NYS Medicaid & Home Care Changes 2022

WSIACA – ESCOTA April 21, 2022

Valerie Bogart eflrp@nylag.org ©

NYLAG
New York Legal Assistance Group

ABOUT NYLAG

The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services, financial counseling, and engages in policy advocacy efforts to help people experiencing poverty.

The Evelyn Frank Legal Resources Program (EFLRP) at NYLAG focuses on access to Medicaid for older people and people with disabilities for long term care.

https://nylag.org/evelyn-frank-legal-resources/

NYLAG
New York Legal Assistance Group

Agenda

1. COVID issues
2. Increase in Medicaid limits – Good news!
3. Independent Assessor – Starts May 16, 2022
4. New Reg Allows MLTC Plans to reduce services after transition from Immediate Need
5. Involuntary Disenrollment from MLTC – allowed to resume on limited grounds
   - Long Term Nursing Home Disenrollment from MLTC
6. Other Changes coming in 2022
   1. Home Care Eligibility – ADL Thresholds/ Minimum Needs (will be later)
   2. Lookback - won't be discussed today
7. What is ICAN? Get HELP!

COVID issues – Medicaid automatically renewed

1. Since 3/2020, Medicaid cannot be discontinued, and spend-down can't be increased.
2. Medicaid is extended automatically for 1 year even if you don't return the renewal. NYC HRA sends out renewals, but not other counties.
3. WHY? **Public Health Emergency (PHE)** "Maintenance of Effort" – States get extra Medicaid $ and in return cannot cut or reduce Medicaid. GIS 20 MA/04;**
   - PHE was extended through July 2022, we don't know if it will be extended again.
   - **After PHE ends, renewals will again matter**. Check for updates at http://www.wnylc.com/health/news/86/. If client moved, make sure HRA/DSS has new address so they'll get renewal. See http://www.wnylc.com/health/entry/227/.

NYLAG New York Legal Assistance Group

*http://www.wnylc.com/health/download/637/

**http://www.wnylc.com/health/news/86/#2.%20NYS%20Medicaid%20Policies%20-%20MOE

COVID issues

Aide Shortage Exacerbated by COVID

- Chronic aide shortage is national.
- *Fair Pay for Home Care* bill sponsored by Senator Rachel May and Assembly Health Chair Richard Gottfried didn't pass. Would have set wages for home care workers at 150% of the highest minimum wage in a region, or $22.50/hour.
- Instead, budget increased wages $3 over 2 years.
- Meanwhile – file grievance with MLTC plan and complaint with NYS DOH -**1-866-712-7197 or e-mail mltctac@health.ny.gov**. Plans must use out-of-network providers if can't staff case.*

*42 CFR 438.206(b)(4); MLTC Partial Capitation Model Contract, Article VII, Section D]; FH No. 7735470N.

NYLAG
New York Legal Assistance Group

COVID ISSUES

Fair Hearing Scheduling Delays

- Citing pandemic, OTDA is not scheduling hearings that have Aid Continuing, prioritizing those that do not.
- TIP: If client seeking increase in home care, make sure she is coded as "homebound." Then she get interim *Varshavsky* **increase to amount of hours requested** - kicks in 45 days after request. These are considered to have Aid Continuing, so are on hold. Good for clients! See http://www.wnylc.com/health/entry/228/
  - **WARNING**: about 10% of MLTC members are in '**Medicaid Advantage Plus" (MAP)** plans – a type of MLTC all-in-one plan that also includes Medicare services.
  - OTDA denies them *Varshavsky* increases – so you must pursue these MAP "FIDE" hearings aggressively (Fully Integrated Dual Eligible). See special MAP-FIDE FH procedures - http://www.wnylc.com/health/entry/225/ or do External Appeals

https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf p. 16; 42 CFR § 431.244

NYLAG New York Legal Assistance Group

MEDICAID INCOME & ASSET LIMITS WILL INCREASE JAN. 2023

For Age 65+/ Disabled/Blind

Also Medicare Savings Program

NYLAG
New York Legal Assistance Group

Backgrounder: Non-MAGI and MAGI

1. Since 2014 - the Affordable Care Act (ACA) increased income limits for people under age 65 who do not have Medicare to **138% Federal Poverty Line (FPL)**.
    1. Called “MAGI” Medicaid – “Modified Adjusted Gross Income” because uses tax rules for income.
    2. Has NO ASSET limit.
2. But age 65+, younger disabled still have old rules. When they get Medicare at 65 or after 2 years on SSD they “fall off the cliff.” Suddenly, Medicaid has a lower income limit (**85% FPL**). Called “non-MAGI Medicaid. Now they have a big spenddown, or lose Medicaid for excess resources.

NYLAG
New York Legal Assistance Group

NYS Budget: Passed Landmark Medicaid Increases

- The NYS Budget enacted historic increases in the Medicaid income limit and asset limit.
- The income limit for Age 65+, Blind & Disabled (non-MAGI) will now be the same used for younger people under the Affordable Care Act (MAGI) at 138% Federal Poverty Line (FPL).
- Medicare Savings Program limits also increased.
  - **QMB** will be the same as Medicaid – 138% FPL (pays for Part B premium AND Medicare cost-sharing)
  - **QI-1** will be 186% FPL (pays for Part B premium only)
  - No more SLIMB program.
- Increases start Jan. 1, 2023 – see next slide

NYLAG
New York Legal Assistance Group

Benefit	% FPL		SINGLES		COUPLES	
	2022	2023	2022	2023	2022	2023
Income limit per Month						
Medicaid	82%	138%	$934	$1563	$1,367	$2,106
QMB	100%	138%	$1,133	$1563	$1,526	$2,106
QI-1	135%	186%	$1,529	$2107	$2,060	$2,838
Medicaid Asset Limit			$16,800	$28,134	$24,600	$37,908

NYLAG
New York Legal Assistance Group

More about the INCOME LIMIT Increases

a. Age 65+, Blind and Disabled group will still be Non-MAGI, using the same budgeting rules as before (like spend-down and spousal refusal).
   a. Just the **income limit** is being increased to the MAGI limit.
   b. If income is above new limits – **can still use Pooled Trust** or "spend down" on medical expenses.
b. Before, many people with MAGI Medicaid on NY State of Health Exchange would lose Medicaid when they got Medicare (whether at 65 or based on disability) because of lower income limits. Now many will no longer *fall off the cliff*.
c. Nursing home budgeting won't change – same calculation of NAMI as before.

NYLAG
New York Legal Assistance Group

Increase in Asset Limit

- NYLAG and other advocates asked NY to REPEAL the ASSET TEST for non-MAGI Medicaid – to be the same as for MAGI Medicaid.
- Why? The asset rules are biased against people of color who statistically are more likely to have savings in bank accounts, not:
  - **Homes** - which are exempt if equity under $955,000
  - **IRAs** and other retirement funds – which are exempt as long as taking distributions.
  - See coalition letters at http://www.wnylc.com/health/news/90/
- Unfair that a tenant can't save $50,000 in the bank but a homeowner can have equity of $955,000, or own a $1 million dollar IRA.
- But – the asset test was not repealed. However, it was slightly increased. See earlier slide.

*CMS State Medicaid Director Letter #14-001, *Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules and Post-Eligibility Income Rules to MAGI Individuals,* https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-001.pdf

NYLAG New York Legal Assistance Group

Medicaid increases – practical issues

- CMS approval will be required for this to go into effect.
- **If approved - Effective date will be Jan. 1, 2023.**
- Old rules continue **for this year** – **new applicants** must use existing asset and income limits.
- **COVID NOTE – Current recipients** have not gone through annual renewals since Public Health Emergency (PHE) started March 2020. Federal "Maintenance of Effort" have banned cutting off Medicaid or increasing spend-down even if ineligible or has excess income.*
  - Public Health Emergency expected to end in 2022 – all 7 Million NYS Medicaid recipients will be evaluated in renewals that will take the State a year. Hopefully, timing will work out to use the new limits on the renewals
  - See tips on renewals - http://www.wnylc.com/health/entry/227/

*http://www.wnylc.com/health/news/86/#2.%20NYS%20Medicaid%20Policies%20-%20MOE

“INDEPENDENT ASSESSOR” FOR HOME CARE

Home Care Regulations adopted 8/31/21 –effective Nov. 8, 2021
but implementation to start May 16, 2022

ADOPTED REGS eff. 11/8/2021 posted at
https://regs.health.ny.gov/regulations/recently-adopted or direct link

https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/Personal%20Care%20Services%20and%20Consumer%20Directed%20Personal%20Assistance%20Program.pdf

NYLAG & NYSBA COMMENTS on proposed regs
http://www.wnylc.com/health/download/771/ (3/13/21)

NYLAG
New York Legal Assistance Group

MRT II Changes Enacted in 2020 - Status

Medicaid Redesign Team II Change	When is it Starting?
Independent Assessor for Personal Care services (PCS) & Consumer Directed Personal Assistance (CDPAP). Being Phased In --	May 16, 2022 – MLTC enrollment, *standard* managed care and DSS requests July 1, 2022 – Immediate Need, *expedited* managed care requests Not yet scheduled – annual reassessments, requests for increases
New **minimum number of 3 ADLs** required for eligibility for PCS & CDPAP (2 ADLS if dementia)	**DELAYED:** CANNOT START TIL AT LEAST OCT. 2022 but Likely Later
30-Month LOOKBACK for MLTC enrollment and all Requests for PCS and CDPAP	

New Independent Assessor – DSS & Plans

NY Medicaid Choice ("NYMC" or Maximus) has huge new role.

Until now they just do Conflict Free Assessment for MLTC.

- Now, NY Medicaid Choice will do **all nursing assessments** previously done by Plans and local districts (DSS/HRA) **+ new medical assessments.**
- No state directives issued as of 4/19/22. Sole details are in Powerpoints DOH presented to plans & LDSS - posted on **new NYIA website** - https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/index.htm.

The *terms* they are a changing'

- **CFEEC** No longer called Conflict-Free Evaluation and Enrollment Center
- **NYIA** **New York Independent Assessor – replaces CFEEC + more!**
- **CHA or IA** **Community Health Assessment or Independent Assessment** (Maximus Nurse assessment using the UAS-NY)
- **IPP** **Independent Practitioner Panel** –Maximus doctors, nurse practitioner, physician assistant who will now complete the physician's orders.
- **CA** **Clinical Appointment** –The examination by a doctor from the IPP.
- **PO** **Practitioner's Order** –Replacement for the M-11q or DOH-4359 physician's order. Will be signed by IPP.
- **IRP** **Independent Review Panel** –New process for cases with more than 12 hours per day on average, for the first time, in the proposed care plan

NYLAG
New York Legal Assistance Group

Independent Assessor being phased in:

A. Starts May 16, 2022:

1. For enrollment into MLTC/MAP (replaces CFEEC)
2. For standard PCS/CDPAP requests for PCS/CDPAP to Local DSS/HRA (for people who are exempt or excluded from MLTC or managed care ie in HOSPICE, OPWDD, TBI or NHTD waivers
3. Mainstream managed care – *Standard* requests for PCS/CDPAP

B. Start July 1, 2022 - Immediate need applications to DSS/HRA and *expedited* requests to mainstream managed care.

– TIP: After May 16th, file requests to mainstream plans as EXPEDITED not regular. (see later slide)

C. Starts Later – No date set yet:

1. Annual reassessments (no longer 6-month) – MLTC, mainstream managed care & DSS/HJRA
2. Every request to plan or LDSS for an ***increase*** or on ***discharge from NH, hospital***.

D. NOT used for PACE

Independent Assessor Process – DSS & Plans

1. **TWO "Independent assessments" by *NY Medicaid Choice (NYMC)* –** can be by telehealth (not telephone) unless consumer requests in-person

   A. **Independent Assessment (IA) –** NYMC nurse does all "Uniform Assessments" (UAS) a/k/a Community Health Assessment (CHA) previously done by plan or LDSS nurse.

   - This replaces nurse assessment by MLTC, LDSS (Immediate Need etc) or mainstream managed care
   - MLTC plan MAY but is not required to do a separate assessment for new enrollee. May need to do assess informal caregiver availability, night-time needs.

   B. **Clinical Assessment (CA)** by Independent Practitioner Panel **(IPP)-** exam by NY Medicaid Choice PHYSICIAN, physician's ass't. or nurse practitioner who prepares a Practitioner's Order **(PO).** See sample of new form*****

   - **Decides if "medically stable"** to receive PCS/CDPAP**. Advocacy concern about pretext to deny home care and require nursing home.**

*https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slides 11-15

2. NYMC "Outcome Notice" – if NOT ELIGIBLE

- If after the 2 assessments NYMC finds NOT eligible for MLTC enrollment or PCS/CDPAP from DSS/HRA or mainstream (because not medically stable)
- NYIA sends consumer an Outcome Notice of denial of PCS/CDPAP/MLTC – can request Fair Hearing.
- For MLTC, this is not a change. NY Medicaid Choice has always sent denial notice to consumer.
- But for DSS/HRA and managed care plans, this is a big change. Denial notice used to come from DSS/HRA or managed care plan. Is this legal?

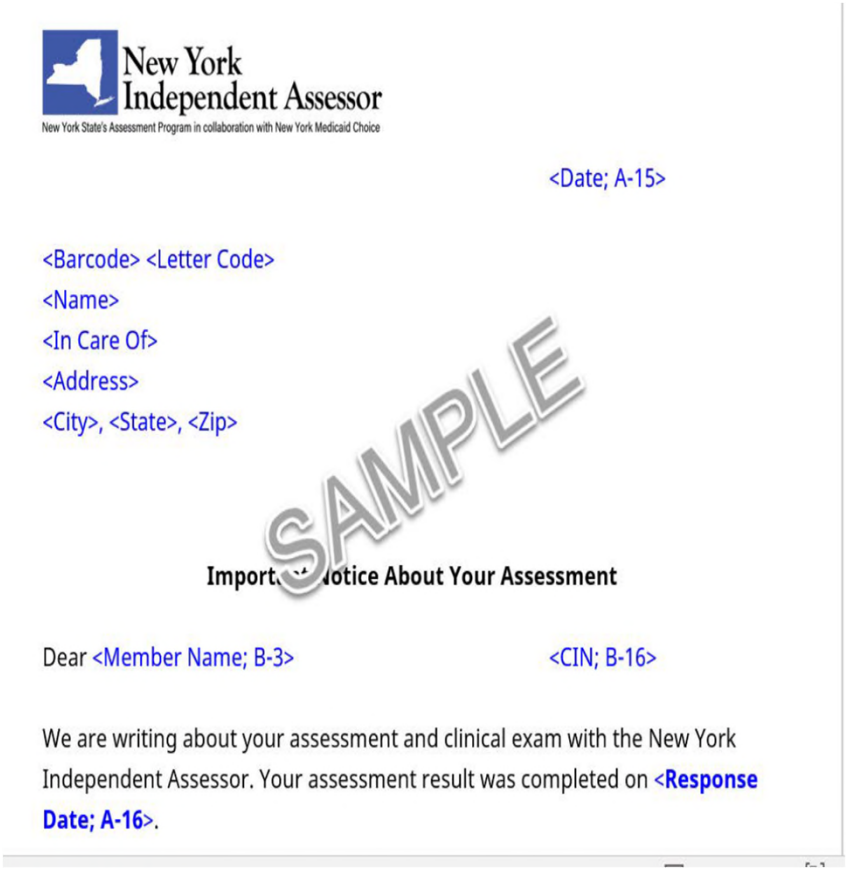
https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_ldss.pdf slides 33-35 and https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_mmco.pdf

2. NYMC "Outcome Notice" – if ELIGIBLE

- If after the 2 assessments NYMC says eligible for PCS/CDPAP (for DSS or mainstream)
- Refers consumer to call DSS or mainstream plan to "share results" for them to develop plan of care.
- ADVOCACY CONCERN – burden on consumer to contact LDSS/ plan to move request forward. Why is this necessary? NYMC sends the results anyway to DSS/plan – that should be enough

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_ldss.pdf slides 33-35 and https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_mmco.pdf

Outcome Notice Content



New York Independent Assessor
New York State's Assessment Program in collaboration with New York Medicaid Choice

<Date; A-15>

<Barcode> <Letter Code>
<Name>
<In Care Of>
<Address>
<City>, <State>, <Zip>

SAMPLE

Import[illegible]otice About Your Assessment

Dear <Member Name; B-3> <CIN; B-16>

We are writing about your assessment and clinical exam with the New York Independent Assessor. Your assessment result was completed on **<Response Date; A-16>**.

- The notice will contain a section entitled **Your assessment showed**, which is where it informs the consumer of the outcome
- There are multiple possible outcomes, depending upon the consumer's situation (MLTC/Mainstream/Immediate Need) and NYIA's findings
  - "You are eligible for CBLTSS"
  - "You may be eligible for CBLTSS"
  - "You may qualify to receive LTSS through a MLTC plan"
  - "...however your health condition is not stable enough to get...care at home"
- These notices will be very confusing for consumers, so **it's important to get a copy of the notice** to properly advise them!

DSS & Plans Develop Plan of Care

3. **HRA/DSS or Plan uses the IA and CA to develop plan of care – and authorize services if 12 hrs/day or less.**
   a. Variance – DSS or Plan may dispute the IA if they have "material disagreement" affecting plan of care. Then IA may make requested change or has 10 days to do a *new assessment*.
   b. Will plan/LDSS still have a nurse assess client? Gray area. DOH acknowledges that the UAS/CHA has gaps – doesn't assess night-time needs or informal caregiver availability. So they still need to assess but won't be paid for it!
4. **If HRA or Plan say needs > 12 hours per day** → see next slide.

The NYIA process

Jargonary

- NYIA – NY Independent Assessor
- CHA – Community Health Assessment
- CA – Clinical Appointment
- IPP – Independent Practitioner Panel
- PO – Practitioner's Order

Step 1

- Consumer, caregiver, LDSS or plan calls NYIA to request initial assessment. Must have Medicaid.
- 855-222-8350, M-F 8:30am-8:00pm, Sat 10:00am-6:00pm

Step 2

- **NYIA will schedule CHA and CA**
- CHA and CA can occur M-F 8:30am-5:00pm, Sa-Su 10:00am-6:00pm

Step 3

- **CHA appointment**
- NYIA nurse will complete UAS-NY

Step 4

- **CA appointment**
- IPP will examine consumer, review CHA, determine if self-directing and stable medical condition, and complete the PO form

Step 5

- **Outcome Notice sent by NYIA.. If denied→ Fair Hearing Rights. If approved→**
- If Mainstream or Immediate Need, plan/LDSS will use CHA & PO to complete plan of care. If plan is > 12 hours/day – go to **Step 6**
- If MLTC/MAP, consumer must then call a plan to enroll.

Step 6

- **Independent Review Panel (IRP)** Maximus panel reviews DSS/plan's proposed plan of care if > 12 hrs/day and makes recommendation to Plan/LDSS, which send consumer notice of approved plan.

Independent Review Panel (IRP) – if Plan/DSS say needs > 12 Hrs/day

4. **If DSS or Plan say needs > 12 hours/day → Must refer for "Independent Review Panel" (IRP) *by NY Medicaid Choice*** – recommends whether proposed plan of care is "reasonable and appropriate" to maintain health & safety in the home.
   a. **ALERT: Saying "unsafe" can be pretext for forcing into nursing home – violate *Olmstead* and ADA.** A "public entity must ensure that its safety requirements are based on **actual risks**, not on **mere speculation, stereotypes, or generalizations** about individuals with disabilities."* 28 CFR §35.130(h)
   b. IRP may recommend changes in plan of care but NOT specific amount of hours. 505.14(b)(2)(v)(f)(p. 50)
   c. **Grandfathering** - IRP not required if consumer already receiving > 12 hours/day, even if requesting increase from live-in to split-shift*
   d. **Plan/DSS make final decision and issue notice** Does not have to take IRP recommendation. 505.14(b)(2)(iii)(f)

*https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slides 48-49 – clarifies 18 NYCRR 505.14(b)(4)(xi)(b);

MLTC enrollment with IA

Our best understanding of how it will work – this is a guess!

1. **Consumer contacts NYMC to do CFEEC** just as now. Now NYMC will schedule BOTH the IA (nurse) and the Clinical Assessment (CA) by MD/nurse practitioner. The CFEEC is now the "IA."
2. IA + CA used to determine eligibility for MLTC –**NYMC sends Outcome Notice that can/cannot enroll in MLTC.** Fair hearing rights if not eligible.
3. Plan enrollment same as now – plan *may* do supplemental nurse assessment to fill in for what DOH acknowledges the UAS doesn't cover well – informal caregiver availability, night-time needs
   - Will plan still tell consumer approved hours? *UNCLEAR*.
4. Enroll in MLTC the same as now. Plan uses IA and IPP to determine plan of care; if that is > 12 hours – refers for IRP/IMR. See previous slide.

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-01-26_mmco.pdf slides 10-19

Independent Assessor Concerns -- Delays!

- HRA/DSS must determine hours within **7 days** of receiving back all of the assessments…but no deadlines on conducting IA and CA assessments!*
  - Immediate Need deadline – 12 Days after application filed - how is that possible to meet?
  - Plan deadlines are on next slide. Impossible to meet these time limits!
- In response to concerns about delays – regs say **DSS/Plan *may* (not *must*) authorize "temporary" care > 12 hours/ day pending the High Need IRP Review* if can't meet deadlines**** - but PowerPoints say temporary plan is only < 12 hours/day!***
- Added delay if DSS/Plan disputes "material fact" in IA –NY Medicaid Choice has **10 days** to schedule 2nd assessment (reg pp. 44, 111).

* 505.14(b)(3)(ii), 505.28(g)(2) (p. 51, 127) **505.14(b)(4)(vi), 505.28(e)(4) (pp. 54, 121). ***https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slide 51

How will MLTC/ mainstream plan comply with federal deadlines to decide requests to Increase or New Services

Type of Request	Maximum time for Plan to Decide
Expedited*	**72 hours after receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.

*Expedited if delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. 42 CFR 438.210(d)

Independent Assessor Concerns

Lack of guidance, public information

- No ADM or MLTC policy yet issued, no public webinar held, no FAQs (as of 4/19/22) – just powerpoints on https://www.health.ny.gov/health_care/medicaid/redesign/nyia/
- LDSS/plans must operationalize huge systems changes, communications & data feeds with NY Medicaid Choice, issue internal procedures, train staff
- Sole guidance issued – 21 ADM-04 & MLTC Policy 21.06 (12/13/21) don't touch on IA, only on relatively minor changes in regs:
  - Reassessments now annual not every 6 months
  - CDPAP: only one FI per consumer; designated rep for non-self directing consumer must be present at all assessments, new agreement between consumer/rep and LDSS/plan
  - **M11q/physician's order may be signed by Nurse practitioner, physician's assistant,** Osteopath – not just MD
  - Tweaks permitted reasons for reductions in MLTC Policy 16.06:
  - Tweaks policy on "safety monitoring" under NYS DOH GIS 03 MA/003 and MLTC Policy 16.07

NYLAG
New York Legal Assistance Group

Independent Assessor - Concerns

Capacity of NY Medicaid Choice to Handle New Assessments

Does NY Medicaid Choice have:

1. **Nurses** to do all of the new IA assessments?
   - Huge nursing shortage aggravated by COVID.
   - CFEEC's already delayed for MLTC, but 5/16 must do ALL standard LDSS & managed care applications and 7/1/22 Immediate Need & Expedited assessments for MLTC/ mainstream– eventually **about 300,000/year**!
2. **MDs**, Nurse practitioners, PA's to do the Physician Order/IPP & Independent Medical Review – also 300,000/year!
3. **Call Center capacity** – Just calls for CFEECs go into voicemail, calls not returned. How will handle massive increase to schedule the new assessments?
   - DOH said referrals by LDSS for the IA will be by a 3-way call with consumer to NY Medicaid Choice.

Independent Assessor – Concerns

IA & IPP Don't Know the Consumer!

- **TIP: Obtain Letter of Medical Necessity from treating physician** and **give to all assessors** and plan/LDSS.
- **Nurse** doing the IA and annual reassessments likely will not know the consumer.
  - Where nurse would normally have an M11q/ physician's order for diagnoses, meds, basic info – those forms have been *eliminated*.
- **Physician/ nurse practitioner** doing the CA/PO & the high-need IMR will not know the consumer or have expertise in their diagnoses.
- Disability community lobbying for a panel of specialist nurses/ NPs/PA's knowledgeable about particular disabling conditions– ie MS, rheumatoid arthritis, quadriplegia.

NYLAG
New York Legal Assistance Group

Independent Assessor – Concerns

Appeal & Fair Hearing Rights

- Plan/LDSS ***may not*** authorize > 12 hours wo/ high-need Independent Review Panel (IRP) unless ordered by a Fair Hearing or court. 18 NYCRR 505.14(b)(4)(vi).
- What if consumer requested 24-hour care, but plan/LDSS approved just 8 hours, so they don't refer for the high-need IMR/IRP? **In FH, may ALJ order 24-hour care?**
  - Reg unclear, DOH said intent is YES – will clarify (otherwise ALJs will remand for the IMR/IRP, causing more delay).
- Reg omits that plan must comply with an External Appeal decision of NYS Dept. of Financial Services (alternate appeal option under Title II of Article 49 of NYS Insurance Law). See http://www.wnylc.com/health/entry/184/#external%20appeals. NYLAG asked DOH to clarify.
- **EVIDENCE PACKET** –consumer should get all assessments & related documents, including IAs that plan disputed as having a material factual error. But PowerPt says UAS disputed by plan/LDSS is REPLACED by new one.* Consumer can't obtain it?
- Will **NY Medicaid Choice be a party** to a hearing?

https://www.health.ny.gov/health_care/medicaid/redesign/nyia/faqs/docs/2022-02-16_mmco.pdf slide 21

Is it really happening May 16th?

- **DOH has acknowledged NYMC & nurse capacity issues**and vowed not to implement if not ready, but then*set May 1st as start date. April. 15th - delayed til May 16th*
- **Phasing it in** – see earlier slide.
- **Advocacy**:
  - 12/15/21 Letter to DOH from NYLAG & Medicaid Matters NY, with 1/6/22 update http://www.wnylc.com/health/download/801/
  - 2/2/22 Letter - http://www.wnylc.com/health/download/807/
  - 3/25/22 Letter - http://www.wnylc.com/health/download/812/
- **Look for updates** at http://www.wnylc.com/health/news/85/ and https://www.health.ny.gov/health_care/medicaid/redesign/nyia/
- **Report delays in scheduling Conflict Free assessments**
  - Independent.assessor@health.ny.gov/ (518) 474-5888
  - DOH MLTC Complaint Unit **1-866-712-7197 or mltctac@health.ny.gov**

RECENT HOME CARE CHANGES NOW IN EFFECT

1. MLTC Lock-In
2. Reductions in Hours after a “Transition Period”
3. Disenrollment from MLTC plans if in Nursing Home 3+ Months
4. Other Grounds for Disenrollment

NYLAG
New York Legal Assistance Group

Changes in "Transition Rights"

- Upshot: If your client receives **Immediate Need** services – they should not enroll in an MLTC plan until after they receive notice from NY Medicaid Choice to enroll 120 days later.
- They might get some pressure to enroll earlier – by the home care agency that wants to keep the case, etc**. DO NOT enroll EARLY**! They will not get TRANSITION RIGHTS!
- Next slides explain--

NYLAG
New York Legal Assistance Group

Involuntary MLTC plan changes – Who has Transition Rights?

- Where member received Medicaid home care services, whether through a managed care/MLTC plan or through LDSS, then was **REQUIRED** to enroll in or change MLTC plans, they have ***Transition*** or ***Continuity of Care*** Rights
- The new MLTC plan is required to:
  - continue the **same plan of care** (**same hours** of home care or other services, e.g. adult day care, PT)
  - In some but not all cases allow the **same providers**, even if they are "out-of-network" of new MLTC plan
- **HOW LONG IS TRANSITION PERIOD?** This period is usually **90 days** (**120 days** if the reason consumer enrolled in the new plan was because the old MLTC plan closed).

*NYLAG Fact Sheet on Transition Rights at http://www.wnylc.com/health/download/797/

Involuntary MLTC plan changes – When Does Member Have Transition Rights?

1. Their old MLTC **plan closed**.*
2. **Received Immediate Need** personal care or CDPAP from HRA/DSS for **120 days**, then was required to enroll in MLTC plan. ***No rights if enroll in MLTC early!!!***
3. **Had Medicaid before enrolled in Medicare**, so was in a "mainstream" managed care health plan. Then got Medicare at age 65 or after 2 years of SS Disability. **If received home care from Medicaid health plan, will be assigned to an MLTC** or Medicaid Advantage PLUS (MAP) plan ("Default enrollment")**
4. Was **involuntarily** disenrolled from MLTC plan and assigned to a different plan (more on this later)

*Rights when Plan Closes – see **MLTC Policy 17.02** and
**Default Enrollment - see http://www.wnylc.com/health/entry/226/

Involuntary MLTC plan changes – What happens after Transition Period (90 or 120 days?)

- **Before Nov. 8, 2021**, MLTC plan could reduce hours only for limited reasons in. MLTC Policy 16.06, which is based on *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996). Reasons are:
  1. Medical condition improved, reducing need for assistance
  2. Social circumstances changed (ex. daughter moved in)
  3. Mistake made in original authorization (very limited ground)
- **BEWARE**: **Eff. Nov. 8, 2021**, change in State regulation allows plans to reduce hours *after transition period* if plan claims that HRA/DSS or previous plan "authorized more services than are medically necessary," without proving any *change*. Plan notice may simply:
  - indicates a clinical rationale that shows review of the client's specific clinical data and medical condition**
- The new regulation only applies after a Transition Period ends. MLTC Policy 16.06* still restricts other MLTC reductions otherwise.

**New regs 18 NYCRR 505.14(b)(4)(viii)(c)(3)(vii), 505.28(i)(4)(iii)(h) –Personal Care reg at https://regs.health.ny.gov/regulations/recently-adoptedpp. 60, 137

Involuntary MLTC plan changes –

If Plan Wants to Reduce Hours after Transition Period

Plan must still send a written NOTICE of a reduction, which member still has the right to appeal -- in 2 stages:

1. ***Initial Adverse Determination*** to reduce or deny an increase → request internal PLAN APPEAL. See sample next slide.

   If that appeal is denied, Plan sends --

2. ***Final Adverse Determination*** to reduce or deny increase → request FAIR HEARING. In request, check that client is Homebound. This gives special extra rights.

- Right to **AID CONTINUING ONLY** if appeal quickly within 10 days of date of BOTH above notices. This means old hours continue while appeal pending. .

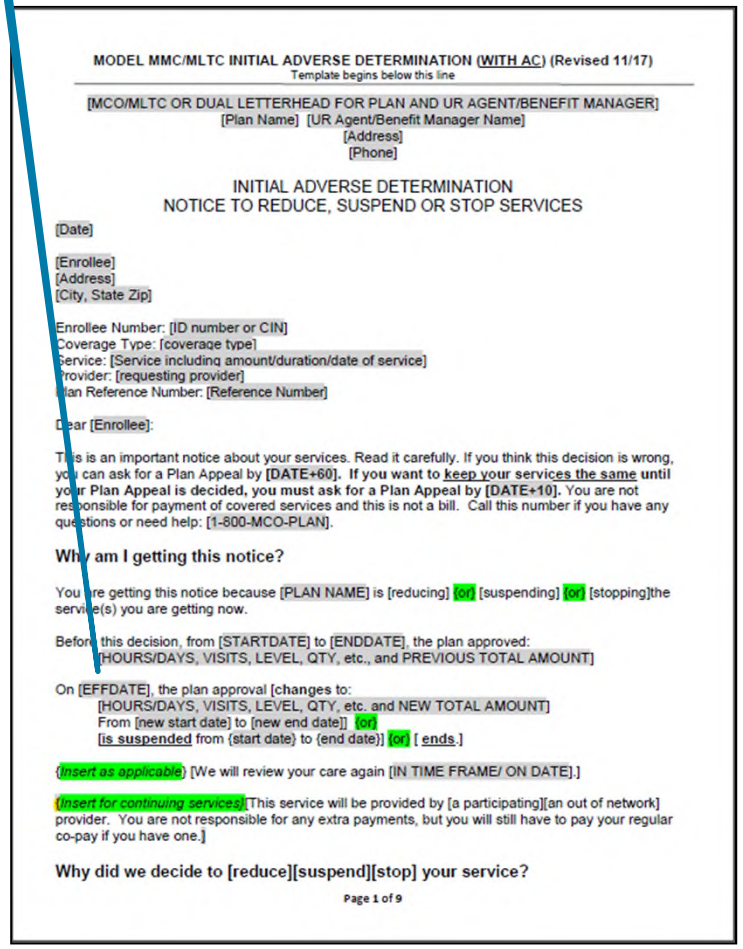
FOR HELP CONTACT ICAN 1-844-614-8800 or EFLRP Mon. 10 AM – 2 PM eflrp@nylag.org 212-613-7310

NYLAG Fact Sheet on MLTC appeals at http://www.wnylc.com/health/downloads/654/ and longer article at http://www.wnylc.com/health/entry/184/

You have the right to written notice

- Whenever your plan takes an **action** regarding your services, they must send you an **adequate, written notice**
  - Among other things, this notice must state the action being taken, the **reason for the action**, and the effective date of the action
- If the plan proposes to **reduce or discontinue** a service you are already receiving, the notice must also be **mailed to you 10 days before the effective date**

10-day Deadline to request Plan Appeal



MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) (Revised 11/17)
Template begins below this line

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [Service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **[DATE+60]. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by [DATE+10].** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

Why am I getting this notice?

You are getting this notice because [PLAN NAME] is [reducing] [or] [suspending] [or] [stopping]the service(s) you are getting now.

Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [EFFDATE], the plan approval [changes to:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT]
From [new start date] to [new end date]] [or]
[is suspended from {start date} to {end date}] [or] [ends.]

{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for continuing services*}[This service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

Why did we decide to [reduce][suspend][stop] your service?

Page 1 of 9

42 C.F.R. § 438.404; 18 NYCRR § § 358-2.2, 358-2.23 & 358-3.3.

You have the right to appeal

- If you disagree with your plan's action, you have the right to request a **plan appeal**.
  - This means you are asking your plan to take another look at their decision, and if they agree with you that they made a mistake, change it.

- **Requesting a plan appeal**
  - Use the plan appeal form included with the notice – can fax.
  - You can request an appeal over the phone, but (unless it is fast-tracked; see next slide) you must also confirm it in writing.
  - You can have another person request the appeal for you by signing a letter giving them permission.

42 C.F.R. § 438.402; 18 NYCRR § 358-3.1.

Plan appeal timelines

- **Aid Continuing**
  - If the proposed action is to reduce or discontinue your services, you can keep your services the same until your appeal is decided. This is called **aid continuing**.
  - If you want aid continuing, you must **request a plan appeal within 10 days** of the notice date, or by the date the change is supposed to start, whichever is later.
- For other kinds of actions (or if you don't want aid continuing), you must request the plan appeal within **60 days of the notice date**.
- The plan must give you a written decision within **30 days** of your request.
  - **Fast Track** – You may be eligible for a decision within **72 hours** if a delay will seriously risk your health, life, or ability to function; and certain other situations.
  - **Extension** – The plan may take up to **14 days** longer if they can show that they need additional information and it would be in your interest.

42 C.F.R. § 438.402; 18 NYCRR § 358-3.1.

Fair Hearings

- If you lose your plan appeal, you have the right to request a **Medicaid fair hearing**.
  - A fair hearing is where you can have an impartial hearing officer listen to you and the plan and decide who is right.
- If you want to keep your services the same until the fair hearing is decided, **you must request the fair hearing within 10 days of getting the plan appeal decision** notice, or by the date the change is supposed to start, whichever is later.
  - You can get aid continuing at this stage even if you did not get it during the plan appeal stage.
- You must complete the plan appeal before you can request a fair hearing.
  - Since 5/1/18, you can no longer request a fair hearing until ***after*** you've received a decision from the plan appeal.

MLTC Lock-In – Limit on *Voluntary* MLTC Plan Changes

- Until 12/2020, you could voluntarily change MLTC plans any time.
- **Since 12/1/20** – If you **first enrolled** in or **changed MLTC plans on or after Dec. 1, 2020**:
  - **90-day grace period** to change plans for any reason
  - **9-month Lock-in** - May change plans only for **good cause** during the next **9 months.** See next slide re Good Cause.
- **What if enrolled before 12/1/20?** May change plans any time, but after 90-day grace period in new plan, locked in for 9 months.
- **Which plans –** Lock-in only for "MLTC plans" - may transfer to or from a PACE or Medicaid Advantage Plus (MAP) plan any time.
- NY Medicaid Choice sends out "End of Lock-in Notices" 60 days before end of 9-month lock-in period.

Sample notice to current MLTC members of new lock-in in Appendix and posted at http://www.wnylc.com/health/download/753/; see more at http://www.wnylc.com/health/entry/114/#LOCK-IN

MLTC Lock-In – What is Good Cause to Change plans?

- **Good Cause** to change plans **after 90-day grace period:**
  1. Member moves from the plan's service area,
  2. Plan fails to furnish services,
  3. Member did not consent to enrollment
  4. Plan and member mutually agree that transfer is appropriate
  5. Aide is no longer working with current plan
- Just because you CAN change plans is it a good idea?? NO. See next slide

See DOH MLTC Policy 21.04 and FAQ at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

COMPARE: VOLUNTARY Plan Changes
No Transition Rights

- If MLTC member changes plans:
  - Within 90-day grace period after enrollment, or in
  - 9 month Lock-in Period with Good Cause to change plans.
- Member has ***no continuity of care or "transition rights"***
- **New plan is not required to continue the same plan of care of former plan**
  - **New plan may give fewer hours,** without proving a change in medical condition or social circumstances
    - Doesn't even have to give advance notice of a "reduction," with right to appeal with Aid Continuing, because DOH does not consider it a reduction.
  - **Member has right to request an increase and appeal** if denied, but has
  - **No "Aid Continuing" rights** to keep old hours during appeal

NYLAG
New York Legal Assistance Group

MLTC INVOLUNTARY DISENROLLMENTS

Starting Again 2021-2022

NYLAG
New York Legal Assistance Group

Involuntary Disenrollments Resuming

MLTC plans may disenroll members involuntarily for certain reasons.* All disenrollments were banned during the pandemic. DOH is allowing some disenrollments to resume. GIS 21 MA/17 and GIS 21 MA/24.

- There are now 5 allowed reasons, and a 6th coming.
- What happens after disenrollment? Depends on which ground.
  1. Member **assigned to a new MLTC plan OR**
  2. **Referred to local DSS** for services.

  Either way, member has Transition Rights to same hours and services for 90 days

*Involuntary disenrollment grounds are in Model MLTC contract, Art. V. D. 3 -4 https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf at pp. 21-23

**List of 13 MAP plans with their aligned Medicare D-SNP by county at http://www.wnylc.com/health/download/784/

Procedure for Involuntary Disenrollment

1. Plan sends member **30-day Notice of Intent to Disenroll**. This notice is NOT appealable.
2. Plan refers case to NY Medicaid Choice, which sends member **10-day Notice of Disenrollment**.
   - Notice has **FAIR HEARING rights**. Must request hearing within 10 days before effective date to get **AID CONTINUING.** This allows staying in plan until hearing decided.
3. After disenrollment - **assigned to a new MLTC plan OR referred to local DSS** for services. Member has Transition Rights.

NYLAG
New York Legal Assistance Group

Grounds for Involuntary Disenrollment

1. **Long Term Nursing Home stay** 3+ months – more below
2. Enrollee **moved out of plan's service area** within NYS.
3. **MAP plans only – (Medicaid Advantage Plus)** - Member changed their Medicare plan, so is disenrolled from MAP plan because the MAP requires enrollment in particular Medicare Dual-SNP (Medicare Advantage Special Needs Plan) operated by same company.**

For #2 & #3 – GIS says case will be referred to LDSS which must continue same Plan of Care pending a reassessment. Advocate must be proactive to demand this or to ask NY Medicare Choice to enroll in MLTC plan – likely disruptions in services.

*Involuntary disenrollment grounds are in Model MLTC contract, Art. V. D. 3 -4 https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf at pp. 21-23

**List of 13 MAP plans with their aligned Medicare D-SNP by county at http://www.wnylc.com/health/download/784/

2 More Disenrollment Grounds - GIS 21 MA/24 -

4. **Behavior** of member or their family seriously impedes plan's ability to deliver home care
   - For reasons other than resulting from member's "special needs" or diagnosis
   - FH rights with Aid Continuing;
   - if don't win FH or don't request FH – **assigned to new MLTC plan.**
5. **Member absent from the service area for more than 30 days** (90 days for MAP).
   - Because of COVID, members were allowed to pause services – while staying with family or to limit exposure.* Plan required to show tried to contact member.
   - NYMC will notify member that may transfer to another MLTC plan. If they don't pick one, dropped from MLTC and **not assigned to another MLTC plan.**

COVID-19 Guidance for Voluntary Plan of Care Schedule Change 4/23/20
https://health.ny.gov/health_care/medicaid/covid19/2020-04-23_guide_volplanofcare.htm
(See ***NYLAG Know Your Rights Fact Sheet for MLTC Members*** **-**
http://www.wnylc.com/health/download/739/

6th Enrollment ground coming

6. No Services provided in prior calendar month

- DOH told plans these disenrollments will be permitted starting May 1, 2022 but delayed – may start July 1, 2022. No directive yet.
- Consumers alarmed because many consumers do not receive authorized services because of **AIDE SHORTAGE.**
- Also, consumers were allowed to PAUSE services because of COVID (see previous slide). That guidance is still in effect.

NYLAG
New York Legal Assistance Group

NEW 3-ADL MINIMUM NEEDS REQUIREMENT

Restricts who is Eligible for Personal Care, CDPAP, & MLTC

ON HOLD because of Public Health Emergency

NYLAG
New York Legal Assistance Group

NEW: 3 ADL "Minimum Needs requirement"

Eligibility for PCS/CDPAP & MLTC will require the need for:

1. *Limited assistance* with **physical maneuvering** with **3 ADLs** ("more than 2" ADLs), with sole exception if have
2. **Dementia** or Alzheimer's diagnosis - need **cueing or supervision** with **2 ADLs** ("more than 1 ADL")

ADLs = Walking/locomotion, bathing, personal hygiene, dressing, eating, toileting/incontinence care, transfer on/off toilet

Compared to Now – just need **ONE ADL** to enroll in MLTC or get PCS/CDPAP from HRA/DSS thru Immediate Need, etc.

- Now, if don't need help with ADLs, can apply to HRA/DSS for Housekeeping up to 8 hours/week. This program is ENDING – no new applicants once changes take effect. Will add to EISEP waiting lists for age 60+.

WHEN? Sometime in 2022 TBD

Current recipients will be grandfathered in – in MLTC, housekeeping, DSS If services authorized before implementation date – even if don't meet new criteria

S.S.L. §§ 365-a subd.2 (e), 365-f, subd. 2, 18 NYCRR § 505.14(a)

3 ADL Requirement

ADL counts only if need "Limited Assistance with "Physical Maneuvering"

Unless dementia or Alzheimer's diagnosis, ADL counts toward the minimum only if needs "at least limited assistance with physical maneuvering."

The **UAS instructions** define seven degrees of assistance as follows, with "7" being the most assistance:

1. Independent
2. Independent, setup help only – Article or device placed within reach, no physical assistance or supervision in any episode.
3. **Supervision – Oversight/cuing. Will Not Count unless has Dementia diagnosis (or "serious mental illness"- see next slide)**
4. **Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight. This is minimum amount of need to count. Does this include "Contact guarding" (hovering)?**
5. Extensive assistance – Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.
6. Maximal assistance – Weight-bearing support (including lifting limbs) by two or more helpers; or, weight-bearing support for more than 50% of subtasks.
7. Total dependence – Full performance by others during all episodes.

Who is left out - needs "supervision" but not physical maneuvering with ADLs?

- Only **Dementia** or **Alzheimer's** diagnosis qualifies with 2 ADL's based on needing "supervision" not hands-on assistance
- Leaves out:
  1. Traumatic Brain Injury
  2. Developmental Disability
  3. Visual impairments
  4. Other cognitive, neurological or **psychiatric impairment***
- This discriminates based on diagnosis and is illegal in our view. Should include anyone who needs supervision because of *any* impairment.
- *In response to comments published with final regulations, DOH agreed to qualify people with "**Serious Mental Illness**" who need cueing assistance with 2 ADLs – treat the same as Dementia. But ***no one else***. And not added to regulation – only says in comments that they will create a procedure to request an exemption as a reasonable accommodation*

*See slide 26 to link to final regulations – see p. 244

NYLAG
New York Legal Assistance Group

Caution on "Supervision"

- A person has dementia is eligible for MLTC or Immediate Need only if they need **cueing or supervision with 2 ADLs**.
- Medicaid **DOES** cover safety monitoring, supervision or cognitive prompting ***to assure safe completion of ADLs, but not stand-alone general supervision.****
- **TIP: Always identify the ADL for which client needs supervision or cueing to assure safe performance,** instead of saying client needs general **"safety monitoring" or "supervision."**
  - Eg**.** Needs cueing and prompting **for** safe ambulation, or **for** toileting, etc. And describe **how** supervises (remind to use walker, remind to do post-elimination hygiene), etc.
- New regulation doesn't change the rule but will lead to more denials for people with dementia, if don't find 2 ADLs client needs supervision with.

*Rodriguez v. DeBuono, 175 F.3d 227 (2nd Circ. 1999; MLTC Policy 16.07 (https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-07.htm); MLTC Policy 21.06: 21ADM-04

LONG TERM NURSING HOME STAY (LTNHS) DISENROLLMENT FROM MLTC

If in nursing home 3+ months and approved for Nursing Home Medicaid

NYLAG
New York Legal Assistance Group

Change in How MLTC Works with Nursing Homes

- **2015 – 8/2020** - MLTC members stayed in MLTC plan if they went into a nursing home, even if permanent NH stay. MLTC plan paid NH and collected the NAMI (member's income contribution).
  - Even then, member still had to submit Medicaid application for NH coverage to HRA/DSS with 5 year lookback.
  - If transferred assets, Medicaid and MLTC were both cut off.
- **Since 8/2020** – MLTC only covers short-term stays up to 3 months. If stay > 29 days, Member must still apply to HRA/DSS for NH Medicaid with 5-year lookback.
  - **If NH Medicaid is approved** → disenrolled from MLTC plan if in NH 3+ months and Medicaid pays NH directly "fee for service." "Long Term Nursing Home Stay" disenrollment Procedure on next slide. **20,353 MLTC members disenrolled** so far in batches since 10/2020. Next batch is Feb. 2022.
  - **If NH Medicaid is denied** → Medicaid and MLTC are cut off.
- **Why do we care?** If MLTC member hopes to return home from NH, much harder to reinstate home care if they are disenrolled from MLTC plan. They do have right to re-enroll within 6 months, but after that must do conflict-free assessment, etc.

MLTC members disenrolled if in Nursing Home (NH) 3+ months ("LTNHS")

- Since 8/1/20 -- MLTC members who are '**Long Term Nursing Home Stay**' are disenrolled from MLTC plan.
- LTNHS = in NH 3+ months AND approved for Nursing Home (NH) Medicaid after 5-year lookback.
- Plan, NH & Open Doors --https://ilny.us/programs/open-doors --are asked to identify members with **active discharge plan**, who should not be disenrolled.
- Members receive **2 notices before disenrollment**
  1. **NEW 30-day Notice from plan* -** Heads up that will be disenrolled because in NH 3+ months. Explains may request assessment to return home & stay in plan. Copy sent to designated rep.
  2. **10-day Notice** from NY Medicaid Choice** with **right to (1) request fair hearing** and/or (2) call NY Medicaid Choice 1-888-401-6582 and request assessment to be discharged home. Either stops disenrollment.
- Right to re-enroll within 6 months – call NY Medicaid Choice 1-888-401-6582
- Only NY Medicaid Choice, not plan, may initiate disenrollment for LTNHS

* http://www.wnylc.com/health/download/793/
**http://www.wnylc.com/health/download/722/
See GIS 20-MA-06; More at http://www.wnylc.com/health/entry/199

NYLAG
New York Legal Assistance Group

How to make sure Notice sent to Family/Rep

1. **30-day Plan notice** should be sent to representative known to plan – may be a family member. If client is in NH approaching 90 days and applied for NH Medicaid, check with plan to make sure family/social worker listed and will get notice.
2. **10-day Notice from NY Medicaid Choice** is only sent to Authorized Rep listed on the NH Medicaid app. To be listed, submit *Form DOH-5247 - Medicaid Authorized Representative Designation/ Change Request* ** to HRA/ Local Dept. Social Services (DSS). In NYC-
   - if the nursing home Medicaid application was approved, fax form to 917-639-0736.
   - If Medicaid application is still pending, ask nursing home to submit it or fax to 917-639-0735. Note the name and address of nursing home. Read more at http://www.wnylc.com/health/entry/199/.

Call ICAN 844-614-8800 and Dept. of Health MLTC Complaints – **1-866-712-7197 if:**

- MLTC Plan refuses to reinstate home care when member ready for discharge, claiming not "safe" to go home. After 3 months, will be disenrolled and then it will be harder to go home.
- If someone was already disenrolled who should not have been.

**https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/17ma017_english.pdf

Stay up to date

- Sign up for NYLAG EFLRP e-lerts with updates here http://eepurl.com/deQxtr - select TOPIC: Elder Law (Medicaid, long-term care)
- See Resource Sheet in materials for other links
- NYS **DOH MLTC Complaint Line:**

  Tel 1-866-712-7197

  or email mltctac@health.ny.gov
- For Help – Call ICAN – next slides

NYLAG
New York Legal Assistance Group

Introduction to ICAN

What is ICAN?

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

ICAN is the New York State Ombudsprogram for people with Medicaid who need long term care or behavioral health services.

We assist New Yorkers with understanding how to enroll in and use managed care plans that cover long term care or behavioral health services.

What do we do?

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

Get help

(844) 614-8800

ican@cssny.org

icannys.org

Who do we help?

We help anyone enrolled in a **Medicaid managed care plan** who needs:

- **long term care services** (like home attendant, adult day care, or nursing home); or
- **behavioral health services** (help recovering from and living with mental illness or substance use disorder.)

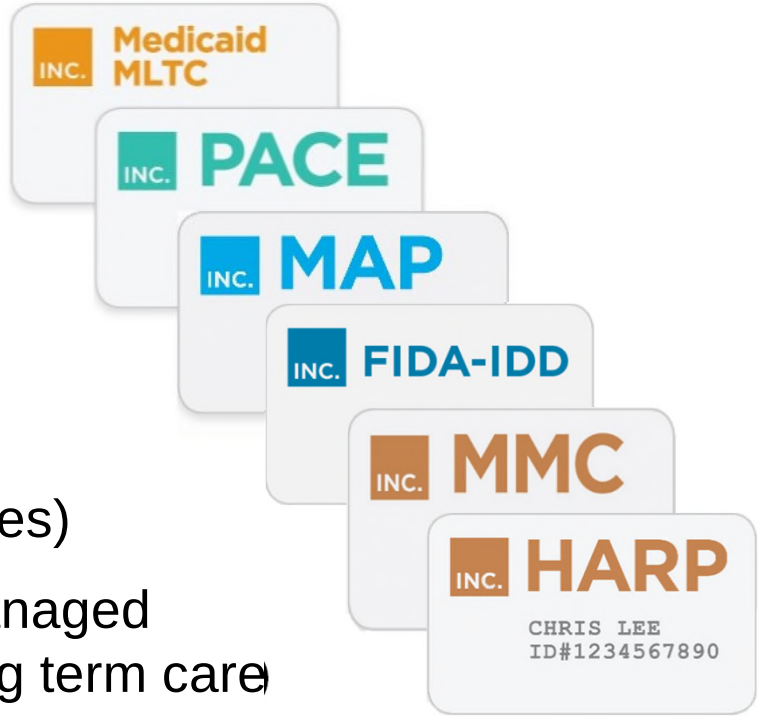
We also help educate people who are newly eligible for enrollment in a Medicaid managed care plan.

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

What kinds of plans does ICAN work with?

The plans we work with are:

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

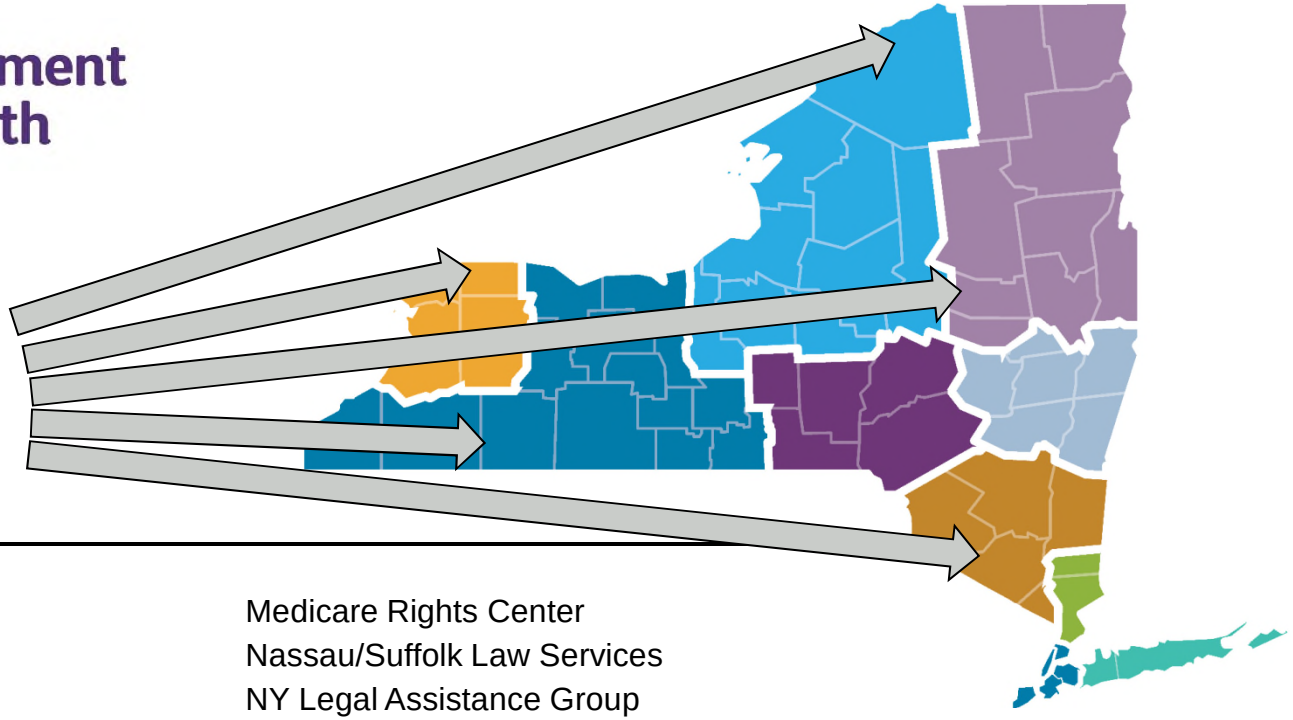


* FIDA is no longer available after 2019.

Who is ICAN?

NEW YORK STATE | Department of Health

Community Service Society | Fighting Poverty Strengthening New York



Our Network of Agencies:

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

How we help

Our trained counselors answer our **toll-free telephone hotline** Monday-Friday, 9am-5pm (also email and online chat)

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

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

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

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

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

Community Service Society | Fighting Poverty Strengthening New York

ICAN

* Interpreters are available for all other languages.

Please donate if receiving CLE credit!

- We are not charging for CLE credits.
- We suggest a $75 donation if you are requesting CLE credit (or even if you're not! ☺)
- Please send a check payable to "NYLAG" earmarked to EFLRP and send to:
  - Helen Murphy – NYLAG, 100 Pearl St., 19th fl. NY NY 10004
- Or donate at https://nylag.org/donate-now/ and earmark for EFLRP/ Evelyn Frank program
- THANK YOU!

NYLAG
New York Legal Assistance Group

THANK YOU

More information at nylag.org and nyhealthaccess.org

Please donate to support us!

https://www.nylag.org/donate-now/

At prompt please designate Evelyn Frank program!

NYLAG
New York Legal Assistance Group