing or get a lawyer, or they agree to accept a reduction without knowing their rights.

*http://www.health.ny.gov/health_care/medicaid/redesign/docs/partnership_plan_2015_annual_rpt.pdf p. 16

Plans reducing hours - Strategies

1. **Request a hearing**. https://otda.ny.gov/hearings/
   a. Must request before effective date of notice to get **AID CONTINUING**, usually within 10 days of notice. But if notice not timely or adequate – can argue for Aid Continuing even if miss effective date. #7165494N
   b. Entitled to advance notice & Aid Continuing, even if plan mischaracterizes action as "denial" -- not a reduction. #7331553Q
   c. Must request FH even if request Internal appeal – No Aid Continuing on internal appeal – only hearing.
   d. Request **evidence packet** from plan to see assessments
2. If you can't rep, refer to ICAN – Statewide Ombudsprogram for MLTC - takes referrals of cases statewide. 1-844-614-8800 www.icannys.org
3. **Class action *Caraballo* lawsuit against one plan – Senior Health Partners** challenging systematic reductions of hours. Contact Ben Taylor at btaylor@nylag.org.

Plans reducing hours – Review Plan's NOTICE

- Notice must state specific **change in medical condition or circumstances,** such as increased availability of family to help, justifying reduction. Not enough just to recite that not "medically necessary." Mayer v. Wing, 922 F. Supp. 902 (SDNY 1996)
  - 18 NYCRR 505.14(b)(5)(c)(2) was amended in 2015 to require more specific description of change - see FH # 7284013H (5/27/2016), 7224444Y (4/26/16), 7208804Q (Tompkins Co**);**
- Use **defects in notice** to win – and to request tolling of statute of limitations to appeal past reduction # 7060609N (NYC 8/11/2015)(notice not timely – must be 10 days in advance); FH# 7068290Q (NYC 9/29/2015)(notice inadequate); #7165494N (3-year old notice found defective so hearing request not barred)

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Helping Clients Defend Reduction or Get More Hours

Strategies for advocacy with plan or at a hearing.

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

More Strategies to keep or get more hours

4. **Informal Help must be Voluntary** - 18 NYCRR 505.14(b)(3)(ii)(b); 12 OHIP-ADM-01 -"…informal caregivers …support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.");
   - GIS 97 MA/033 ("…contribution of family members or friends… cannot be coerced or required in any manner whatsoever." FH #: 7085459Y (9/16/2015); 7111878L (10/16/2015).
   - Have family member state clearly in writing the times they are available and willing to provide care.
5. **Mayer -3:** If client has 24-hour needs, even if family covers one shift, the plan my NOT use "task based assessment" to calculate the number of hours. They must cover the full span of time family is not available. 18 NYCRR 505.14(b)(5)(v)(d); GIS 97 MA 033, FH 7145223P and 7254996Z.

New Definitions 24-hour Care - 12/2015

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

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

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

Aides entitled to Overtime

- Federal labor regulations used to exempt home care aides from the Fair Labor Standards Act overtime requirements.
- Eff. Oct. 13, 2015, Aides must be paid overtime if work over 40 hours/week or Live-In aides working over 3 days in a work week.
- **Travel time** between different clients of the same employer/ home care agency must be paid. Travel to and from aide's home is not paid.
- **Live-in** – Must be paid for 13-hour day, and more if aide reports that 3 meal periods or 8 hours of sleep time are interrupted by a client's needs. Chronic problem of plans not paying 13 hours.
- http://www.health.ny.gov/health_care/medicaid/redesign/2015-11-09_flsa_decision.htm
- Fallout for clients – aides limited to 40 hours per week, wage cuts

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Useful Contacts

- New York Medicaid Choice (888) 401-6582
- CFEEC scheduling (855) 222-8350
- DOH MLTC Complaints (866)712-7197 mltctac@health.state.ny.us
- Conflict free Assessment complaints - CF.Evaluation.Center@health.ny.gov
- DOH Mainstream Managed Care Complaints
  - (800) 206-8125
  - managedcarecomplaint@health.state.ny.us
- SEE SEPARATE LIST OF RESOURCES in materials.

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1-844-614-8800
www.lcannys.org
ican@cssny.org

INDEPENDENT CONSUMER ADVOCACY NETWORK (ICAN)

State-funded Ombudsprogram for:

Managed Long Term Care, Long Term services in Managed Care Plans, FIDA

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Intermediate Elder Law Update CLE
November 2016
IV. Community Medicaid
[Immediate Need]

New York Elder Law by David Goldfarb & Joseph Rosenberg (Lexis/Matthew Bender, 2016)

Chapter 9
§9.02 [3] Immediate Need and Emergency Needs

If it shall appear that a person is in immediate need, emergency needs assistance or care must be granted pending completion of an investigation by the local agency.[25] Additionally, services may be available under "presumptive eligibility" (see § 9.02[1], *above*) and retroactive reimbursement is available (see § 9.02[5], *above*). In *Coleman v. Daines*,[26] plaintiffs asserted the right to emergency services pursuant to Social Services Law Section 133. The Appellate Division reversed the lower court's dismissal, reinstated the petition, and remitted for further proceedings; the Court of Appeals affirmed. Social Services Law Section 133 has since been amended in 2015 by adding, "Nothing in this section shall be construed to require the social services district or any state agency to provide medical assistance, except as otherwise required by title eleven of this article."[27] There is still no provision for medical care prior to an eligibility determination.[28] The Department of Health has adopted "Immediate Need for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA)" regulations which

[25] SSL § 133. However, SSL § 364-i *amended by* 2012 N.Y. Laws 56 and 2015 N.Y. Laws 57 to provide that, notwithstanding SSL § 133:

> where care, services, or supplies are received prior to the date an individual is determined eligible for assistance under this title, medical assistance reimbursement, regardless of funding source, shall be available for such care or, services, or supplies only (a) if the care, services, or supplies are received during the three month period preceding the month of application for medical assistance and the recipient is determined to have been eligible in the month in which the care or, service , or supply was received, or (b) if provided during a period of presumptive eligibility. pursuant to this section.

[26] Coleman v. Daines, 19 N.Y.3d 1087, 955 N.Y.S.2d 831, 979 N.E.2d 1158 (2012), *aff'g* Coleman v. Daines, 79 A.D.3d 554, 913 N.Y.S.2d 83 (1st Dep't 2010). *See also* Konstantinov v. Daines, 101 A.D.3d 520, 956 N.Y.S.2d 38 (1st Dep't 2012) and Konstantinov v. Daines, 2014 N.Y. Misc. LEXIS 1137 (Sup. Ct. New York County Mar. 12, 2014) (court refused to dismiss as moot due to 2014 legislative change to SSL § 364-i(7)). *Konstantinov* was also decided based on the federal and state constitutional grounds and the Appellate Division dismissed an appeal and remanded for further proceedings in light of 2015 legislative changes (June 2, 2015).

[27] 2015 N.Y. Laws 57 Part B § 35.

[28] GIS 14 MA/006 (03/13/2014) provides, "Finally, districts are reminded that, with the exception of Presumptive Eligibility programs, there is no legal authority to provide Medicaid coverage prior to a determination of eligibility."

add 18 NYCRR § 505.14(b)(7) and (8) and § 505.28(k) and (l).[29] These regulations meet the requirement for the Department of Health to develop expedited procedures for determining medical assistance eligibility within seven days rather than 45 days.[30] However they do not address the statutory provision that the Department of Health must require managed care providers and, managed long-term care plans and other long-term service programs to adopt expedited procedures for approving personal care services for medical assistance recipient who require immediate personal care or consumer directed personal assistance services or other long-term care, and provide such care or services as appropriate, pending approval by such provider or program.[31] Instead they provide for local agencies to provide these services.

Social Service Districts must provide expedited procedures for determining both Medicaid eligibility and eligibility for personal care services for applicants with immediate needs for personal care services. This includes new Medicaid applicants and recipients who are not authorized for long term care services. These applicants or recipients must present the district with a physician's order for personal care services and a signed attestation (on a Department of Health form) that they have an immediate need for personal care services and that they have no informal caregivers, are not receiving personal care services from a home care agency, have no adaptive or specialized equipment to meet their needs, and have no third party insurance or Medicare coverage that will pay for the needed assistance.[31.1]

An applicant must also submit a complete Medicaid application. However the applicant may attest to the value of real property and the current value of bank accounts. If the agency later has information indicating an inconsistency with the attestation, it can request documentation to verify resources.[31.2] The district must determine if the application is complete, or request additional documentation within four days.[31.3] When the application is complete, the district then has seven days to determine Medicaid eligibility and notify the applicant.[31.4] Simultaneously to processing the application and within twelve days the district should obtain a social assessment, nursing assessment and assessment of other services and determine eligibility for personal care services and the amount and duration of those services.[31.5]

There are similar provisions for existing Medicaid recipients who have an immediate need for personal care services. They may be exempt or excluded from managed long term care or not yet enrolled in a plan. And in addition they have been determined eligible as an immediate need applicant under the above provisions for new applicants or they are a recipient eligible for Medicaid coverage of community-based long term care services and provided the district with a physician's order for personal care services

[29] New York State Register, May 25,2016 at p. 14 (effective 07/06/16). See also 16ADM-02 (07/01/2016).
[30] SSL § 366-a(12) *added by* 2015 N.Y. Laws 57 Part B § 36-c.
[31] SSL § 364-j(31) *added by* 2015 N.Y. Laws 57 Part B § 36-b.
[31.1] 18 NYCRR §505.14(b)(7)(i)(a). The attestation form is an attachment to 16ADM-02 (07/01/2016).
[31.2] 18 NYCRR §505.14(b)(7)(i)(b).
[31.3] 18 NYCRR §505.14(b)(7)(ii); See 16ADM-02 (07/01/2016) which provides, "The four-day period starts the day after receipt of the three documents (application/request, physician's order, and signed attestation form). A complete Medicaid application means a signed Medicaid application and all documentation necessary for the district to determine the applicant's Medicaid eligibility. If the applicant has not submitted a complete Medicaid application, the district must notify the applicant of the additional documentation that the applicant must provide and the date by which the applicant must provide the documentation."
[31.4] 18 NYCRR §505.14(b)(7)(iii); See 16ADM-02 (07/01/2016) which provides that the seven-day period starts the day after all documentation is received.
[31.5] 18 NYCRR §505.14(b)(7)(iv); 16ADM-02 (07/01/2016) notes that no referral to the local professional director is required in 24-hour cases or in any other case in which the regulations otherwise require such referrals to the LPD.

and the signed attestation of immediate need on the required form,[31.6] In such cases the district must perform the assessments for personal care services and determine the amount and duration of services to be authorized within twelve days. If the recipient is not exempt or excluded from enrollment in a managed care entity, the district must authorize services until the person is enrolled.[31.7]

There are similar regulations governing the consumer directed personal assistance program.[31.8] The amended regulations also permit the nursing assessments to be performed by registered professional nurses under contract with the local districts.[38.9]

New York City Human Resources Administration has advised of the following procedures to obtain immediate need services:

The immediate need home care request must have: (1) a fully completed M11-Q form annotated with "Immediate Need - Emergency Home Care Request" on top of the first page; (2) for new applicants, a fully completed Medicaid Application with required income documentation; and (3) a cover letter providing details of the reason for the immediate need, other relevant information (a contact person would be helpful to expedite processing but not required).

The request should be faxed to (917) 639-0665. The fax cover sheet should be addressed to: "Immediate Need Emergency Home Care Liaison – Ms. Donna Jones". Subject: Immediate Need - Emergency Home Care Request.

[31.6] 18 NYCRR §505.14(b)(8).
[31.7] 18NYCRR §505.14(b)(8)(iii)(a).
[31.8] 18 NYCRR §505.28(k) and (l).
[38.9] 18 NYCRR §505.14(b)(3) and §505.28(d)(3).