TRACK 9
Basics of Managed Long Term Care (MLTC) Advocacy: More Than Just Filling in the Application

Presented By:
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Basics of Managed Long Term Care MLTC) Advocacy:
More Than Just Filling in the Application
By Richard A. Marchese, Esq. & Britt Burner, Esq.

1. What is Medicaid Managed Long Term Care (MLTC)?
    a. Helps people who are chronically ill or have disabilities and who need health and long term care services to help them stay in their homes communities as long as possible.
    b. Two basic models Programs for All-Inclusive Care for the Elderly (PACE) and the MLTC.
        i. PACE- both Medicare and Medicaid pay a capitated rate to a PACE Plan for services.
        ii. PACE members are required to use PACE physicians and work with the PACE interdisciplinary team to develop a care plan for on-going care management.
        iii. PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services.
        iv. MLTC provides long term care services and ancillary services in exchange for receiving a capitated rate paid by Medicaid.
        v. MLTC members may retain their primary care physician and they retain their Medicare card for Medicare reimbursable services.
2. Eligibility Requirements
    a. Have a chronic illness or disability that would make you eligible for nursing home care.
    b. Able to stay safely at home at the time you join the plan.
    c. Expected to need 120 days or more of long term care services in the community.
    d. Meet the age requirement (age 21 or older).
    e. Are "dual eligible", i.e., eligible for both Medicare and Medicaid.
        i. See attached notice re mandatory enrollment in Medicare as a condition of Medicaid eligibility for certain individuals.
    f. Live in the area served by the Plan.
3. Long Term Care Services which require enrollment in a MLTC:
    a. Personal Care Services
    b. Consumer Directed Personal Assistance Program
    c. Adult Day Care
    d. Private duty Nursing
    e. Certified Home Health Agency long-term services
    f. Nursing Home residential care
4. **Practice Tip:- DO NOT OVER PROMISE HOURS!**
5. UPSTATE VS. DOWNSTATE DIFFERENCES
    a. Turn-around time
    b. Shortage of aides in Upstate counties

6. Community-Based Medicaid
    a. Remember, no five year look-back, and no penalty for transfers.
    b. Must complete Supplement A and provide current asset/income documentation.
    c. If seeking retroactive coverage, supply documentation for past three months, and copies of medical bills (paid and un-paid) for this period.
    d. **Practice Tip**: Indicate on top of application and in cover letter- "seeking MLTC".
    e. Single vs. married:
        Income level (for one): $842.00
        Resource level (for one): $15,150.00
    f. Post- eligibility spousal impoverishment rules apply!
    g. **Practice Tip**: If applying for a married individual, assuming there are excess resources, always submit a spousal refusal for the non-applying spouse. Again, Upstate vs. Downstate differences.
7. Becoming Eligible: The Plan
    a. Is your client eligible as of the first of the month?
    b. There are no transfer rules, but you want to think ahead in case your client may need a nursing home in the future.
    c. **Practice Tip**: You may want to wait an additional month after making transfers, if possible, so the bank statements do not show the transfers. While the client is eligible either way, the application review time may be less if there are not large transfers to review.
    d. Transfers to a spouse
8. Advise your clients regarding spousal contribution. (should they apply or wait?)
    a. Usually makes sense to apply, unless the spouse has so much income that the contribution would be more than they are currently paying for care.
        i. Suffolk/Nassau: not currently seeking contribution from spouses.
        ii. Contributions sought in Upstate counties- some are very aggressive in their pursuit of spouses.
            1. Any negotiations are directly with the County Law Department, or counsel for DSS. Aggressiveness varies County to County.
        iii. NYC: actively seeking contribution
            1. Letter usually comes 6-12 months after spouse is approved for Medicaid.
            2. Negotiate claim with investigator – can get a reduction in amount owed. Does not cover future claims.
        iv. Income: 25% of excess over MMMNA ($3,090)

v. Assets: for each month over CSRA ($123,600), Spouse is asked to pay Medicaid rate
    1. Opportunities for spouse to transfer assets to an irrevocable trust.

b. Other options for transfers to gain eligibility:
    i. Medicaid Qualifying Trust.
    ii. Family member.
    iii. Pooled asset trust
    iv. **Practice Tip**: Again, be cautious and advise your client, in writing, with copy for your file, that any transfers will have an impact if the client needs skilled nursing care within the next five years and seeks to have Medicaid coverage for such care.

9. Forms:
    a. Access NY Health Care (DOH-4220)
    b. Access NY Supplemental A (DOH-4495A) application
    c. HIPAA form
        i. Realize that you will need this each time you call for an update; they will often ask you to fax it over before any case examiner speaks to you.
10. Application Cover letter:
    a. Outlining what the assets are, if there are any transactions over $2,000, and the income calculation.
        i. All gross income added up, subtract health insurance premiums, subtract $842 + $20 disregard, then list resulting excess.
        ii. Indicate that the client intends to spend down through the use of a pooled income trust.
        iii. **Practice Tip**: If the applicant is not in receipt of SSD or SSI and you want to utilize a pooled trust for the spend-down, you must complete and submit the disability application documents with your Medicaid application.
        iv. Subtract housing disregard if Medicaid paid in NH and being discharged to community.
            1. NYC: $1,171 / Long Island $1,285 / Northern Metro $892
11. If the client is the beneficiary of a trust, irrevocable or revocable:
    a. Include trust document, list of assets in trust with supporting documentation (i.e. bank statements, deed to house, etc.), and list the income generated by trust (and add this to income calculation).
12. Application processing time:
    a. 45 days
    b. 90 days if:

i. Awaiting a disability determination, i.e. has not previously been deemed disabled by the Social Security Administration
    1. This applies to most of our clients looking to utilize a supplemental needs trust, including a pooled income trust. 18 NYCRR 360-2.4

c. What can you do if you do not receive a timely determination?
    i. Can you find out who the caseworker is?
    ii. Suffolk will always send a deferral.
    iii. NYC only sends a deferral if they really need something.
    iv. Upstate-find out who the caseworker is, make sure the caseworker has all the documentation needed, try to explain the circumstances, sympathize with their caseload, and ask them to please expedite.

13. Immediate Need Application
    a. Put immediate need on cover letter; pursuant to 16 ADM-02 – Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services.
    b. Additional documentation:
        i. Immediate Need Transmittal to the Home Care Services Program (HCSP-3052 (E)); Medical Request for Home Care (HCSP- M11Q); Attestation of Immediate Need (OHIP-0103);
    c. NYC can submit application via Email:
        i. HCRequests@hra.nyc.gov
    d. M11-Q –
        i. Must be completed within 30 days of medical examination and filed with local district within 30 days
        ii. State regulation 505.14(b)(3)
14. Financial Approval with a spend down:
    a. What to submit for pooled trust approval?
        i. Joinder agreement
        ii. Welcome letter
        iii. Verification of Deposit statement
        iv. Disability Questionnaire (LDSS-1151)
        v. Medical Report for Determination of Disability (LDSS-486T)
        vi. HIPAA form (OCA No. 960)
        vii. Authorization to Release Medical Information form (MAP-751e(E))
    b. Can apply for Medicare Savings Program (MSP) once the pooled trust is accepted and the case is re-budgeted with a $0 spend-down.
        i. Pays Medicare premium; keep in mind this will increase the client's surplus income amount.

c. **Practice Tip**: make sure power of attorney is sufficient to allow agent to join and fund a pooled income trust (Nt.- this has yet to become an issue Upstate).
    i. Pre-approval of power of attorney
    ii. See MARC Alert attached.

15. Conflict Free Assessment through MAXIMUS
    a. MLTC Policy 14.06: implementation of the conflict free evaluation and enrollment center (CFEEC)- https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care
        i. Do you qualify for more than 120 days of long term care?
    b. When?
        i. Only valid for 75 days
            1. See NYS MLTC Policy 16.08
        ii. **Practice Tip**: You can have your client schedule the Conflict Free Evaluation before the approval comes in.
            1. Ex. After 30-45 days have passed after application is submitted
    c. When making appointment:
        i. Need: full name, address, DOB, SSN, Medicaid number, phone number
    d. At appointment:
        i. Insurance cards available
        ii. Medications available
        iii. Name and number for primary care physician
        iv. Bathing, grooming, dressing, meal preparation, reheating, chores, assistance with ambulation (use of a cane or walker, indoor and outdoor), transfers (getting up/down from a seated position, getting up/down from a laying position), toileting (use of diapers or liners any incontinence of bowel or urine)
        v. Cueing and reminding for tasks
    e. Conflict free assessment must be conducted within 7 days of request.
    f. After approval- mandatory enrollment packet sent by NY Medicaid Choice to recipient, who has 75 days to pick a plan or recipient will be auto-assigned to a plan.
    g. Note – the conflict free assessment does not determine hours- that is done by the Plan.
16. MLTC Assessment
    a. Must enroll in MLTC Plan, exceptions:
        i. Hospice
        ii. NHTDI/TBI/OPWDD/
        iii. ALP
        iv. Those who only need housekeeping – personal care level 1 services; see 18 NYCRR 505.14 – no ADL help

b. **Practice Tip**: Always tell clients you cannot promise hours and document the conversation.
c. How many appointments to schedule?
    i. Shop around
    ii. Plans can see when others have come in but CANNOT see the services offered
d. Who should attend the assessment?
e. Make a decision with the client regarding who should appear at the assessment.
f. **Practice Tip**: some firms employ a non-attorney to appear at assessments. Others have an attorney attend the assessment or refer the client to a geriatric care manager.
g. Prepping client/caregivers
    i. Doctor's letter
    ii. List from current caregiver of daily tasks
    iii. Give the narrative of the worst day
    iv. Why there are no informal supports, i.e. caretaker's limitations
h. Uniform Assessment tool

17. How do you pick a MLTC Plan?
    a. Providers
        i. If your client receives dental, audiology, podiatry, and/or optometry services, then make sure that the MLTC plan you choose has the client's providers within its network
    b. Knowing the market – what plans are giving clients the hours they need and providing good customer service.
    c. Enrollment in plan by 19th day of month to allow coverage for the 1st day of the following month.
18. Immediate Need Assessment
    a. 8 days
    b. Auto enrolled into agency or FI
    c. CDPAP –issue
    d. Pooled trust not approved – agency may want spend down
    e. After 120 days of immediate need services client will get a letter requiring enrollment in MLTC. Will be auto-enrolled in 60 days.
19. Spousal Impoverishment Protections for Married MLTC members
    a. Choice- budget as household of one with a spend down (and use pooled trust) - or utilize post-eligibility spousal impoverishment budgeting. Compare budgeting, and use whichever one is most advantageous. GIS 14 MA/25

b. GIS 13 MA/018: " Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance, a family member allowance, if applicable, and a personal needs allowance ($391.00 for 2018)."
c. 12 MA/013 sets forth how to do the budgeting comparison:
    i. Use with spousal refusal
d. -Submit request for spousal impoverishment budgeting after enrollment in Plan.

20. Miscellaneous:
    a. Reimbursement
        i. After pooled trust approval
        ii. Can only be reimbursed up to the number of hours that are approved by MLTC after assessment
        iii. Must get a retroactive eligibility determination and then seek reimbursement for paid services (but only at the Medicaid rate).
            1. Make sure you ask for retroactive coverage on the application (Section G.)
    b. What happens when your MLTC leaves market?
        i. What to tell your client
            1. Appeal rights?
            2. See sample letter.

Other Resources

- MARC – join to get results
    - http://a069-marc.nyc.gov/marc/home.aspx
- Western New York Law Center; NY Health Access – updated by NYLAG
    - http://www.wnylc.com/health/
- Medicaid Reference Guide
    - https://www.health.ny.gov/health_care/medicaid/reference/mrg/
- Fair Hearings Database
    - https://otda.ny.gov/hearings/search/
- State Complaint Number for MLTC Problems- 1-866-712-7197
    - E-mail mltctac@health.ny.gov- put "COMPLAINT" in subject line
- **For enrollment complaints - call NY Medicaid Choice -**
    - **1-855-886-0570** (Advocates line)
    - **1-888-401-6582** (Consumers line)

Human Resources Administration
Department of Social Services

MEDICAID ALERT

Medicare Enrollment

December 13, 2017

The purpose of this Alert is to provide organizations assisting Medicaid consumers with information regarding the requirement for certain Medicaid applicants/recipients (A/Rs) to apply for Medicare as a condition of Medicaid eligibility.

Medicaid applicants/recipients who appear to be eligible for Medicare benefits are required to apply for Medicare as a condition of Medicaid eligibility. This requirement applies to individuals who are eligible for payment of their premiums either through the Medicare Savings Program or as a fully eligible Medicaid recipient (without deducting the premium payment from income). These Medicaid A/Rs are required to apply for Medicare as these benefits will reduce the costs incurred by the Medicaid program. This includes recipients receiving Medicaid on a Temporary Assistance case.

I. Medicare Eligibility

Some individuals get Medicare automatically and others must sign up for it. In most cases, it depends on whether the individual is receiving Social Security benefits. Individuals receiving Social Security or Railroad Retirement Benefits will automatically be enrolled in Medicare Parts A and B when they turn 65.

Individuals age 65 or over, who are not receiving Social Security retirement benefits or Railroad Retirement benefits, must enroll in Medicare by contacting the Social Security Administration. When an individual turns 65, the individual becomes eligible for Medicare if he or she:

- Receives or qualifies for Social Security retirement benefits or Railroad Retirement benefits; or
- Currently resides in the United States and is either a United States citizen or a lawful permanent resident who has lived in the US continuously for five years prior to applying.

An individual is eligible for Medicare Part A, at no cost, at age 65 if:

- The individual receives or qualifies for Social Security benefits or Railroad Retirement benefits; or
- The individual's spouse (living or deceased, including divorced spouses) receives or is eligible to receive Social Security or Railroad Retirement benefits; or
- The individual or individual's spouse worked long enough in a government job through which Medicare taxes were paid for at least 10 years.

Individuals who do not meet any of these requirements, may be able to get Medicare Part A by paying a monthly premium.

Before age 65, an individual is eligible for Medicare Part A at no cost if the individual:

- Has been entitled to Social Security disability benefits for 24 months; or
- Receives Social Security disability benefits for ALS; or
- Has End Stage Renal Disease (ESRD) and is:
    - Eligible for or receives monthly benefits under Social Security or the Railroad Retirement system; or
    - Worked long enough in a Medicare-covered government job; or
    - Is the child or spouse (including a divorced spouse) of A worker (living or deceased) who worked long enough under Social Security or in a Medicare-covered government job.

Anyone who is eligible for free Medicare Part A can enroll in Medicare Part B by paying a monthly premium. Anyone not eligible for free Part A, can buy Part B, without having to buy Part A, provided they are a U.S. citizen or a lawful permanent resident who has lived in the U.S. continuously for five years.

Most people who meet the eligibility criteria for Medicare apply for the benefits once eligible. Some individuals may decline Medicare Part B because of the premium cost and may not know that Medicaid can pay the premiums for fully eligible recipients and for individuals who qualify under the Medicare Savings Program. Each year, from January 1 through March 31, there is a Medicare General Enrollment Period (GEP) for Part B. The GEP is for individuals who did not sign up during their initial enrollment period Individuals who fail to enroll during their initial enrollment period, or refuse automatic enrollment, may only enroll during the GEP. Individuals whose Part B has ended because of non-payment of premiums or voluntary withdrawal, may reenroll only during the GEP. Medicaid recipients and individuals eligible for the Medicare

Savings Program do not have to wait for the GEP to enroll in Medicare. They are eligible to enroll in Medicare at anytime. Fully Medicaid recipients and individuals eligible for the Medicare Savings Program may be enrolled into the Medicare Savings Program at any time during the year if the individual has established Medicare entitlement with the SSA.

I. Medicaid Program Implications

A Individuals Who Must Apply for Medicare

Fully eligible Medicaid A/Rs (with income at or below the applicable income level) and A/Rs with income at or below 120% of the Federal Poverty Level (FPL) and who are age 64 and 9 months or older must apply for Medicare as a condition of eligibility for Medicaid. This requirement applies to Medicaid only applicant/recipients as well as cash assistance/Medicaid applicant/recipients.

B. Individuals Excluded from the Medicare Requirement

Individuals who are presumptively eligible for Medicaid, individuals who are not fully eligible for Medicaid and individuals who have income above 120% of the FPL are excluded from the requirement to apply for Medicare. Most immigrants and non-citizens are excluded from this requirement. Only lawful permanent residents who have lived continuously in the U.S. for five years must apply for Medicare as a condition of Medicaid eligibility.

C. Documentation Requirements

Medicaid A/Rs can apply for Medicare by calling the SSA at 1-800-772-1213 to apply by phone or to make an appointment at the local SSA office. Individuals may also apply on-line at https://www.ssa.gov/medicare/. Individuals who apply on-line may be re-directed to apply either by phone or in person if it is determined that the person does not have 40 work quarters. Once an application is completed, the SSA will issue an award or denial letter by mail within two weeks. The Medicare card is mailed separately and is usually issued after the award letter is mailed.

If applying on-line, the applicant will receive an on-line confirmation stating that "You have applied for Medicare with the Social Security Administration." This confirmation may be printed and used a proof of application. The award or denial letter, a copy of the Medicare card, or the printed on-line confirmation, are all acceptable forms of documentation.

Consumers Applying for Medicaid

Consumers aged 64 and 9 months or older who are applying for Medicaid will be required to apply for Medicare unless otherwise excluded. The OHIP-0112 has been added to our application kits to explain this requirement to applicants until the DOH 4220 can be revised. If an applicant fails to apply for Medicare and applied for Medicaid coverage for the three month

retroactive period, the individual will be ineligible for Medicaid prospectively and for any month in the three-month retroactive period where the condition of eligibility applies (i.e. the consumer was aged 64 and 9 months or older). The individual can qualify for assistance for the months in which the individual had not yet reached age 64 and 9 months. If an applicant provides proof of applying for Medicare following a denial or discontinuance of Medicaid but within 30 days of the effective date of the denial/discontinuance, the receipt of the documentation will be treated as a reapplication. Medicaid eligibility will be redetermined if all other documentation requirements were met. A new three month retroactive period may apply based on the date the documentation is received (reapplication month). The documentation received satisfies the requirement for the three-month retroactive period.

The Medicare requirement will also be applied when an individual aged 64 and 9 months or older is requested to be added to a case, or when an individual applies for a separate determination after losing cash assistance benefits.

E. Consumers Renewing their Medicaid

HRA's renewals for disabled, aged, and blind consumers, including those turning 65 include a notice regarding the Medicare requirement. If renewals are received for consumers aged 64 and 9 months or greater who appear to meet the income standard for the Medicare requirement but are not in receipt of Medicare, the client will receive a deferral for proof of Medicare application. If consumers fail to submit the required proof of application, their coverage will be discontinued. Consumers can request more time to provide the proof of Medicare application if needed by calling the Medicaid Helpline (888 692-6116).

F. Consumers already in Receipt of Medicaid

While the requirement to enroll in Medicare is not new, recent audits have found that it has not been consistently enforced across the state. Therefore, the New York State Department of Health (SDOH) has developed a project to identify consumers turning 65 or aged 65 and above who appear to meet the requirements of Medicare but who have not yet enrolled. This project will target consumers who have not enrolled in Medicare at all (not those enrolled only in Part A or only in Part B). These consumers (if not currently in the renewal cycle (see consumers renewing above)) will receive a notice requiring the individuals to submit proof of application for Medicare. Consumers eligible for Medicaid with a surplus, consumers in a nursing home, and consumers in the 5 year ban will be excluded from this selection. Surplus consumers with incomes at or below 120% of FPL and Nursing Home consumers will be subject to the requirement at renewal unless otherwise excluded. If an individual does not provide the required proof by the designated due date (approximately 30 days

from the notice date), the consumer will be sent a Notice of Intent to close their Medicaid coverage and the case will close 14 days from the Notice date. Prior to selection for closing,

however, system records will be checked to determine if the Welfare Management System now shows Medicare coverage for the individual. If the consumer has provided proof of application or denial or if the Welfare Management System now shows Medicare enrollment, the client's coverage will not be terminated.

In New York City, this notice process for current Medicaid only recipients will be divided into three separate mailings. The first mailing is expected to go out in early- mid December with the second and third mailings expected to occur in three to four month intervals.

Medicaid only consumers in this group who request more time to comply will be issued a new deferral and will receive a notice with a new due date. This process will allow us to properly track these consumers.

G. Consumers Needing More Time

If an A/R or the A/Rs legal representative requires additional time to meet the documentation requirement, additional time will be allowed. For Medicaid only clients, client representatives should submit MAP 3062(c) to the Undercare Processing Division to request more time for their clients. Alternatively, consumers or their representatives can call the HRA Medicaid Helpline (888-692-6116) to request additional time.

For additional information please see 17 OHIP/ADM-01 Medicare Enrollment at Age 65.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

REQUEST FOR A TIME EXTENSION:
MEDICARE APPLICATION

NYC Human Resources Administration
Department of Social Services

MAP-3062c 12/13/2017

Date: _____

Case Name: _____

Case Number: _____

CIN: _____

I am unable to provide the documentation that HRA requested at this time. I am requesting additional time past the deferral due date that HRA provided. I understand that this extra time will delay the final processing of my case which could result in an eligibility determination taking longer than the normal case processing timeframe of 30 days for a case containing a child, 45 days for a case containing adults only, or 90 cases for a case based on a disability.

INITIAL EXTENSION REQUEST (place a checkmark in the appropriate box or boxes)

My due date to provide documents is_____.

☐ I am requesting the following:

☐ Up to_____additional calendar days to give you my documents

Reason for Extension: _____

_____

_____

_____

FOLLOW-UP EXTENSION REQUEST (place a check in the box below if this is **not** your first extension request)

☐ I am requesting up to_____additional calendar days to give you my documents

Reason for Extension: _____

_____

_____

_____

Please tell us what you have done to get the documents. Include the name and contact information of the third party contacted (e.g. Bank, Life Insurance Company, Pension Company, IRS, SSA, etc.) the dates contacted and the response received. Attach any relevant correspondence.

I understand that if I do not provide the documents requested by the date it is due, or send HRA a request for an additional extension explaining why I need more time, HRA will make an eligibility determination based upon the documents and information on file and:

My application may be:

- Denied for Medicaid. HRA will not authorize Nursing Home coverage or any other type of Medicaid coverage
- Determined eligible for Medicaid Community Coverage **with** Community Based Long Term Care; **only**
- Determined eligible for Medicaid Community Coverage **without** Long-Term Care, **only**

Name of Consumer/Representative (Print)	Name of Consumer/Representative (Sign	Date

Do you have a medical or mental health condition or disability? Does this condition make it *hard for you to understand this notice or to do what this notice is asking? Does this condition* make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

July 26, 2017

Power of Attorney Form *and* Statutory Gifts Rider

This Alert is to inform Providers, Client Representatives, Community Based Organizations and all organizations assisting clients with their Medicaid applications that a Power of Attorney signed in New York State after September 1, 2009, must comply with the detailed requirements of Title 15 of General Obligations Law to be valid. In particular**, to be valid**, the agreement must fully comply with all requirements of General Obligations Law § 5-1501B.

Furthermore, the New York Statutory Short Form Power of Attorney (NYSPOA) may only be used to establish a trust, if section (h) of the NYSPOA is initialed **and** if a Statutory Gifts Rider (SGR) is also signed and witnessed by two persons, who are not named in the SGR as permissible recipients of gifts, at the same time as the referencing NYSPOA. The SGR must meet the requirements of General Obligations Law § 5-1514.

All trusts signed by an agent with authority under an NYSPOA must also be accompanied by a properly executed SGR to be considered valid for Medicaid eligibility purposes.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program• Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* **• Maria Teresa Arce,** *Chief External Affairs Officer* **• Maria Ortiz-Quezada**, *Director of EIS*

Human Resources Administration
Department of Social Services

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Medical Assistance Program• Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* **• Maria Teresa Arce,** *Chief External Affairs Officer* **• Maria Ortiz-Quezada**, *Director of EIS*

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care

ATTACHMENT: LDSS-3183, "Provider or Managed Long Term Care Plan/Recipient Letter"

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the expansion of spousal impoverishment budgeting for persons enrolled in managed long term care (MLTC) plans. There are three types of MLTC plans: Partially Capitated Plans, Program of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus. This GIS also informs LDSS staff of the requirement to apply institutional eligibility rules, including transfer of assets provisions, when an enrollee is in receipt of long term nursing facility services or is an institutionalized spouse.

Pursuant to federal approval under the State's 1115 waiver, all individuals enrolled in MLTC with a spouse residing in the community who is not participating in a home and community-based services (HCBS) waiver or enrolled in MLTC ("community spouse"), must have Medicaid eligibility determined under the spousal impoverishment rules that apply to HCBS waiver participants. Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance (up to a maximum of $2898 for 2013), a family member allowance (up to $647 for 2013), if applicable, and a personal needs allowance (PNA), ($375 in 2013). If it is more advantageous to budget only the MLTC enrollee's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one, this option is available. This budgeting methodology also applies to couples with a spouse participating in PACE. See GIS 12 MA/013, "Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program," for a further explanation of the rules to be used when spousal impoverishment post-eligibility rules are not favorable for a couple. Under both options, spousal impoverishment rules are to be applied to the couple's resources.

Effective April 1, 2013, certain Long Term Home Health Care Program (LTHHCP) waiver participants began transitioning into MLTC. For couples with a "community spouse," spousal impoverishment rules will continue to apply as they transition to MLTC. Therefore, the transition to MLTC should not result in a change in eligibility.

NOTE: When the MLTC enrollee is subject to eligibility under spousal impoverishment rules, the special income standard described in Administrative Directive, 12 OHIP/ADM-5, "Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program" does not apply.

If an individual with a "community spouse" was enrolled in MLTC prior to April 1, 2013, eligibility must be re-determined using spousal impoverishment budgeting at next client contact, case maintenance or at renewal, whichever occurs first.

Monthly Spenddown

Medicaid recipients with a monthly spenddown are eligible for participation in MLTC. Once the LDSS receives verification that an individual is eligible for participation in a MLTC plan, 06 (provisional coverage) or 19 (community coverage with community based long term care) coverage, as applicable, should be authorized. Currently, Coverage Code 06 will not convert to the Prepaid Capitation Plan (PCP) Coverage Code 30 (PCP full coverage) in order to allow payment to the MLTC plan. However, a system change is pending that will convert the 06 to 30, when there is a prospective MLTC enrollment line in the PCP subsystem. Until districts are notified of the effective date of this change, 01 (full coverage) must be authorized.

The MLTC plan is responsible to collect the amount of the spenddown from the enrollee. The LDSS must inform both the Medicaid eligible applicant/recipient and the plan of the amount of the spenddown. A copy of the eligibility notice with just the enrollee's information displayed may be used for this purpose. Additionally, WMS will pass the spenddown amount to the MLTC plan on a monthly roster. A list of providers that participate in MLTC can be found on the website of the Division of Long Term Care.

Since certain out-of-pocket medical expenses (e.g. co-insurance charges) and expenses for necessary medical and remedial services that are recognized under State law but are not covered by Medicaid, which are the responsibility of the enrollee, must be used first to meet a spenddown liability, the amount owed to a MLTC plan must be reduced by these costs. Receipts, bills or other evidence of incurred expenses must be submitted to the LDSS by the enrollee. The district will need to advise both the MLTC enrollee and the plan when such expenses have been applied toward the monthly spenddown. The LDSS-3183, "Provider/Recipient Letter (Financial Obligation of Recipient Toward Medical Expenses)" has been revised for use in providing this notification. The revised letter is attached to this GIS.

Nursing Facility Admissions, Institutional Eligibility Rules, NAMI

The local district will be notified by the MTLC plan when an enrollee is in receipt of long term nursing facility services (more than 29 days of short-term rehabilitation) or the person is an institutionalized spouse. When an enrollee is to receive more than 29 days of short-term rehabilitation or the person is an institutionalized spouse, the LDSS must conduct a 60 month resource "look back" to determine whether a prohibited transfer of assets was made that may affect eligibility. If the individual is also determined to be permanently institutionalized or the person is an institutionalized spouse, chronic care budgeting rules are applied to determine the institutionalized individual's net available monthly income (NAMI). Since the responsibility for collection of the NAMI from the enrollee is pursuant to a contract between the nursing home and the MLTC plan, the local district must send a

copy of the eligibility notices to the nursing facility and the MLTC plan. The LDSS does not make a principal provider subsystem entry on WMS.

> **NOTE:** For a permanently institutionalized spouse whose eligibility was determined under spousal impoverishment rules while in the community, the nursing home budget needs to be changed to include a $50 PNA instead of a PNA of $375.

If the LDSS determines that the enrollee has transferred assets within the 60 month look-back period and as a result, is not eligible for Medicaid coverage of nursing facility services, the district must notify the plan that the enrollee is ineligible for payment of nursing facility services. The enrollee must be involuntarily disenrolled by the district. Upon disenrollment, the coverage must be changed to the appropriate coverage code based on the specific case circumstances (see 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long Term Care Medicaid Eligibility Changes").

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Reform and Health Insurance Exchange Integration

SUBJECT: Spousal Impoverishment Budgeting with Post-Eligibility Rules for Individuals Participating in a Home and Community-Based Waiver Program

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518)474-8887 NYC (212)417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services of a change in policy concerning the use of spousal impoverishment budgeting with post-eligibility rules for married individuals who receive home and community-based waiver services under a waiver authorized under Section 1915(c) of the Social Security Act.

Pursuant to federal approval under the State's 1115 waiver program, individuals with a "community spouse," as defined in Section 366-c of the Social Services Law, who are receiving waiver services in the Nursing Home Transition and Diversion (NHTD) waiver, Traumatic Brain Injury (TBI) waiver or Long Term Home Health Care Program (LTHHCP) must have eligibility determined under spousal impoverishment budgeting with post-eligibility rules, unless it is more advantageous to budget only the waiver participant's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one.

Spousal impoverishment with post-eligibility treatment of income includes a deduction for a community spouse monthly income allowance (CSMIA), family member allowance (FMA), if applicable, and a personal needs allowance (PNA) for the waiver participant. These deductions are not available when the total net income of only the waiver participant is budgeted and compared to the Medicaid income level for one.

In order to determine whether spousal impoverishment budgeting with post-eligibility rules is more advantageous, a comparison must be made of the deductions allowed under each of the two methodologies. If the sum of the waiver recipient's PNA, CSMIA and FMA, if applicable, is less than or equal to the sum of the Medicaid income level for a household of one and the $20 unearned income disregard, spousal impoverishment budgeting with post-eligibility rules is not more advantageous.

For example: The waiver recipient has a CSMIA of $400. The 2012 PNA for the waiver recipient (the difference between the two-person and one-person income levels) is $367 ($1,159 minus $792). Since the sum of the CSMIA and the PNA ($400 + $367 = $767) is less than the Medicaid income level for one plus $20 ($792 + $20 = $812), it is more advantageous to budget only the waiver participant's total net income, after applying all appropriate community SSI-related income disregards, and compare it to the Medicaid income level for one.

In 2012, it will only be advantageous to the waiver recipient to apply the post-eligibility rules if the CSMIA, plus FMA, if applicable, exceeds $445.

NOTE: In both situations, spousal impoverishment rules for treatment of resources, including a community spouse resource allowance (CSRA), apply.

The CSMIA and FMA, if applicable, can be determined offline, using the LDSS-4346, "Budget Worksheet – Medical Assistance Institutionalized Spouse Budget Worksheet," or by using the appropriate MBL budget – Chronic Care Budget Type 08, 09 or 10. If the CSMIA plus the FMA, if applicable, is greater than $445 (for 2012), the income continues to be budgeted under the appropriate Budget Type 08, 09 or 10. If the CSMIA, plus the FMA, if applicable, is equal to or less than $445, only the waiver spouse's income is budgeted using Budget Type 04, case count of one. Income of the community spouse is not considered available and is not included in the income calculation. Only resources attributed to the waiver spouse, after providing for any CSRA, is entered on the 04 budget.

Please direct any questions to your local district support liaison.

MEDICAID MANAGED LONG TERM CARE

WOODS OVIATT GILMAN
ATTORNEYS
The art of representing people

BURNER LAW GROUP, P.C.

RATED BY Super Lawyers

NEW YORK STATE'S VISION OF MEDICAID MANAGED LONG TERM CARE

THE SOMETIME REALITY OF THE MMLTC TODAY!

"I JUST CAN'T BELIEVE THIS CAN GO ON THIS LONG WITH PEOPLE'S LIVES ON THE OTHER END.. CAN I DO ANYTHING TO MOVE THIS FORWARD?"

WHAT IS MEDICAID MANAGED LONG TERM CARE (MLTC) ?

a. Helps people who are chronically ill or have disabilities and who need health and long term care services to help them stay in their homes communities as long as possible.
b. Two basic models:
   i. Programs for All-Inclusive Care for the Elderly (PACE)
   ii. the MLTC.

PACE

PACE- both Medicare and Medicaid pay a capitated rate to a PACE Plan for services.

PACE members are required to use PACE physicians and work with the PACE interdisciplinary team to develop a care plan for on-going care management.

PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services.

MLTC

MLTC provides long term care services and ancillary services in exchange for receiving a capitated rate paid by Medicaid.

MLTC members may retain their primary care physician and they retain their Medicare card for Medicare reimbursable services.

MLTC ELIGIBILITY REQUIREMENTS

a. Have a chronic illness or disability that would make you eligible for nursing home care.
b. Are able to stay safely at home at the time you join the plan.
c. Are expected to need 120 days or more of long term care services in the community.
d. Meet the age requirement (age 21 or older).
e. Are "dual eligible", i.e., eligible for both Medicare and Medicaid.
f. Live in the area served by the Plan.

LONG TERM CARE SERVICES WHICH REQUIRE ENROLLMENT IN A MLTC

- Personal care services
- Consumer Directed Personal Assistance Program
- Adult day care
- Private duty nursing
- Certified Home Health Agency long-term services
- Nursing home residential care

PRACTICE TIP – DO NOT OVER PROMISE!

UPSTATE VS. DOWNSTATE DIFFERENCES

- Turn-around time.
- Shortage of aides in Upstate counties.

FIRST STEP: APPLY FOR COMMUNITY BASED MEDICAID

a. Remember, no five year look-back, and no penalty for transfers.
b. Must complete Supplement A and provide current asset/income documentation.
c. If seeking retroactive coverage, supply documentation for past three months, and copies of medical bills (paid and un-paid) for this period.
d. Indicate on top of application and in cover letter-"seeking MLTC."

SINGLE VS. MARRIED

- Income level (for one): $842.00 + $20.00 disregard
- Resource level (for one): $15,150.00
- Post- eligibility spousal impoverishment rules apply!
- If applying for a married individual, assuming there are excess resources, always submit a spousal refusal for the non-applying spouse. Again, Upstate vs. Downstate differences.

BECOMING ELIGIBLE: THE PLAN

Is your client eligible as of the first of the month?

- There are no transfer rules, but you want to think ahead in case your client may need a nursing home in the future.
- Practice tip: You may want to wait an additional month after making transfers, if possible, so the bank statements do not show the transfers. While the client is eligible either way, the application review time may be less if there are not large transfers to review.

SPOUSAL TRANSFERS

- Advise your clients regarding spousal contribution. (Should they apply or wait)?
  - Usually makes sense to apply, unless the spouse has so much income that the contribution would be more than they are currently paying for care.
  - Suffolk/Nassau: not currently seeking contribution from spouses.
  - Contributions sought in Upstate counties- some are very aggressive in their pursuit of spouses.
  - NYC: actively seeking contribution
    - Letter usually comes 6-12 months after spouse is approved for Medicaid.

SPOUSAL SUPPORT

- Income: 25% of excess over MMMNA ($3,090).
- Assets: for each month over CSRA ($123,600). Spouse is asked to pay Medicaid rate.
  - Opportunities for spouse to transfer assets to an irrevocable trust.

SPOUSAL SUPPORT

- Negotiate claim with investigator – can get a reduction in amount owed. Does not cover future claims.
- Upstate: Any negotiations are directly with the County Law Department, or counsel for DSS. Aggressiveness varies County to County.

PLANNING OPPORTUNITIES

Other options for transfers to gain eligibility:

- Medicaid Qualifying Trust.
- Family member.
- Pooled asset trust.
- Again, be cautious and advise your client, in writing, with copy for your file, that any transfers will have an impact if the client needs skilled nursing care within the next five years and seeks to have Medicaid coverage for such care.

APPLICATION PROCESS (FORMS):

- Access NY Health Care (DOH-4220).
- Access NY Supplemental A (DOH-4495A) application.
- HIPAA form (OCA 960).
  - Realize that you will need this each time you call for an update; they will often ask you to fax it over before any case examiner speaks to you.

COVER LETTER WITH APPLICATION

- Outlining what the assets are, if there are any transactions over $2,000, and the income calculation.
- All gross income added up, subtract health insurance premiums, subtract $842 + $20 disregard, then list resulting excess.

COVER LETTER WITH APPLICATION

- Indicate that the client intends to spend down through the use of a pooled income trust.
- Practice Tip: If the applicant is not in receipt of SSD or SSI and you want to utilize a pooled trust for the spend-down, you must complete and submit the disability application documents with your Medicaid application.
- Subtract housing disregard if Medicaid paid in NH and being discharged to community.
  - NYC: $1,171 / Long Island $1,285 / Northern Metro $892

DOCUMENTATION

If the client is the beneficiary of a trust, irrevocable or revocable:

- Include trust document, list of assets in trust with supporting documentation (i.e. bank statements, deed to house, etc.), and list the income generated by trust (and add this to income calculation).

APPLICATION PROCESSING TIME:

- 45 days
- 90 days if:
  - Awaiting a disability determination, i.e. has not previously been deemed disabled by the Social Security Administration.
  - This applies to most of our clients looking to utilize a supplemental needs trust, including a pooled income trust.
  - 18 NYCRR 360-2.4.

AWAITING A DETERMINATION

What can you do if you do not receive a timely determination?

- Can you find out who the caseworker is?
- Suffolk will always send a deferral.
- NYC only sends a deferral if they really need something.
- Upstate-find out who the caseworker is, make sure the caseworker has all the documentation needed, try to explain the circumstances, sympathize with their caseload, and ask them to please expedite.

IMMEDIATE NEED APPLICATION

- New York City
  - Put immediate need on cover letter; pursuant to 16 ADM-02 – Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services.
  - Additional documentation:
    - Immediate Need Transmittal to the Home Care Services Program (HCSP-3052 (E)); Medical Request for Home Care (HCSP- M11Q); Attestation of Immediate Need (OHIP-0103).

IMMEDIATE NEED APPLICATION

- VIA Email: **HCRequests@hra.nyc.gov**
- M11-Q –
  - Must be completed within 30 days of medical examination and filed with local district within 30 days
  - State regulation 505.14(b)(3)
  - Upstate vs. Downstate- Upstate counties may have different requirements for a physician's statement of need.

FINANCIAL APPROVAL

- With spend down- utilize a pooled trust.
- What to submit for pooled trust approval?
  - Joinder agreement.
  - Welcome letter.
  - Verification of Deposit statement.
  - Disability Questionnaire (LDSS-1151).
  - Medical Report for Determination of Disability (LDSS-486T).
  - HIPAA form (OCA No. 960).
  - Authorization to Release Medical Information form (MAP-751e(E)).

FINANCIAL APPROVAL

- Can apply for Medicare Savings Program (MSP) once the pooled trust is accepted and the case is re-budgeted with a $0 spend-down.

  - Pays Medicare premium; keep in mind this will increase the client's surplus income amount.
- Practice Tip: make sure power of attorney is sufficient to allow agent to join and fund a pooled income trust (Nt.- this has yet to become an issue Upstate).
- Pre-approval of power of attorney.
- This has not yet been an issue in Upstate counties.
- See MARC Alert attached.

CONFLICT FREE ASSESSMENT THROUGH MAXIMUS

- MLTC Policy 14.06: implementation of the conflict free evaluation and enrollment center (CFEEC)- https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care.
- Do you qualify for more than 120 days of long term care?
- When?
  - Only valid for 75 days.
    - See NYS MLTC Policy 16.08.
  - Can schedule it before approval comes in.
    - After 30 days have passed.

APPOINTMENT FOR ASSESSMENT

- When making appointment:
  - Need: full name, address, DOB, SSN, Medicaid number, phone number.
- At appointment:
  - Insurance cards available.
  - Medications available.
  - Name and number for primary care physician.

ACTIVITIES OF DAILY LIVING

- Bathing, grooming, dressing, meal preparation, reheating, chores, assistance with ambulation (use of a cane or walker, indoor and outdoor), transfers (getting up/down from a seated position, getting up/down from a laying position), toileting (use of diapers or liners any incontinence of bowel or urine).
- Cueing and reminding for tasks.

APPROVAL THROUGH CONFLICT FREE ASSESSMENT

- Conflict free assessment must be conducted within 7 days of request.
- After approval- mandatory enrollment packet sent by NY Medicaid Choice to recipient, who has 75 days to pick a plan or recipient will be auto-assigned to a plan.
- Nt.- the conflict free assessment does not determine hours- that is done by the Plan.

MLTC ASSESSMENT

- Must enroll in MLTC Plan, exceptions:
  - Hospice.
  - NHTDI/TBI/OPWDD.
  - ALP.
  - Those who only need housekeeping – personal care level 1 services; see 18 NYCRR 505.14 – no ADL help.

MLTC ASSESSMENTS

- Practice Tip: Always tell clients you cannot promise hours and document the conversation.
- How many appointments to schedule?
  - Shop around.
  - Plans can see when others have come in but CANNOT see the services offered.
- How do you pick a MLTC Plan?

MLTC ASSESSMENTS

- Providers
  - if your client receives dental, audiology, podiatry, and/or optometry services, then make sure that the MLTC plan you choose has the client's providers within its network.
- Knowing the market – what plans are giving clients the hours they need and providing good customer service.

MLTC ASSESSMENTS

- Prepping client/caregivers
  - Doctor's letter.
  - List from current caregiver of daily tasks.
  - Give the narrative of the worst day.
  - Why there are no informal supports, i.e. caretaker's limitations.

MLTC ASSESSMENTS

- Who should attend the assessment?
  - Make a decision with the client regarding who should appear at the assessment.
  - Practice Tip: some firms employ a non-attorney to appear at assessments. Others have an attorney attend the assessment or refer the client to a geriatric care manager.
- Uniform Assessment tool.
- Enrollment in plan by 19th day of month to allow coverage for the 1st day of the following month.

IMMEDIATE NEED ASSESSMENTS

- 8 Days
- Auto enrolled into agency for FI
- CDPAP – Issue
- Pooled trust not approved – agency may want to spend down
- After 120 days of immediate need services client will get a letter requiring enrollment into MLTC . Will be auto – enrolled in 60 days

SPOUSAL IMPOVERISHMENT PROTECTIONS FOR MARRIED MLTC MEMBERS

- Choice- budget as household of one with a spend down (and use pooled trust) - or utilize post-eligibility spousal impoverishment budgeting. Compare budgeting, and use whichever one is most advantageous. GIS 14 MA/25.

SPOUSAL IMPOVERISHMENT PROTECTIONS FOR MARRIED MLTC MEMBERS

- GIS 13 MA/018: " Spousal impoverishment treatment of income includes a post-eligibility deduction from the MLTC enrollee's income for a community spouse monthly income allowance, a family member allowance, if applicable, and a personal needs allowance ($391.00 for 2018)."
- 12 MA/013 sets forth how to do the budgeting comparison:
  - Use with spousal refusal.
  - Submit request for spousal impoverishment budgeting after enrollment in Plan.

REIMBURSEMENT

- After pooled trust approval.
- Must get a retroactive eligibility determination and then seek reimbursement for paid services (but only at the Medicaid rate).
- Make sure you ask for retroactive coverage on the application (Section G.)

AFTER MLTC APPROVAL

- Second Step planning?
- Spousal refusal issues.
- What happens when your MLTC leaves market?

OTHER RESOURCES

- MARC – join to get results
  - http://a069-marc.nyc.gov/marc/home.aspx
- Western New York Law Center; NY Health Access – updated by NYLAG
  - http://www.wnylc.com/health/
- Medicaid Reference Guide
  - https://www.health.ny.gov/health_care/medicaid/reference/mrg/

OTHER RESOURCES

- Fair Hearings Database
  - https://otda.ny.gov/hearings/search/
- State Complaint Number for MLTC Problems
  - 1-866-712-7197
- E-mail mltctac@health.ny.gov- put "COMPLAINT" in subject line
- For enrollment complaints - call NY Medicaid Choice
  - 1-855-886-0570 (Advocates line)
  - 1-888-401-6582 (Consumers line)

THANK YOU!

CONTACT US

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