26th Annual
ELDER LAW FORUM

SESSION I:
Starting Soon…

26th Annual ELDER LAW FORUM

WELCOME! HOUSEKEEPING:

- Your mics are muted
- Click link in “Chat” to view materials for today’s program
- Type questions for speakers into Q&A section at the bottom of your screen
- Fill out Survey following program
- Social workers: be present for entire program and fill out evaluation form for CE credits

INTRODUCTION

Louis W. Pierro, Founding Partner
Pierro, Connor & Strauss LLC

PIERRO, CONNOR & STRAUSS, LLC
Trusted Counsel

Our 26th Year

- 1965: Medicare's Promise vs. Medicaid's Reality
- 1996: Governor's Task Force on Long-Term Care Reform
- Changing Demographics, Life Expectancy, Chronic Conditions and Costs has Caused Problems with the Quality and Quantity of Care
- Broken Financing System

The Impact of COVID

- The Push for Home and Community Based Care
- The Coming of Age of Telemedicine
- Labor Shortages exacerbated by COVID
- Budget Deficits, Insurance Markets, Cost of Care
- Innovation Lacking in Both the Provision and Payment for Care

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VivaLynx
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PIERRO, CONNOR & STRAUSS, LLC
Trusted Counsel

Our Attorneys

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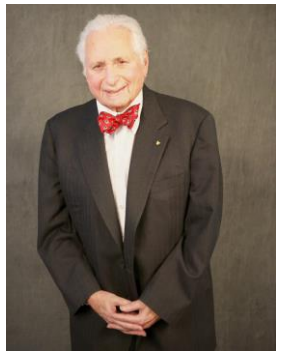

Harvey Schneider

Anthony Khatchoui

Frank Hemming

Lorese Phillips

Theresa Skaine

Jiah Kim

Michael Gadomski

Victor Oberting, Special Counsel

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FORUM AGENDA

8:40 — **Medicaid Update**

Valerie Bogart, Director, Evelyn Frank Legal Resources Program, New York Legal Assistance Group

9:20 — **The Future of Home Care**

Al Cardillo, President, Home Care Association of NYS

9:55 — **Q & A**

10:05 — **Coffee Break**

Stretch!

10:15 — **Anatomy of a Home Care Application: Case Study**

Moderator: Peter J. Strauss, Esq. with expert panel

11:25 — **Winning Strategies: Fair Hearings & Appeals**

Moderator: Peter J. Strauss, Esq. with expert panel

11:50 — **Q & A, Preview of Session II**

SESSION II
FRIDAY, JUNE 4
8:30am-12:00pm

Senator Kirsten Gillibrand
U.S. Senate Special Committee on Aging
"Welcome and Remarks" (video)

PAYING FOR LONG-TERM CARE: HOW CAN NEW YORK LEAD THE WAY?

- Washington and State Lawmakers: Long-Term Care Updates
- The Nursing Home Dilemma
- State Agency Leader: Impacts of Covid on Aging in New York
- Insurance Options for LTC
- Holy Grail: Public-Private Financing

NEW! "OPEN FORUM" BREAK-OUT SESSIONS IN ZOOM

12:00-12:30pm

1. Private Insurance Options for LTC
2. Technology Solutions for LTC
3. Public Policy: Medicaid, Medicare & Alternative Solutions

Valerie Bogart

Evelyn Frank Legal Resources Program, New York Legal Assistance Group (NYLAG)

Medicaid Update: New York's New Home Care Rules and Other Developments

Medicaid Cuts Coming in 2021-2022

Focus on the New Lookback & Home Care Eligibility and Assessment

Pierro & Associates May 2021

Valerie Bogart eflrp@nylag.org

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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 represents seniors and people with disabilities on health care access issues, trains professionals, maintains www.NYHealthAccess.org, and advocates on a policy level to improve health & long term care access.

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Agenda

1. Past budget cuts now being implemented –Lock-In & Nursing Home disenrollment from MLTC
2. New 30-Month Lookback starting Jan. 1, 2022
3. Medicaid Home Care Eligibility & Assessment Changes Coming in 2021-22
4. COVID easements - ban on discontinuing or reducing Medicaid eligibility, may fax applications, etc.

   http://www.wnylc.com/health/news/86/#NYS%20Medicaid%20Policies
5. Not covered but see online:
   - Changes for Medicaid recipients who newly enroll in Medicare – "Default Enrollment" http://www.wnylc.com/health/entry/226/
   - New fair hearing system for MLTC members in Medicaid Advantage Plus (MAP) plans http://www.wnylc.com/health/entry/225/
   - Special fair hearing protections for homebound consumers appealing denial of a home care increase – Varshavsky - http://www.wnylc.com/health/entry/228/

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NOW IMPLEMENTING CHANGES ENACTED IN EARLIER YEARS

MLTC Lock-In

Disenrollment from MLTC plans if in Nursing Home 3+ Months

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MLTC Lock-In – Limit on Voluntary MLTC Plan Changes

- Until Dec. 2020, members could voluntarily change MLTC plans at any time.
- New MLTC enrollees or those who changed MLTC plans **on or after Dec. 1, 2020**:
  - Have a **90-day grace period** to change plans for any reason
  - May change plans only for **good cause** during the next 9 months.
- Lock in only for "MLTC plans" - may transfer to or from a PACE or Medicaid Advantage Plus (MAP) plan any time.
- **BEWARE** when changing plans voluntarily - member has **no *continuity of care* rights – new plan may give fewer hours,** without proving a change in medical condition or circumstances
- **Good Cause** to change plans after 90-day grace period:
  - Member moves from the plan's service area,
  - Plan fails to furnish services,
  - Member did not consent to enrollment
  - Plan and member mutually agree that transfer is appropriate
  - Aide is no longer working with current plan
- If enrolled in MLTC plan before 12/1/20, may change plans any time, but then after initial 90-day grace period in new plan, locked in for 9 months.

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

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Involuntary MLTC Plan Changes – Member DOES Have Transition Rights

- Lock in applies to "Voluntary" MLTC plan changes.
- INVOLUNTARY changes are different:
  - When an MLTC **plan closes**.
  - After receive Immediate Need personal care or CDPAP from local Medicaid agency for 120 days, required to enroll in an MLTC plan
  - When received home care from a "mainstream" managed care plan, then got Medicare – and was switched to MLTC or Medicaid Advantage PLUS (MAP)
- The NEW MLTC plan is required to continue the **same plan of care** (same hours of home care or other services) for **90 days** (120 days if MLTC plan closed).

Rights when Plan closes – see **MLTC Policy 17.02** and NYLAG Fact Sheet at http://www.wnylc.com/health/download/757/

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Involuntary MLTC Plan Changes – Member DOES Have Transition Rights

- After transition period, plan may reduce hours only for "cause" –
  1. medical condition improved,
  2. change in social circumstance
  3. Mistake in original authorization
- **BEWARE**: State has proposed regulation changes to allow plans to reduce hours after transition period based on plan's view of "medical necessity" without proving any change

Rights when Plan closes – see **MLTC Policy 17.02** and NYLAG Fact Sheet at http://www.wnylc.com/health/download/757/

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MLTC Members Disenrolled if in Nursing Home 3+ Months ("LTNHS")

- Since 8/1/20 -- MLTC members who are "**Long Term Nursing Home Stay**" – in NH 3+ months + approved for Nursing Home Medicaid after 5-year lookback → disenrolled from plan.
- Members receive notice from NY Medicaid Choice,* with right to (1) request fair hearing or (2) call NY Medicaid Choice 1-888-401-6582 and request assessment to be discharged home
- Plan and NH identify which members have an **active discharge plan**, who are NOT disenrolled. (But they don't identify many, such as those who the plan has denied an increase, etc).
- Disenrollments in batches – last was April 1, 2021 – over 20,000 so far (most outside NYC).
  - If disenrolled, right to re-enroll without conflict-free assessment within 6 months

* Copy at http://www.wnylc.com/health/file/722/
GIS 20-MA-06, See http://www.wnylc.com/health/entry/199/

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MLTC Members Disenrolled "LTNHS" con'd.

- With visitation just opening up in nursing homes, families don't see notice so can't help member request a Fair Hearing or call NY Medicaid Choice for an assessment.
- Only person listed as Authorized Rep on the Medicaid app receive a copy of the notice. To be listed, submit *Form DOH-5247 - Medicaid Authorized Representative Designation/ Change Request*** to Local Dept. Social Services (DSS). In NYC:
  - if nursing home application was approved, fax form to 917-639-0736.
  - If the Medicaid application is still pending, ask nursing home to submit it or you can fax it to 917-639-0735. Note the name and address of nursing home. Read more here.

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

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STATE BUDGET – NEW LOOKBACK FOR HOME CARE

DOH request to CMS to amend MLTC waiver – https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm (March 2021)

Download State budget law S. 5608 at https://legislation.nysenate.gov/pdf/bills/2019/S7506B - Section MM starts at 259.

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NEW 2.5 Year Lookback for Home Care + CB-LTC

- New applications for Medicaid to obtain Community-Based Long Term Care (CB-LTC) filed **after Jan 1, 2022** will require a "**lookback**" **back to Oct. 1, 2020**
- **Lookback** = Application must include copies of all financial records **back to Oct. 1, 2020** for applicant and spouse.
- At first, lookback period will be 14 months, and add a month every month until it is **30 months (2.5 years**)
- **Transfer Penalty -** If a "non-exempt" transfer was made in the lookback period, Medicaid will not pay for CB-LTC services for the penalty period. Will use **same penalty rate** as for nursing homes (more below).
- **WHO:** For ***new*** applications and **requests for "increased coverage" filed** after 1/1/2022 (See below).
- Delayed until Jan. 1, 2022 because of federal COVID-19 protections – States can't restrict eligibility.

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More on Lookback for Home Care & CB-LTC

- **BACKGROUND** - Under federal law, states **MUST** do a **5-year** lookback for nursing home care.
- States **MAY** require a lookback for Medicaid home care and other **community-based long term care services** (**CB-LTC**).
- NYS never had a lookback for CB-LTC *until* enacted in State Budget April 2020.
- Lookback only for **long term care** services -- States **may NOT** require a lookback for hospital care, acute & primary care.
- No final regulations or guidance issued yet. Some details in DOH request to CMS to amend the MLTC "waiver"*

*https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm

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Which Community-Based Long Term Care Services WILL Require a LOOKBACK?

1. Personal care services (a/k/a home attendant)
2. CDPAP (Consumer-Directed Personal Assistance Program)
3. Private Duty Nursing
4. Assisted Living Program (ALP)
5. Adult day health care
6. MLTC, Medicaid Advantage Plus and PACE plan enrollment
7. Certified home health agency (CHHA) – *if > 29 days*

No lookback for:

1. Waivers (but how does applicant show she wants these?)
   a. Nursing Home Transition (NHTDW)
   b. Traumatic Brain Injury (TBI) waiver
   c. OPWDD waiver
2. Mainstream Managed care (these plans provide most of the above services for those without Medicare)
3. Acute, primary care, hospital, ER

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Who is Grandfathered in – so does Not have to do Lookback? And who MUST do lookback?

Who is grandfathered in?

- If applied for Medicaid with CB-LTC before 1/1/22 (does not matter if already receiving services)

Who Must Submit Lookback with Application?

- **NEW Applicants** for Medicaid coverage of CB-LTC filed after 1/1/2022 (unless delayed)
- Those who applied for Medicaid *without* long term care coverage and "attested" to the amount of resources, without verifying the amount.** If they want CB-LTC after 1/1/22, they must **request an "increase"** in coverage by submitting **Supplement A** and the **lookback** documents. *During pandemic, applicant may attest to amount of resources.*

*https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf
**04ADM-06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources

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ALERT! New Supplement A Used in NYC after Jan. 1, 2021

- Starting Jan. 1, 2021, NYC has a **new Supplement A** form -- DOH-5178A https://www.health.ny.gov/forms/doh-5178a.pdf.
  - **NEW**: **Spouse** must sign it, **even if doing spousal refusal** or **not applying**.
  - **NEW**: Supplement A must now be submitted even if NOT seeking CB-LTC. So anyone who applies and submits Supp. A with proof of assets before 1/1/2022 should be grandfathered in with no lookback.
  - See http://www.wnylc.com/health/news/89/ (HRA Medicaid Alert posted).

**04-ADM-06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources

Phase-In Period

- **Any transfers of assets BEFORE 10/1/2020 will NOT be subject to a penalty.**
- Lookback is back to 10/1/20 – not before. This is true even if lookback is delayed past 1/1/22

Apply on or after	Length of lookback
Jan. 1, 2022	14 months
Add 1 month every month so that:	
Jan. 1, 2023	26 months
May 1, 2023	30 months

TIP: If transfer was made after Oct. 1, 2020, apply before Jan.1, 2022!

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Lookback for Married Applicants – Spouse's Records

- Medicaid applications must include up to 30 months (after phased in) of **all financial records for applicant and spouse**.
- Even if using "spousal refusal," must document spouse's assets during lookback period. **THIS IS A BIG CHANGE**.
- **Spousal Refusal** is still in effect – (not repealed as proposed in April 2020 budget) but this doesn't protect applicant from lookback and transfer penalty
- **Example**: Pat's spouse Randy transferred $50,000 during lookback period. Randy still has $200,000.
  - Randy may do spousal refusal so $200,000 won't count as Pat's asset (subject to DSS claim for spousal support)
  - but the $50,000 transfer will give Pat a transfer penalty, unless it was an exempt transfer.

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How Long is the Transfer Penalty?

1. **Total up every uncompensated transfer** in the lookback period to determine the length of the penalty.
2. Divide that total amount by a number called the **Regional Nursing Home Rate** – DOH publishes it every year.* The result is the **penalty period** – the number of months that Medicaid will NOT pay for the nursing home stay OR for home care/ALP.

Total Transfers	÷	Regional Nursing Home Rate	=	Penalty Period (in Months) (rounded)
EX. $39,000		$13,037*		3 months

* This is NYC. See rate for other regions at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma12.pdf

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Exceptions to Transfer Penalty – Assets other than the home

Exceptions same as for nursing home. No penalty for transfer by the applicant or spouse of an asset other than the home to:

1. **spouse**
2. **child** who is **certified blind or disabled**
   - may transfer cash, does not require put into trust;
   - Child may be over age 65 - Disability Reviews for Adult Children over 65, GIS 08 MA/036
3. **Supplemental needs trust for disabled person <65**
   - Can be for oneself if <65 and disabled or for someone else
4. **Transfer of an exempt asset** has no penalty – ie. Holocaust restitution, assets under $15,900

18 NYCRR § 360-4.4 (c)(1)(ii); see http://www.wnylc.com/health/entry/38/ .

More Exceptions to Transfer Penalty (assets other than home)

5. Meant to sell asset for its **fair market value**;
6. Transfer was made **exclusively for purpose other than to qualify for Medicaid long term care** (young, healthy client had stroke after gift)
7. All of the transferred **assets have been returned** to the individual.
   - Partial return reduces penalty proportionally*
8. Individual used assets to purchase:**
   - an annuity, life estate, promissory note, loan, or mortgage

* 2006 ADM, p. 18.

** must follow rules in SSL §366 subd. 5 (e)(3)(i-iii)

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Transfer of the home

Advocates believe ALL transfers of the home should be exempt –Since a home is exempt for community Medicaid (if single and equity < $906,000 or if a spouse, minor or disabled child live there).

But NYS DOH disagrees. No final state policy yet. DOH proposes to allow only the same transfer penalty exemptions that apply for nursing home Medicaid. That would mean transfer of the home to certain people is exempt:

- to spouse or disabled child
- to "caregiver" child or sibling with equity interest – only if lived with applicant for 1-2 years **before institutionalized**. Makes no sense in the community!

See more in NYLAG lookback comments - http://www.wnylc.com/health/download/746/.

Soc. Serv. L. § 366(5)(e)(4)(i); See *Mondello v. D'Elia*, 39 N.Y.2d 978, 1976 N.Y. LEXIS 2927, 387 N.Y.S.2d 232.

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Transfer Penalty Would Cause "Undue Hardship"

- Denial of eligibility because of transfer would cause an undue hardship - it would:
  - **deprive the individual of medical care** such that the **individual's health or life would be endangered**
    - Hardship if nursing home threatens discharge if Medicaid not secured and payment not made. FH 6657601M Albany,
      FH 67841713Z Schenectady; FH No. 6660774R Suffolk
  - **would deprive the individual of food, clothing, shelter**, or other necessities of life. §366 subd. 5 (e)(4)(iv) and
- **And applicant is unable to have the resources returned despite best efforts,** or can't obtain fair market value for them, or cannot void a trust fund where transferred to.

*How much cooperation & effort is required of applicant or agent with power of attorney – to get funds back – has been the subject of fair hearings. See, e.g,. FH #5153034Y (Albany Co. 5/12/09)(no hardship found), FH No. 6660774R, Suffolk Co. 3/12/2014 (undue hardship exemption granted)

More on Undue Hardship

- **Undue hardship - State created definition for nursing home Medicaid and makes no sense for community care!**
- **Undue hardship is limited to those who,** after payment of medical expenses, have income and/or resources **below the Medicaid limits**. ($884/mo. Income).
  - For nursing home, this limit didn't matter since all income except $50/mo must be paid as "NAMI" unless has a spouse.
  - But in the community, this **would deny the hardship exception to anyone with a spend-down or who uses a pooled trust or spousal refusal.**
  - **DOH MUST change this rule for home care!**
- **Must request hardship waiver with application** – when you might not realize it will be needed (don't yet know another exception is denied)
- If denied, consumer entitled to notice with fair hearing rights.

96 ADM-8 at 23; 06 OMM/ADM-5 at 19-20;18 NYCRR § 360- 4.4(d)(2)(iii)

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Lookback Will Likely Delay Medicaid Application

- Medicaid applications must be decided within **45 days**, or 90 days if require a determination of disability* (i.e. with pooled trust)
- "Immediate need" applications must be decided in **12 days** – NYLAG asked DOH to allow applicant to "attest" no transfers made.** DOH said NO so far.
- The lookback adds work for the local district. Even though the poorest applicants won't have transfers, delays will affect them too.
- In nursing home, delay doesn't hurt client because they are getting the needed care. Not true when apply for home care!

*42 USC Sec 1396a(a)(8); 42 C.F.R. Sec. 435.911; 18 NYCRR 360-2.4; see also article about delays - http://www.wnylc.com/health/entry/175/

** Soc. Serv. L. §366-a(12)

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May Income Still Be Placed In A Pooled Trust?

- **This is still unclear.** A ***transfer penalty*** applies not only to transfers of ***ASSETS*** but ***transfers of INCOME***.
  - If a deposit of income into pooled trust is a TRANSFER, this is an exempt transfer if < 65 and disabled. But what about age 65+?
- Advocates think CMS policy allows it –
  - "Resources placed in an exempt trust for a disabled individual are subject to…**a penalty… unless the resources placed in the trust are used to benefit the individual, and the trust purchases items and services … at fair market value … .These rules apply to both income and resources** placed in the exempt trusts…."**
- **We urge DOH to say that because SNTs can only pay for expenses to meet the needs of the individual, there is no penalty**. NYS DOH 2008 GIS MA/020.
- May require spending money quickly every month – a problem if need to save for annual or irregular expenses – property taxes, etc.

**CMS Medicaid Manual § 3259.7(B)(2): https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 (CH. 3)

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When Does Penalty Period Begin?

New law says "The period of ineligibility shall begin … **the first day the otherwise eligible individual is *receiving* services** for which…" Medicaid would pay but for the transfer penalty. Soc. Serv. L. §366 Subd. 5(e)(5)

- In a **nursing home**, the applicant is already **receiving** services in the NH when they apply. Even if application takes forever to be approved, once it's approved, the penalty can begin retroactively back to nursing home admission.
- In **home care**, one cannot receive MLTC, CDPAP or personal care services until Medicaid is approved. Penalty can't start running until start receiving those services. Much worse than nursing home!

*CMS State Medicaid Director Letter SMD#18-004, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18004.pdf

When Does Penalty Begin? Community

- **Solution** - CMS guidance on 1915(c) waivers* (NHTDW, TBI) says penalty begins when "**would otherwise be receiving" home care at required level of care**, rather than when "is receiving" services.
- DOH has indicated that it will require applicant to submit a physician's statement stating that the applicant has the functional need for home care.
- This way, once Medicaid is approved, transfer penalty could begin retroactively back to month application was filed, or even three months before. A short transfer penalty could expire by the time the Medicaid application is approved and client is ready for services to start.
- **Otherwise, transfer policy would be more favorable in the nursing home** than in community. This **could violate *Olmstead*** and ADA.

*https://www.medicaid.gov/federal-policy-guidance/downloads/smd18004.pdf

CHANGES IN HOME CARE ELIGIBILITY & ASSESSMENT

Proposed regulations to implement budget changes re-issued January 2021; comments were due 3/13/2021

PROPOSED REGS
https://health.ny.gov/health_care/medicaid/redesign/mrt2/express_terms_summary.htm
NYLAG COMMENTS:
http://www.wnylc.com/health/download/771/

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Personal Care (PCS) & CDPAP changes – Overview

1. New **minimum number of ADLs** required for eligibility for PCS/CDPAP & MLTC enrollment
2. **New assessment procedure** for both HRA/DSS, MLTC and mainstream managed care plans – Expanded role for Maximus
   - New "high need" review if need > 12 hours/day
3. Easier for plans to **REDUCE hours**

These changes were supposed to start Jan. 1, 2021, no new date announced.

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RAISING THE BAR OF WHO is ELIGIBLE for PCS/CDPAP – Minimum 2 or 3 ADLs

- **CURRENT LAW:** if need **any** assistance with "Activities of Daily Living" for 120+ days – may enroll in MLTC.
  - If don't need ADL assistance, may get "Housekeeping" service up to 8 hrs/week from LDSS/HRA ("Level 1" personal care*) for "Instrumental ADLs" (IADLs)
- If qualify for PCS or CDPAP – you obtain it from:
  1. An MLTC plan, or
  2. LDSS/CASA (Immediate Need or if excluded/exempt from MLTC, or
  3. If don't have Medicare – from "mainstream" managed care plan

18 NYCRR § 505.14(a)

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NEW: 3- or 2- ADL Requirement

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

- *Limited assistance* with **physical maneuvering** with **3 ADLs** ("more than 2" ADLs) **or**
- If have a **dementia or Alzheimer's** diagnosis - "at least **supervision** with **2 ADLs** ("more than one ADL")

WHEN? Sometime in 2021 or 2022. Stay tuned.

Current recipients grandfathered in – If *receiving* PCS or CDPAP services (who is grandfathered is a little unclear)

§ 2-a, 2-b, 3, 21, amending S.S.L. §§ 365-a subd.2 (e), 365-f, subd. 2

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2 or 3 ADL Requirement – Which ADLs?

- **DOH Proposes to use list of ADLs in UAS assessment:**
  1. Bathing
  2. Personal hygiene
  3. Dressing
  4. Walking/locomotion
  5. Transferring on & off toilet
  6. Toilet use/incontinence care
  7. Bed mobility – Turn & Position
  8. Eating
- What's Missing??
  1. Administration of Medications
  2. Transfer – other than for toilet use
  3. IADLs – next slide

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3- or 2- ADL requirement

Leaves out IADLs – Housekeeping services

- **Instrumental ADLs (IADLs)** = housekeeping tasks – shopping, laundry, cleaning, meal prep., phone use, medication administration- are not considered in whether one meets new ADL requirement.
- If meets the ADL requirement, the personal care/CDPAP aide does both ADLs and IADLs.
- If only needs IADL and NOT ADL assistance, until now could apply to DSS/HRA for Housekeeping services. **THIS IS ENDING.**
  - **Current "Housekeeping" recipients grandfathered in** (600 NYC cases in 12/2020)
  - But **no NEW applications will be accepted** for Housekeeping
- Will lead to falls, other accidents **--** and then will need ADLs. Not smart policy to eliminate this PREVENTATIVE service.
- Only option – non-Medicaid **EISEP** services through County office of the aging/ NYC DFTA.**

*18 NYCRR 505.14(a)(5)(i)

** https://aging.ny.gov/expanded-home-services-elderly-eisep

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3 ADL Requirement

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

If no dementia or Alzheimer's diagnosis, ADL counts toward the minimum only if needs "at least limited assistance with physical maneuvering." The **UAS instructions** define the degrees of assistance as follows:

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**
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.

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Who Is Left Out - Needs "Supervision" But Not Physical Maneuvering With ADLs?

- Only **Dementia** or **Alzheimer's** diagnosis qualifies to count ADL based on needing "supervision" not hands-on assistance
- Leaves out:
  - Traumatic Brain Injury
  - Developmental Disability
  - Visual impairments
  - 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.

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Caution on "Supervision"

- Since a 1999 court decision,* NY Medicaid does not provide aide for "stand alone" *supervision* or *safety monitoring*.
- Medicaid DOES cover safety monitoring, supervision or cognitive prompting to assure safe completion of IADLs or ADLs.
- **TIP: Always identify the ADL (or IADL) client needs supervision or cueing for to assure safe performance. Don't just say needs "safety monitoring" or "supervision."**
  - Must need 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.
- Proposed regulation doesn't change the rule but may lead to more denials

*Rodriguez v. DeBuono; MLTC Policy 16.07

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New Assessment System – DSS & Plans

NY Medicaid Choice ("NYMC" or Maximus) has huge new role. Until now they just do Conflict Free Assessment. New steps:

A. **Two "independent assessments" by *NY Medicaid Choice* –** Both required initially AND on annual reassessments (no longer every 6 months), AND if consumer requests an increase mid-year based on medical change.

   1. **Independent Assessment (IA) –** by ***nurse.*** Now, NYMC already does this as the Conflict Free assessment for new enrollees. MLTC plan and HRA will no longer do a separate assessment.
   2. **Independent Practitioner Panel (IPP)**- exam by PHYSICIAN, physician's ass't. or nurse practitioner.

B. **HRA/DSS or Plan authorizes services if needs > 12 hrs/day.**

C. **If HRA or Plan say needs > 12 hours/day** → see next slide.

DOH encouraging **TELEHEALTH** for all assessments

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New Assessment System – DSS & Plans *con'd*

C. **If DSS or Plan say needs > 12 hours/day →Must refer for High–Need "Independent Review Panel" (IRP) *by NY Medicaid Choice*** – recommends whether proposed plan of care is appropriate to maintain health & safety in the home.

- **Saying "unsafe" can be pretext for denying needed high hours → force 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 generaliza-tions** about individuals with disabilities."*
- IRP not required on reassessment if IRP previously reviewed plan of care of > 12 hours/day

D. Plan/DSS make final decision.

* ADA regulation 28 CFR §35.130(h)

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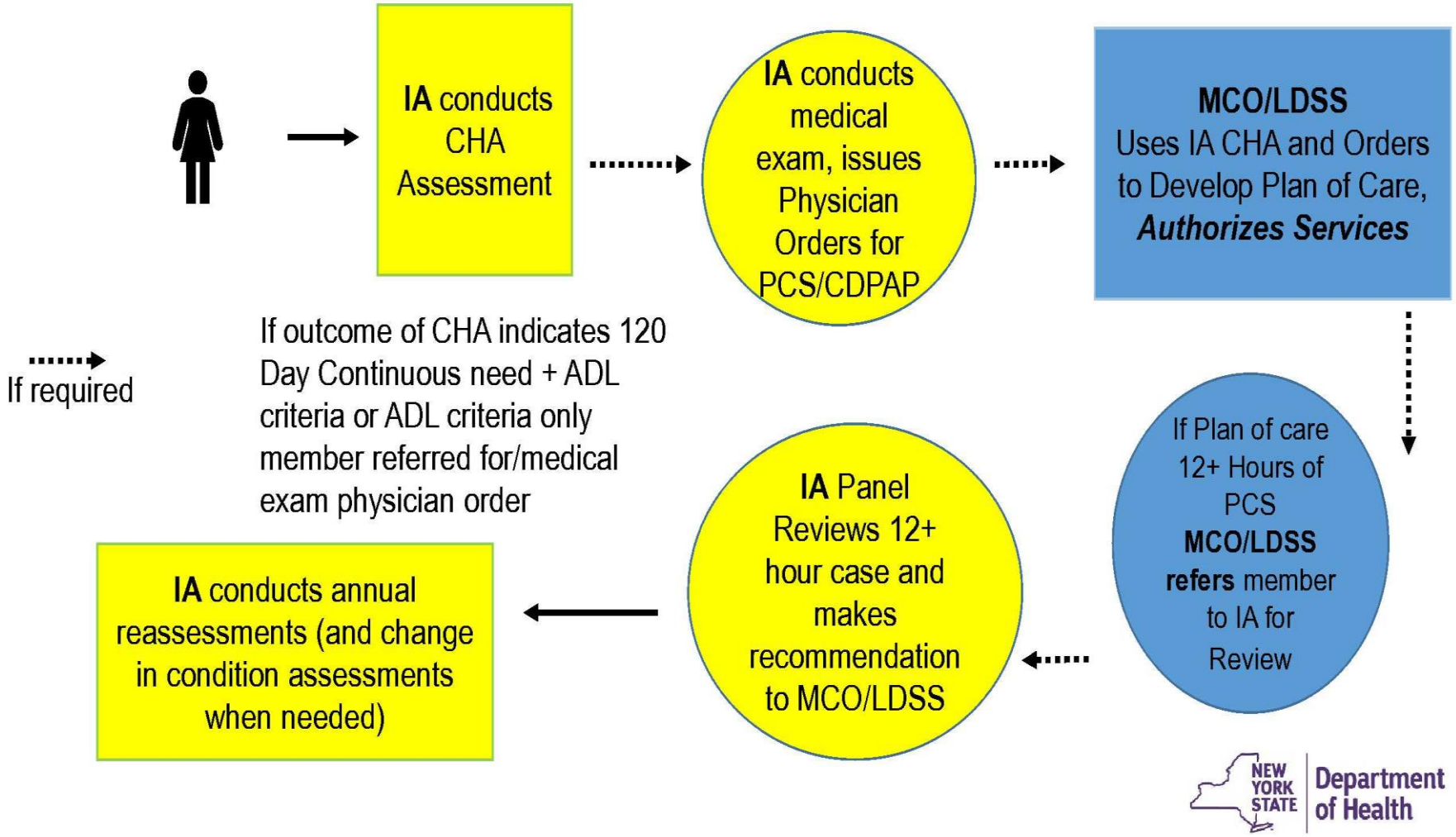
Role Independent Assessor and MCO/LDSS in New PCS/CDPAP Authorization Process



NEW YORK STATE | Department of Health

Delays from the New Assessments!

Adding in these new assessments will cause inevitable delays in:

1. MLTC enrollment & authorization of services
2. Immediate Need applications at HRA/DSS
3. Requests for increases in hours
4. Hospital & Rehab discharges where home care needed

The proposed regulations say:

- HRA/DSS must determine hours within 7 days of receiving back all of the assessments…but no deadlines on conducting assessments!*
  - Immediate Need deadline – 12 Days after application filed to approve Medicaid AND home care
- DSS/Plan *may* (not *must*) authorize interim care pending the High Need Review.

*Proposed 505.14(b)(3)(i), 505.28(e)(i)(7)

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Delays –MLTC/ Mainstream Plan Have Short Deadlines To Decide Requests for Increase or New Services

Type of Request	Maximum time for Plan to Decide
Expedited*	**3 business days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Medicaid covered home health care services following an inpatient admission**	(1) business day after receipt of necessary info; except when request made the day before a weekend or holiday, **no more than three (3) business days** after receipt of the request for services.

42 C.F.R. 438.210(d). *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
**NY Insurance Law § 4903(c)(1).

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COVID-19 PROTECTIONS

See NYLAG Resources on Medicaid & Covid-19

http://www.wnylc.com/health/news/86

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COVID "Maintenance of Effort" – No Medicaid Discontinuances or Reductions in Eligibility Until PHE Ends

- **MOE prohibits terminating or reducing Medicaid eligibility** for anyone who had Medicaid on March 18, 2020 or obtains it during PHE -- thru end of month in which PHE ends (now July 31, 2021 but likely to be extended til end of 2021).
- Renewals granted automatically for 12 months, even if cut off SSI or public assistance
- You retain MAGI Medicaid & stay in managed care plan even if enroll in Medicare.*
- If meet spenddown for one month, given 6 months coverage

*https://healthlaw.org/resource/overview-of-the-medicaid-related-provisions-of-the-coronavirus-response-packages/
**NYS DOH GIS 20 MA/04 – see http://www.wnylc.com/health/news/86/

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Easier to Apply for Medicaid, Submit Pooled Trusts

- To many Medicaid offices closed in NYC, HRA now accepting e-FAX applications & pooled trusts
  - PUBLIC e-fax 917-639-0732
  - Authorized Submitters (C-Rep) 917-639-0731

  If already have Medicaid -
  - Submit pooled trusts (Spend-down unit) 917-639-0645
- May "attest" rather than verify income & assets, even if for nursing home or home care. Medicare enrollment not required. Still need to complete Application & Supplement A.
- Must verify citizenship or immigration status, but if cannot verify it, will get 90 days coverage while obtain documents, may be extended 90 more days
- Requests for Information – HRA/DSS must call or email applicant and accept info by phone

DOH Covid 19 Guidance on Medicaid Eligibility & Enrollment , NYS DOH GIS 20 MA/04; more info at http://www.wnylc.com/health/news/86/

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Medicaid Home Care

- **UAS assessments** – nurses may do with telehealth/ by phone, including NY Medicaid Choice conflict free assessment.
  - Mid-year nurse reassessments suspended for DSS/HRA, MLTC & managed care plans. M11q for reassessment also suspended, if no changes, but re-auth only for 90 days
- **M11q/physician's order** – MD may sign based on telehealth/telephone exam OR phone it in to DSS/HRA/MLTC. If phone, must submit written form within 120 days of verbal order
- **CDPAP personal assistants** not required to get annual health exam, but must still get initial exam & vaccines

DOH COVID long term care guidance – updated 4/8/2020
https://health.ny.gov/health_care/medicaid/covid19/docs/2020-03-18_guide_authorize_cb_lt_services.pdf

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Medicaid Home Care – Pausing Services

- DOH guidance April 23, 2020 allows consumer to voluntarily pause or reduce home care services on a temporary basis because of the pandemic.
- Plan must confirm the change in writing and have the consumer sign agreement.
- Plan must reinstate original service plan on 72 hours request.

DOH Guidance - http://www.wnylc.com/health/news/86/#voluntary%20service%20plan
NYLAG Fact Sheet - http://www.wnylc.com/health/download/739/

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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!

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Valerie Bogart

Evelyn Frank Legal Resources Program, New York Legal Assistance Group (NYLAG)

More Information at: nylag.org
and nyhealthaccess.org

www.nyhealthaccess.org

Al Cardillo

President, Home Care Association of New York State

The Future of Home Care in a Post-Covid World: Overcoming the Challenges Faced by New York's Home Care Providers

26th Annual ELDER LAW FORUM

HOME CARE BEYOND THE PANDEMIC:

Committing To A NY "Home Care *First* " Policy

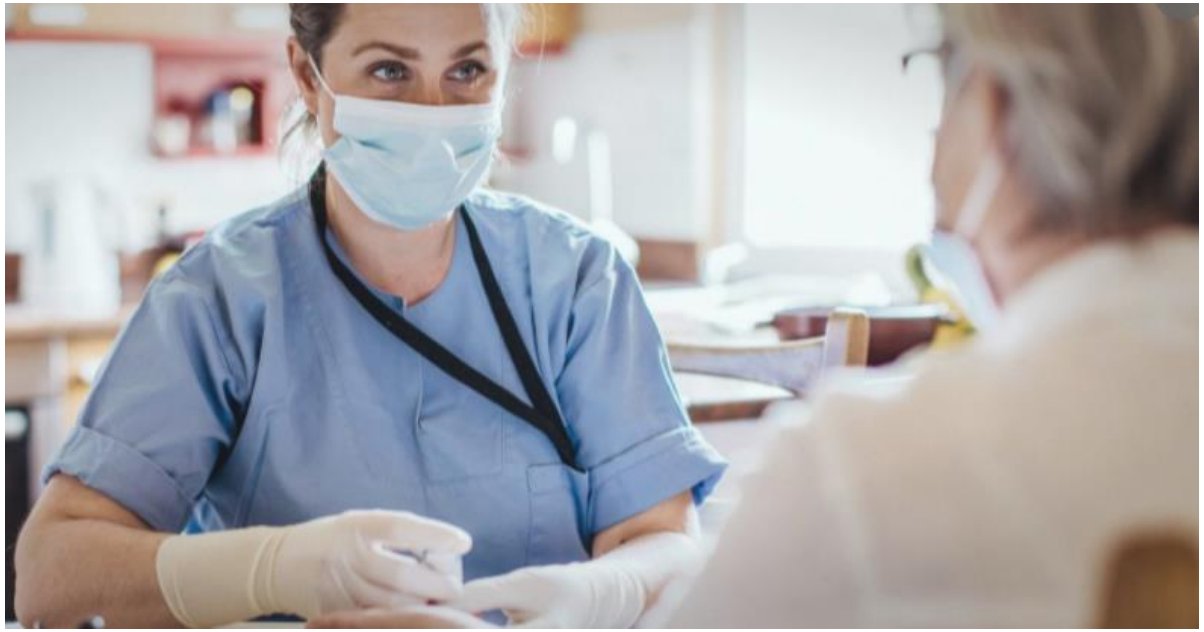
Al Cardillo, LMSW
President & CEO

HCA HOME CARE ASSOCIATION OF NEW YORK STATE

The Home Care Association of New York State

The Home Care Association of New York State (HCA) is the statewide health association comprised of all levels of home care, hospice, managed long term care, consumer-directed and waiver programs serving hundreds of thousands of New Yorkers annually.

Salute to the Home Care and Hospice Heroes



- *Every day*, home care and hospice providers serve with a profound scope and impact on the health of New Yorkers and on the overall operability of the health care system.
- *Every day*, home care and hospice providers work miracles for patients and solutions for the health care system.
- *Every day*, home care and hospices respond with individual and family support in a manner and venue unlike any other service.

Salute to the Home Care and Hospice Heroes

- These pivotal home care and hospice roles have been exponential throughout the pandemic.
- They have helped sustain the health and the lives of patients, functionality of the health system (mitigating hospital surge, enabling hospital decompression), and provided key support in virtually all spaces of the system.
- Home care also showed the way to innovation, working both individually and with hospital, physician, health plan and other partners to develop new and improved paths to access, quality, efficiency.

Beyond the Pandemic

New Recognition of Home Care Role, Need, Prioritization

- In the pandemic, it became clear that, as individuals were being directed to high risk settings (venues also destined for isolation from family and loved-ones) home care should have been considered the prioritized option.
- HCA started pressing for this consideration during the surge, and brought the issue into center-focus in our call for the Legislature's intervention in its public hearings.
- HCA testified with a priority recommendation that NY affirm a "Home Care *First*" Policy for patients – not only as a first option to facility care, but for any point across the continuum of health needs when home care might be an effective service for a person.

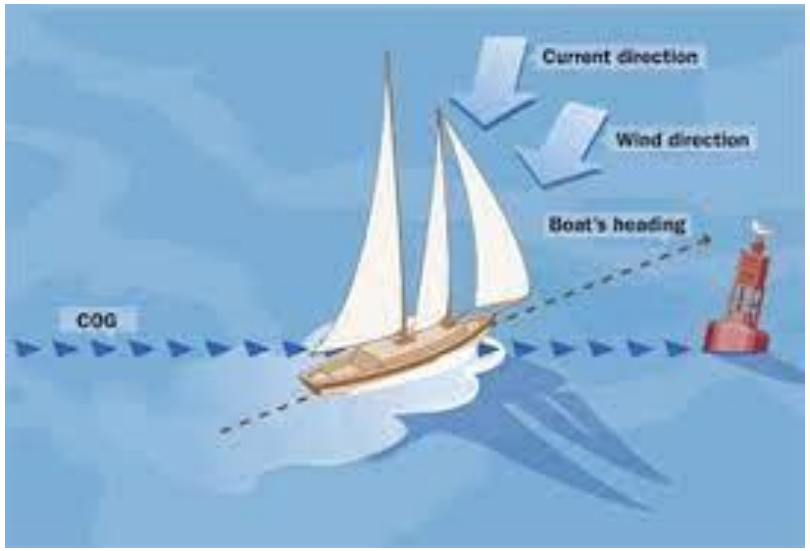
Beyond the Pandemic

- HCA survey and discussions with providers statewide found among the greatest challenges exacerbated by the pandemic:
  - An exacerbated workforce shortage; related issues of worker safety, patient care safety and access; and worker compensation and recruitment, training and retention support.
  - Severe fiscal impact from pandemic costs and losses.
  - Increased need and demand for telehealth.
  - Need for appropriate recognition of home care's role by principal decisionmakers and partners, including "essential personnel" designation and prioritization.
  - Need for regulatory flexibility for operations, service and staff.
  - Need for data and Situational Awareness

Status of Home Care

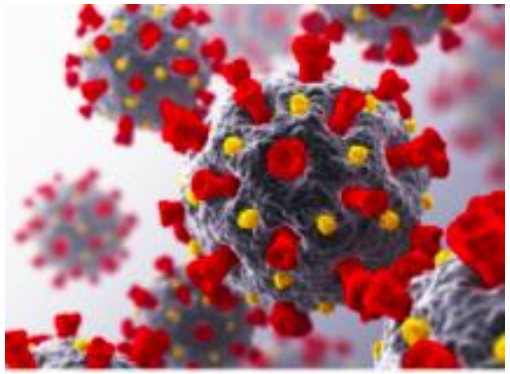
Where has the pandemic left us?

Where are we positioned?



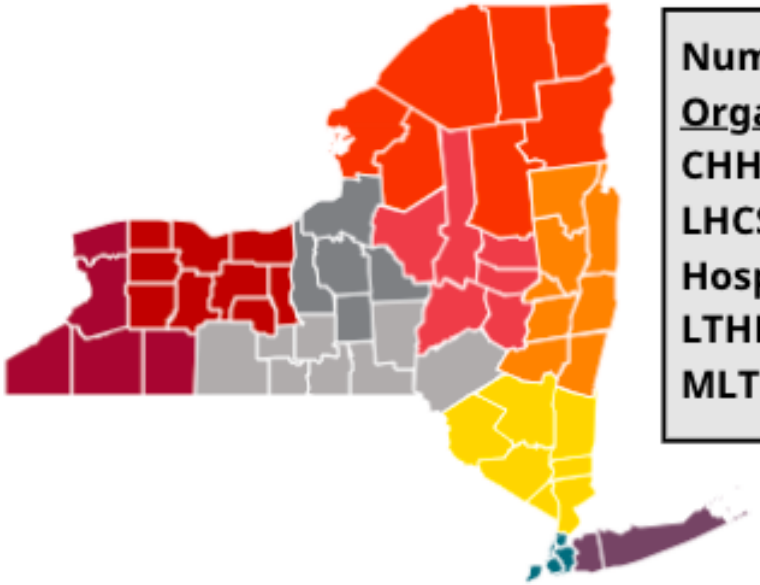
Status of Home Care

Although the pandemic trend is in the right direction, its impact on operations, workers, services and patients continues to be felt.



Inasmuch as a snapshot permits, let's look at the system's status.

State of Home Care



Number of Organizations
CHHA: 114
LHCSA: 1,484
Hospice: 42
LTHHCP: 14
MLTC: 37

Over **700,000** patients are served by home care and hospice providers annually.

There are **444,880** home health and personal care aides.

55% of all home care agencies are estimated to have had a negative operating margin in 2019.

State of Home Care

- An estimated **79%** of CHHAs had negative operating margins in 2019.
- **-14%** was the estimated average operating margin for CHHAs in 2019.

CHHA

- **76%** of hospices had negative operating margins in 2018.
- **-17%** was the average operating margin for all hospices in 2018.

Hospice

- 40% of LHCSAs with operating losses in 2019
- - 3.4% average negative operating margins for LHCSAs in 2019

LHCSA

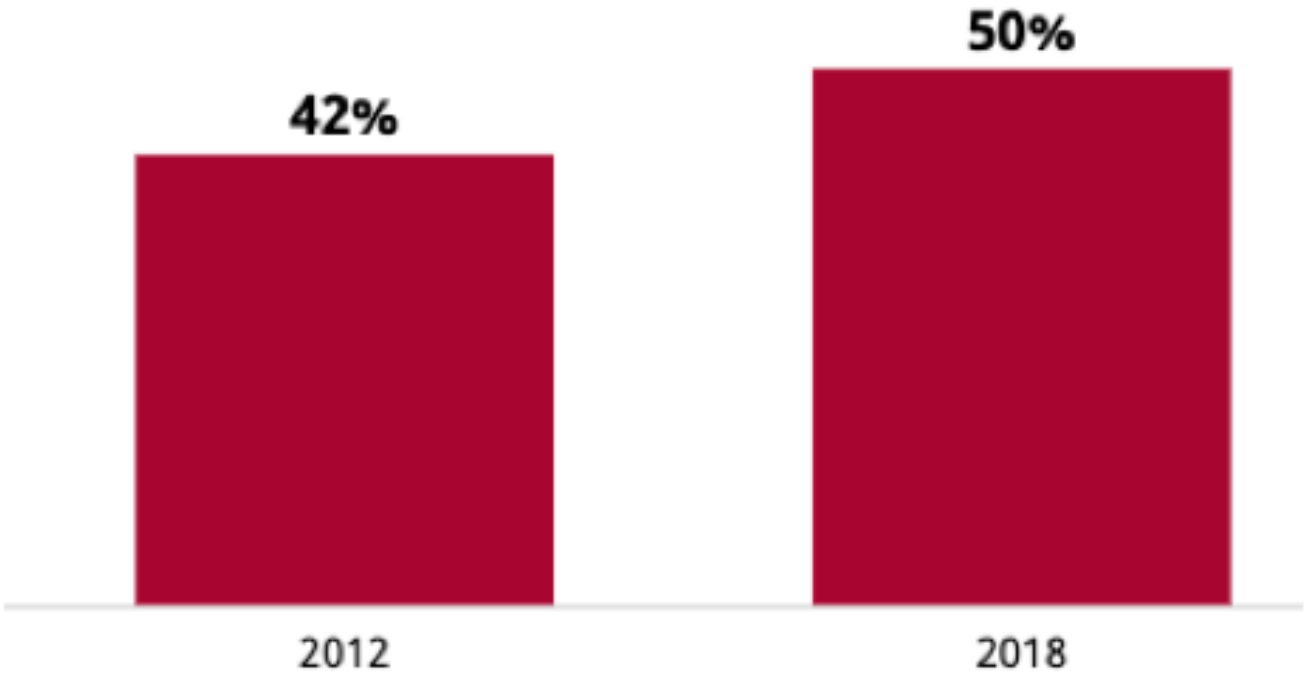
State of Home Care

Home health agencies experienced an estimated loss of **$200 million** since the onset of COVID-19.

State of Home Care

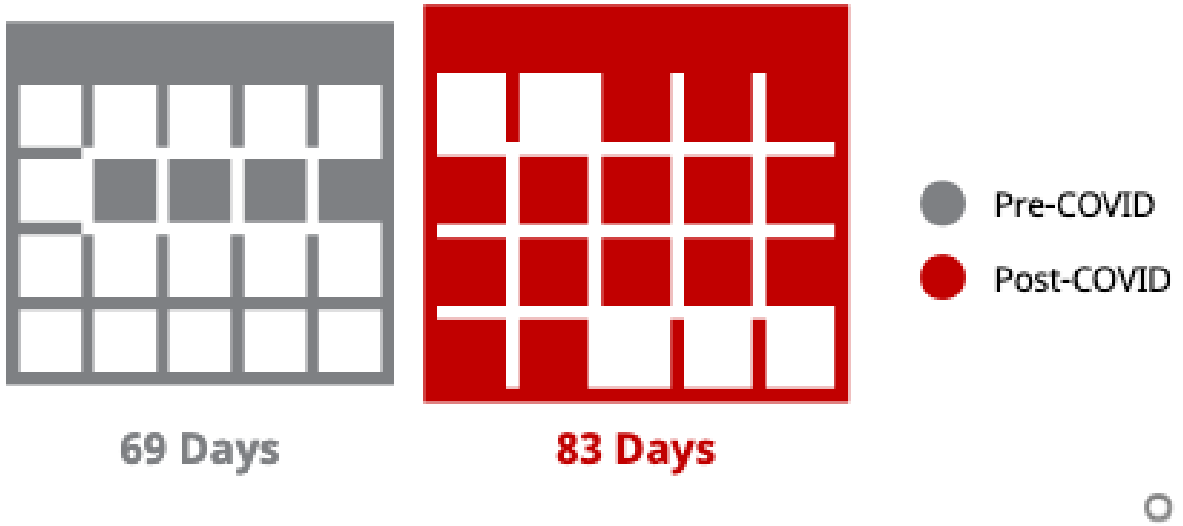
Percent of MLTC Plans with Negative Premium Income

A negative premium income is the difference between a plan's premium receipts from the state and its expenses for services and other functions.



State of Home Care

Average Number of Days Outstanding in Accounts Receivable



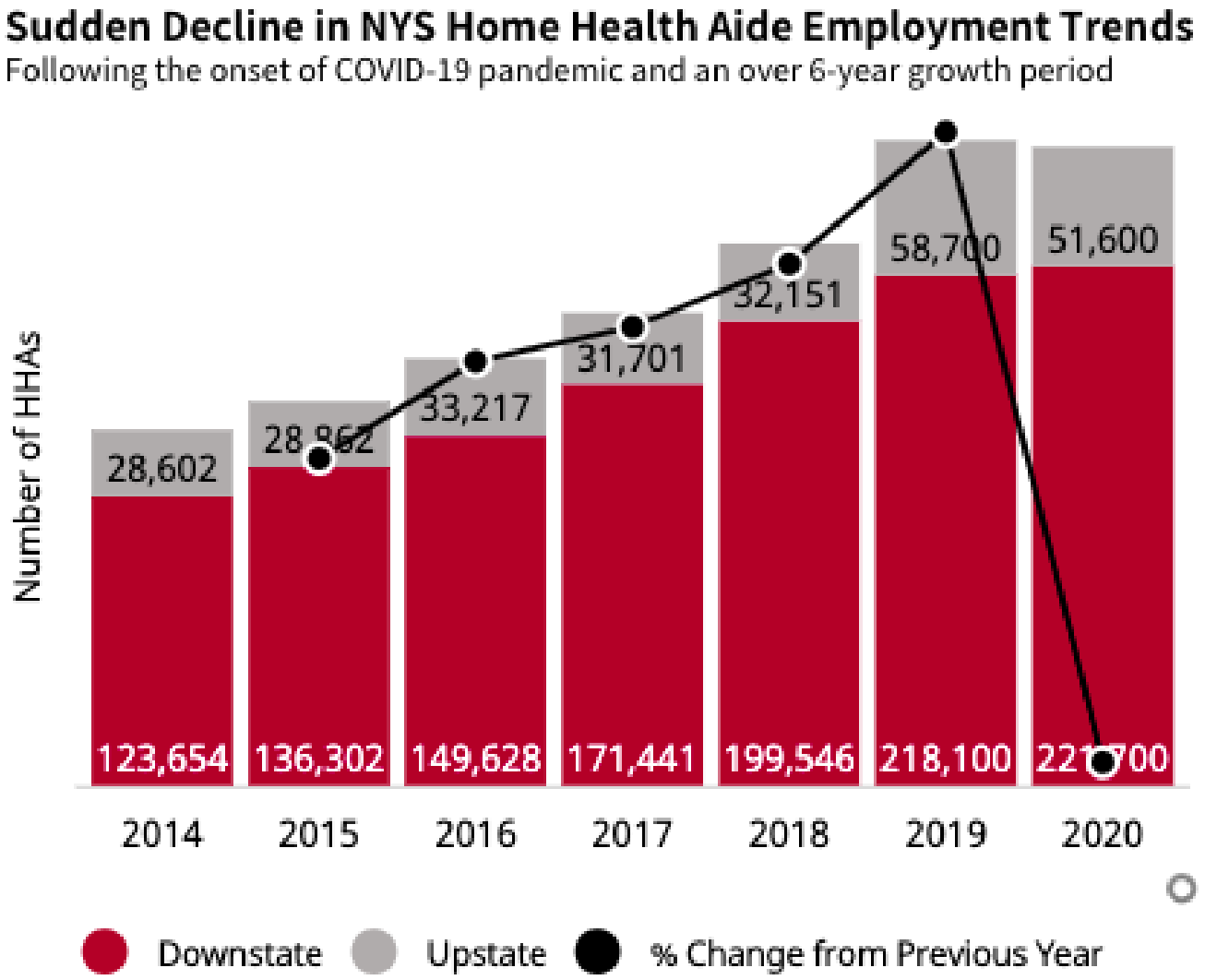
State of Home Care

Major Impact on Workforce

85% of agencies report that existing structural workforce shortages have been greatly amplified by COVID-19.

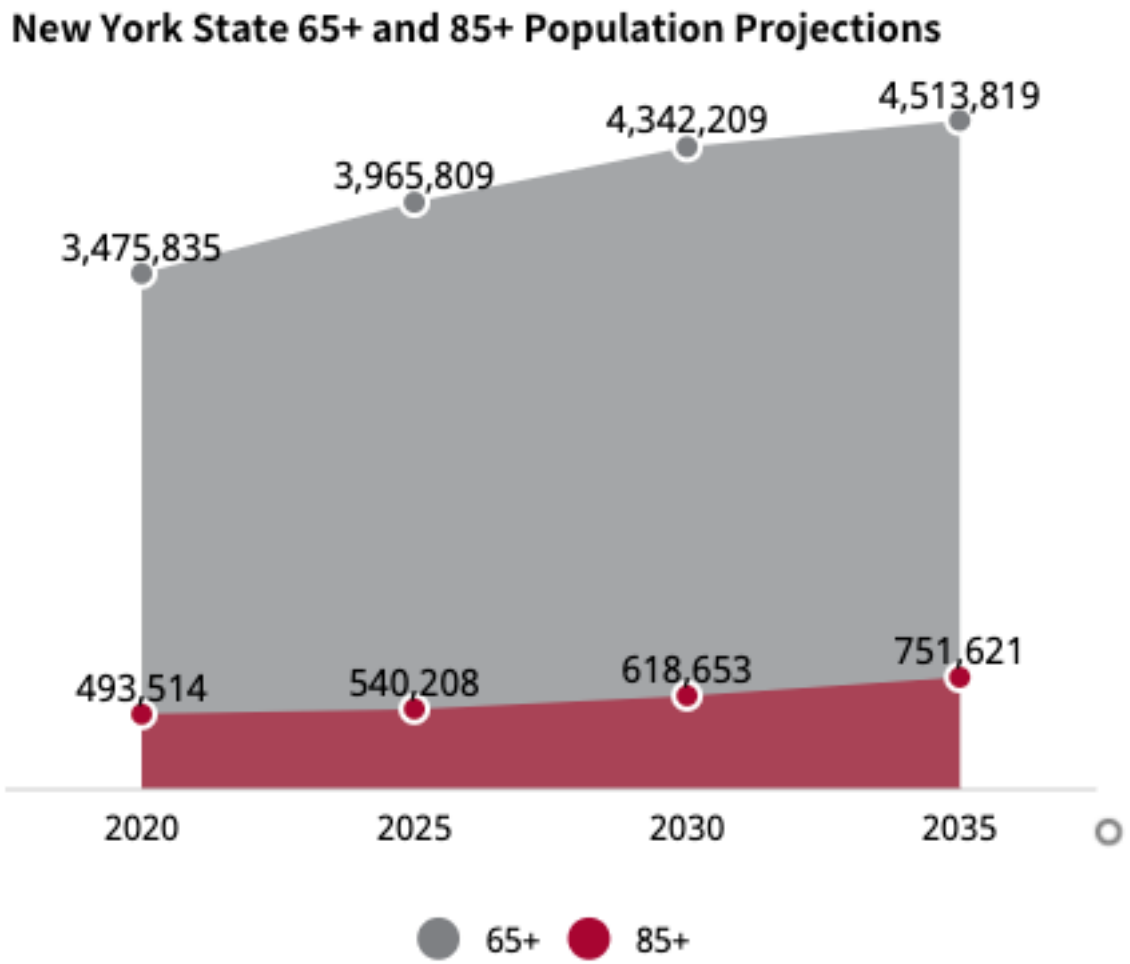
Capacity of Home Health Aide training programs has been greatly diminished due to pandemic restrictions; online/in-person hybrid created, but state approval process needs accommodation and streamlining.

State of Home Care



Beyond the Pandemic

Demand Trend Ever-Increasing
Now Surging Post-Pandemic



State of Home Care

Patients overwhelming prefer in-home care.

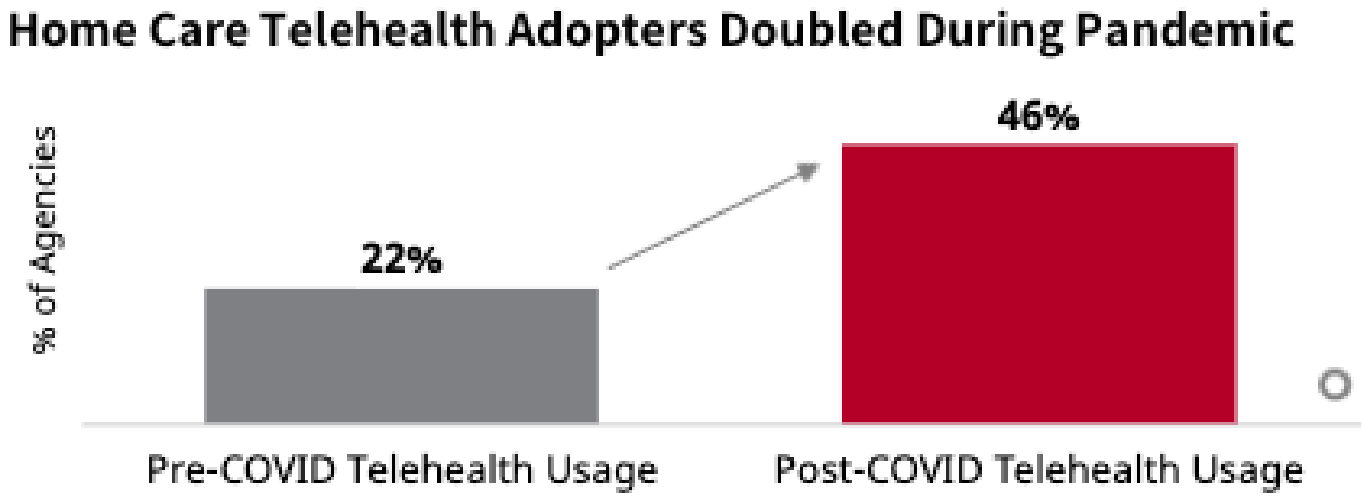
90% of people would prefer to receive care for themselves in their own home.

Nearly **1 in 6** New Yorkers are now aged 65 and over.

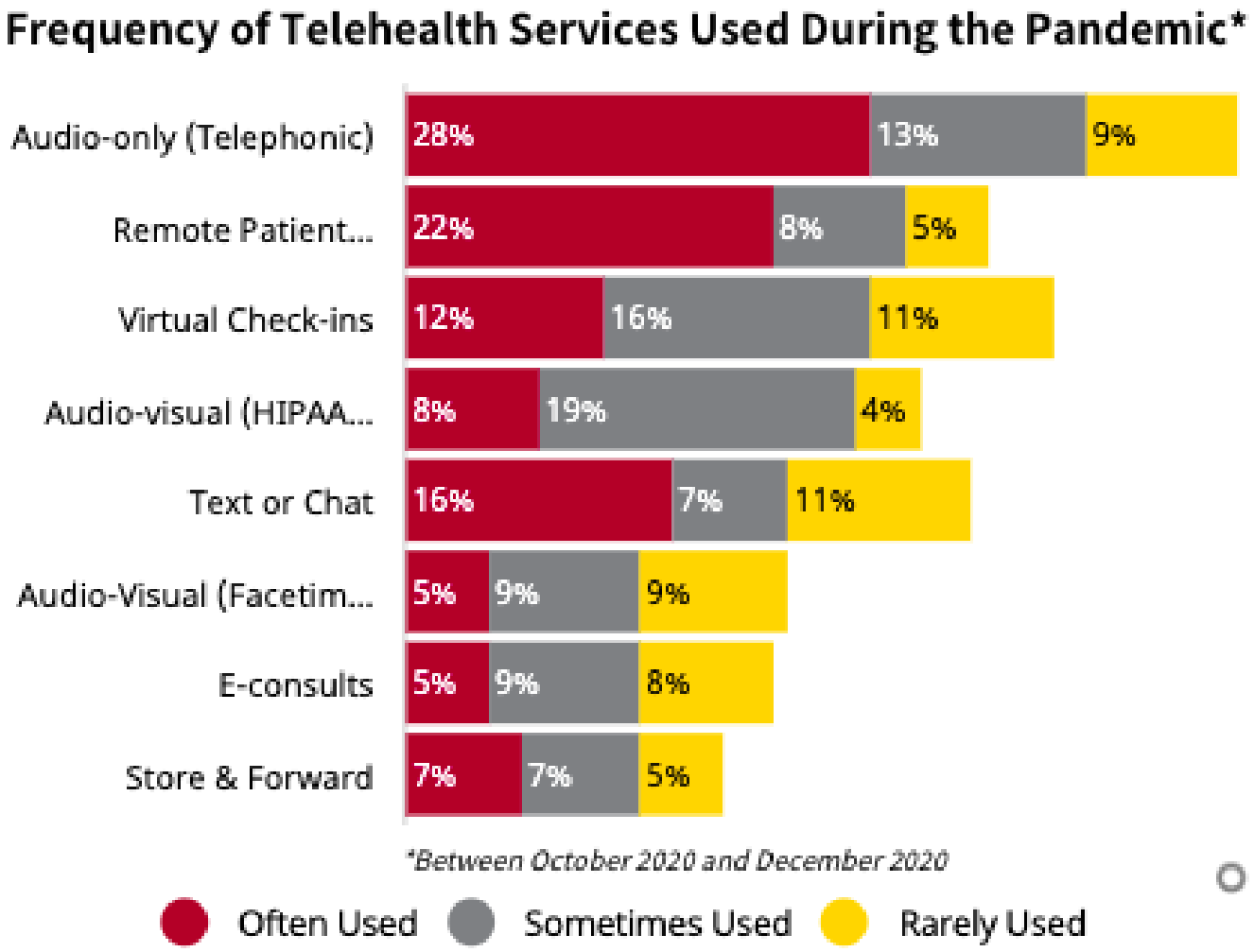
On average, **52%** of people who turn 65 today will develop a severe disability that will require long-term support at some point, accounting for **2 years of care** over a lifetime.

State of Home Care

Telehealth Surge and Trend



State of Home Care



Where Next?

Status of Home Care

Home Care has been heavily, profoundly and consequentially impacted in COVID-19, but always resilient, and possibly repositioned to be…….

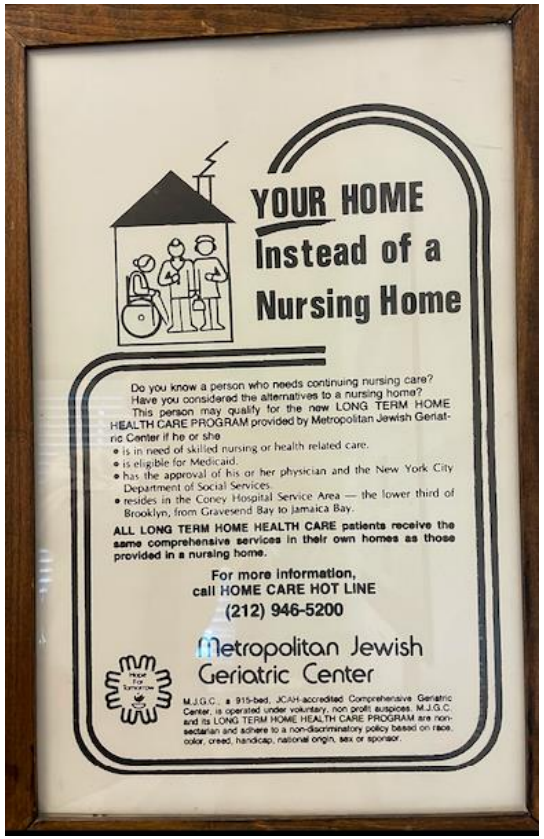
Home Care's Time

- The crisis has not only spotlighted the value and desire for care at home whenever and wherever possible, but has driven demand to unprecedented proportions.
- The focus on system investment to meet home need and desire is at a 40 year high, at the national and state level.

- Not since the late 1970's and onset of the 1980's has home care been so looked to……been so positioned.

Home Care's Time

- The time is now; the window is open.
- With $1.6 billion inserted in the newly adopted 2021-22 NYS budget to invest into HBBS, and $400 billion for HCBS among the federal" Infrastructure" proposals: if not now, then when?
- HCA recently concluded it's annual meeting with the conference of theme of "Meeting the Moment."
- For all of us in this virtual "Elder Law Room" today, and across the state, home care's "moment" has "come." (Come back!) It is *"<u>now</u>."*



NY "Home Care *First*" Policy

HCA supports the adoption of a New York Home Care First policy that ensures that home care is a principal option for patients across the continuum of need, whenever it is most appropriate for an individual, and that aligns all policies, rates and procedures to support this option and goal in real terms.

Chapter 795 of 1977
Establishment of Article 36

NYS Public Health Law

Article 36 Preamble

Declaration of legislative findings and intent.

"The legislature hereby finds and declares that the provision of high quality home care services *to residents of New York state is a priority concern. Expanding these services to make them available throughout the state* ***as a viable part of the health care system and as an alternative to institutional care should be a primary focus of the state's actions".***

HCA Post Budget Legislative Priorities

Adopt a 'Home Care *First*' policy for NY

- Home and community-based care should be a principal care option across a person's continuum of need, and a first option over facility care, whenever appropriate.
- It's also overwhelmingly preferred by patients and families, especially amid safety concerns in the COVID-19 pandemic.
- **Adopt HCA legislative language for a 'Home Care *First*' policy** strengthening consumers' option to choose home care, and aligning the statutes, regulations, and appropriate state reimbursement and program supports necessary to ensure that a Home Care *First* option is a reality.

HCA Post Budget Legislative Priorities

Post-Budget Action for Home Care Workforce

The new state budget appropriates $1.6 billion for the community-based workforce, with distribution details TBD.

New CMS guidelines provide wide parameters.

- **HCA is seeking a principal role in the design and implementation of this distribution** to maximize the support home care and hospice workforce.
- **Additionally, HCA is advocating adoption of its legislative proposal to secure future rates and funding** for enhanced worker compensation, key occupational supports, and targeted shortage regions and disciplines.

HCA Post Budget Legislative Priorities

Repeal the LHCSA RFO and Amend the FI RFO

- Repeal the NYS DOH Request For Offers (RFO) on licensed home care services agencies (LHCSAs) contracting. (S.6640/A.7304 by Assemblyman Dick Gottfried and Senator Rachel May) This DOH RFO is an overreach in deciding whether and which duly licensed home care services agencies (LHCSAs) can continue to operate and serve constituents.
- Without repeal, DOH can arbitrarily rule in and rule out which LHCSAs will be able to continue operating, including many organizations who have been licensed and serving patients with quality care for years.
- It threatens major upheaval in a system that hundreds of thousands of New Yorkers depend upon amid rising demand for home care services. HCA urges full repeal, and a restudy of state objectives and options.

HCA HOME CARE ASSOCIATION OF NEW YORK STATE

HCA Post Budget Legislative Priorities

Repeal the LHCSA RFO and Amend the FI RFO

- HCA also urges amendment to the RFO process used by DOH to decide who can operate as a consumer-directed home care program fiscal intermediary (FI).
- The RFO was amended in the budget, but further amendments are needed to allow currently qualified FIs (arbitrarily excluded by the RFO) to be continued. HCA is advocating a supplemental RFO, with legislative accountability.

HCA Post Budget Legislative Priorities

Telehealth Equity for Home Care & Quality Safeguards

- As the state pursues telehealth expansion, similar flexibility is needed for home telehealth.
- Also important are guardrails to preventing conflicts, duplication, and fragmentation of services across the various telehealth settings.
- **HCA is circulating legislative amendments to address home telehealth flexibility and guardrails across multiple telehealth services**

HCA Post Budget Legislative Priorities

Additional Legislative Supports and Needs in Home Care to leverage home care solutions and to support providers, workers and patients:

- Support home care rate stability (S.2117 /A.293).
- Extend/maintain COVID-era regulatory relief.
- Support mental health/home health collaboration for integrated physical/mental health services (A.3657/S.4534 with amendments).
- Incentivize collaborative models to address health disparities (S.1374/A.1155).
- Support hospice access for Assisted Living patients.
- Provide parking placards to support home care worker safety and access to patients.

HCA Post Budget Regulatory Advocacy

- **Nurse Practitioner/Physician Assistant Ordering Authority for Home Care** – Finalization of state procedural changes to permit.
- **Regulatory Relief** - Continued advocacy for permanentizing and/or extending meaningful COVID-era regulatory relief.
- **DOH Reforms** - Continue implementation advocacy related to Independent Assessor, physician prior approval, MLTC/home care eligibility and other DOH pending reforms
- **CMS Proposed 2022 Federal Payment Rules for Hospice and Home Care**
- **HCA Outreach to White House, Congress** on Home Care Vision, Future, New Federal Funding considerations

Federal Advocacy Areas

Support national investment in home and community based services.

- President has proposed $400 billion for home and community based services as part of national infrastructure support legislation.
- Most significant national investment in home care since the 1981 national home and community based services waiver program.
- HCA urges adoption of these critical investments.
- A new national home and community based services authority is being drafted in Congress, with the intent of replacing the waiver programs. Still in formulation. Could have + and - and is still fluid.

Post Budget Regulatory Advocacy

Telehealth reimbursement equity for Home Care and Hospice under Medicare.

- In COVID, Congress and CMS provided wide latitude for health care providers to utilize telehealth/telemedicine services and to be reimbursed accordingly.
- While home care has been the mainstay of telehealth for individuals cared for at homes, no such Medicare flexibility or reimbursement was provided for home care or hospice.
- HCA continues to urge Congress and the Administration to equitably provide telehealth flexibility and reimbursement for Medicare home and hospice care.

Post Budget Regulatory Advocacy

Build upon homebound flexibility provided in COVID-19.

- The Federal gov't flexed the otherwise antiquated and rigid Medicare "homebound" requirement for COVID-19 patients.
- HCA is urging *extension of this flexibility to all Medicare home care beneficiaries*, or at least to the clinical-functional categories which, similar to COVID-19 patients, would be extremely beneficial both for patient care and Medicare. A similar but limited proposal is in legislation by Senator Collins and Representative Sewell.
- Medicare coverage should be flexed to allow home care to be a principal option for patients wherever appropriate in the course of care, and to be a *first* option prior to institutional level care.

Post Budget Regulatory Advocacy

Remove CMS-presumptive "behavioral adjustment" rate cuts.

- Remove CMS's self-anointed authority to presumptively cut rates for home care based on assumptions about agency behavioral changes under CMS's new PDGM reimbursement methodology.
- Support legislation (TBA for 2021) led by Senator Collins and Representative Sewell to allow CMS changes for so-called behavioral adjustments *only* in response to observed evidence of such behavioral changes.

Post Budget Regulatory Advocacy

Create Authorities for Home Care Innovation.

- Home care is repeated excluded from major federal health legislation that invests in innovation (e.g., the ACA, the HITECH Act) .
- HCA is urging Congress and the White House to create new and specific authority and investment within the Centers for Medicare and Medicaid Innovation (CMMI) for home care and hospice provider innovations for quality, access, efficiency and workforce that promote federal and patient care objectives.

HCA “Home Care Innovations”

Beyond budget and policy, get involved in Pro-active Home Care Innovations!

Visit HCA’s HC Innovations Page at:
https://hca-nys.org/innovations

- Selfhelp Virtual Senor Center and Statewide Initiative w/HCA
- Training for COVID-19 In-Home Testing
- Statewide Hospital-Home Care Collaborative
- Home Care Sepsis Screening and Intervention Initiative
- Best Operational and Clinical Practices in COVID and Beyond

Participation is supported through special foundation grants to HCA.

Al Cardillo

President, Home Care Association of New York State

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www.hca-nys.org

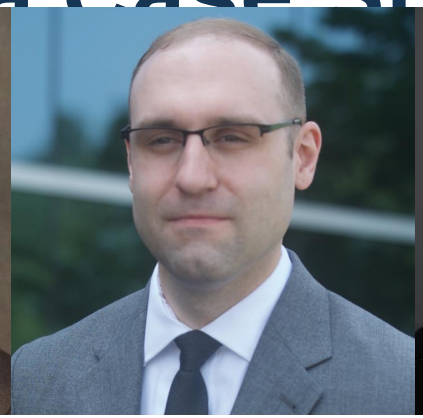
VALERIE BOGART AND AL CARDILLO

Q & A

26th Annual ELDER LAW FORUM

Anatomy of a Home Care Application: The Impact of Dramatic Rule Changes Illustrated through a Case Study

Moderator: Peter J. Strauss, Esq., Senior Partner, Pierro, Connor & Strauss



Frank Hemming III, Sr. Associate Attorney, Pierro, Connor & Strauss

Nadia Arginteanu, Dir. of Legal Affairs, NYSARC Trust Services

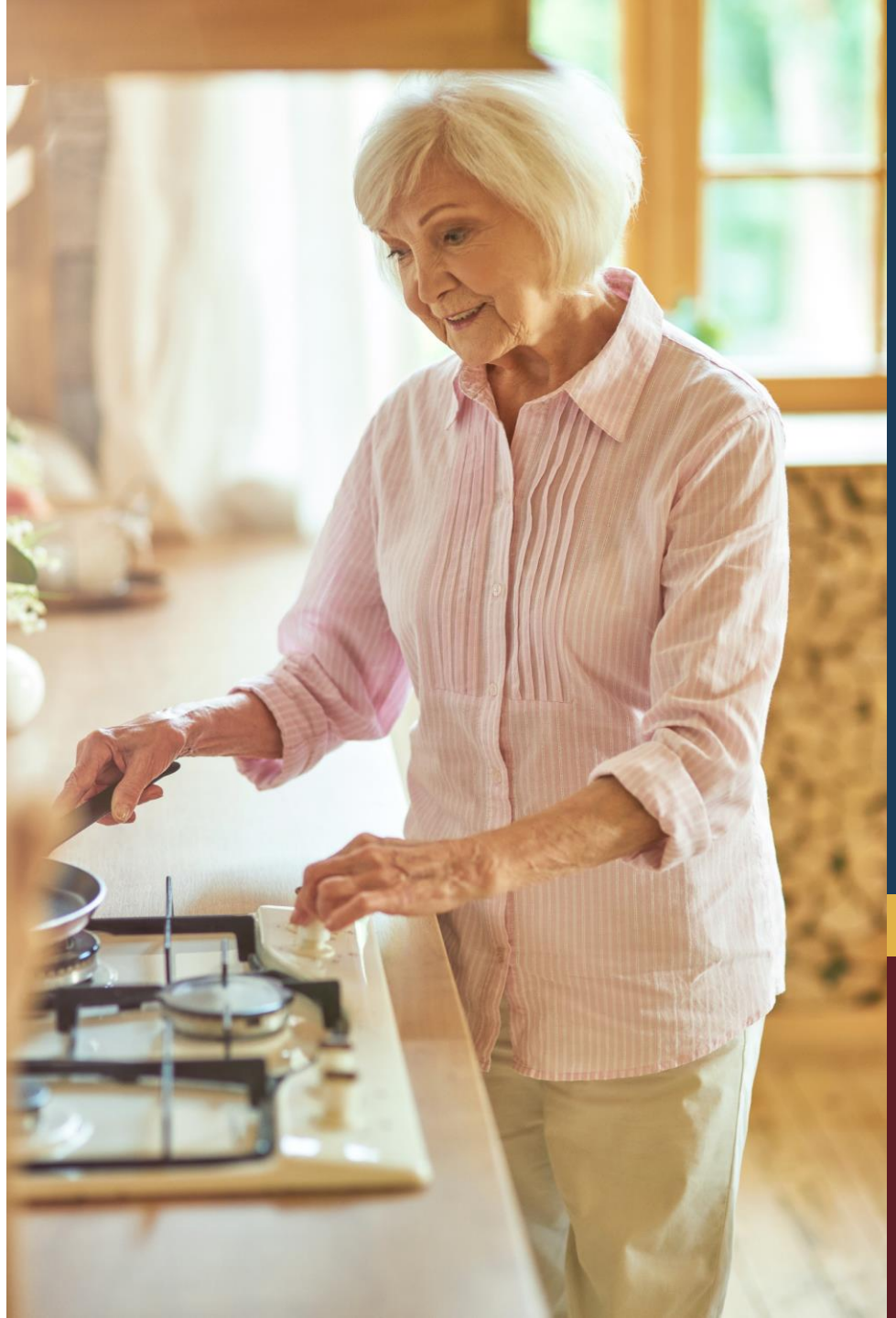
Nora Baratto, Dir. of Client Services, EverHome Care Advisors

Suzanne Paolucci, Owner, NY Care Consultants

Frank Melia, Vice President, Quontic Bank

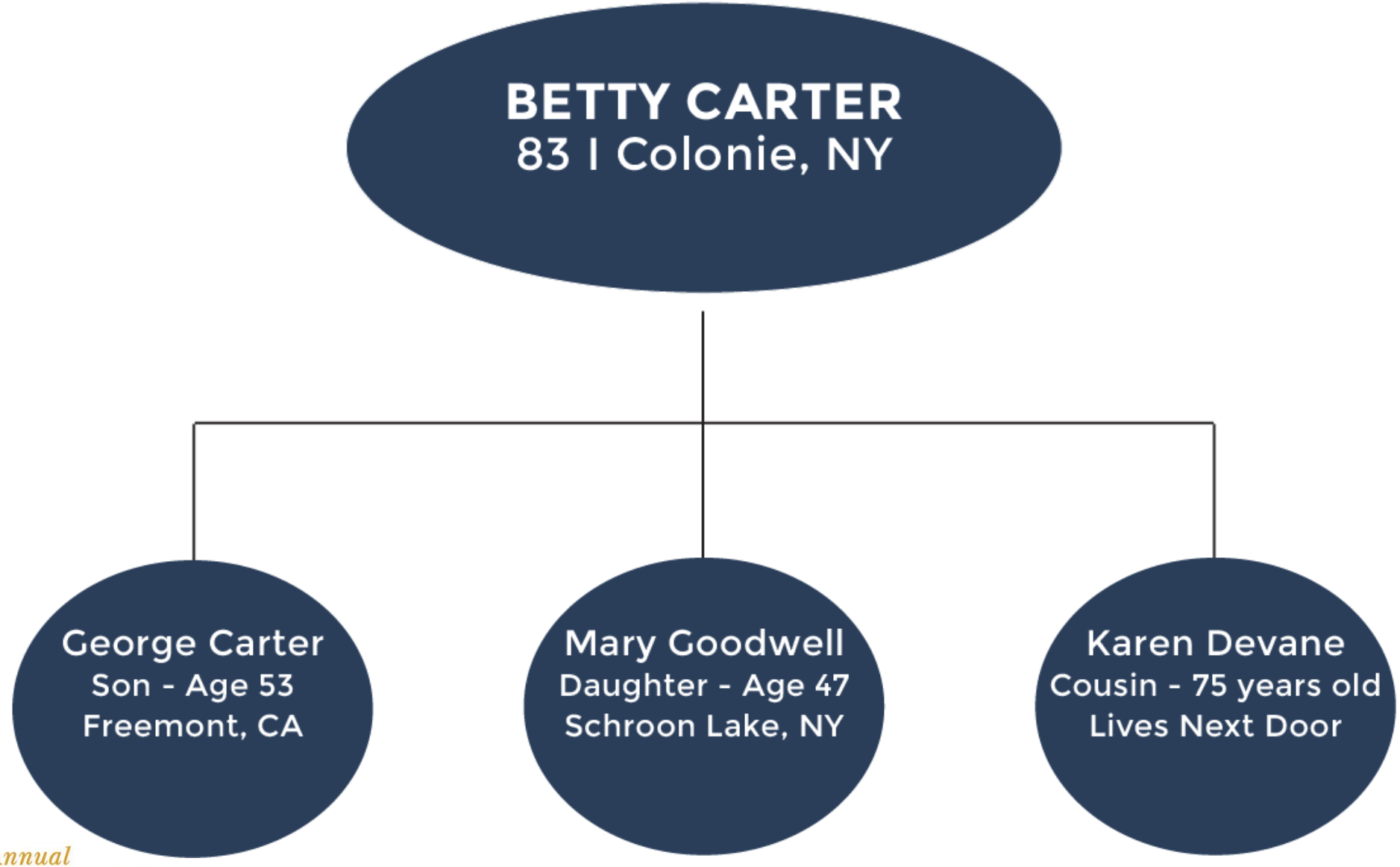
Case Study Overview

- Meet Betty Carter
- Social Worker Evaluation of Betty
- Is Betty financially eligible for Medicaid?
- Is Betty medically eligible for Medicaid?
- How do we design her care plan?
- How will all these questions be impacted by the new Medicaid rules?



Meet Betty Carter

- Wants to age in the comfort of her own home!
- Age 83, widow, lives in Upstate New York
- Cousin Karen lives next door, checks on Betty
- Two children live nearby but can't provide enough care


BETTY CARTER
83 I Colonie, NY
George Carter
Son - Age 53
Freemont, CA
Mary Goodwell
Daughter - Age 47
Schroon Lake, NY
Karen Devane
Cousin - 75 years old
Lives Next Door

Betty's Health

- Recently hospitalized
- Declined short term rehab due to concerns of Covid and quarantining in a facility
- At discharge, a VNA referral made to a Certified Home Health Agency, but Betty's family thought she had too much income to qualify for Medicaid despite having 24/7 chronic home care needs.

At Discharge:

At the time of discharge Betty received a discharge summary from Hospital. It stated the following:

"We are referring you to a Certified Home Health Agency. We also recommend someone is always with you for your safety and supervision."

Betty's Diagnosis and Legal Planning

MEDICAL INFORMATION	LEGAL DOCUMENTS	
COPD	Will	No
Congestive Heart Failure (CHF)	Power of Attorney	Yes (Mary)
	-with gifting rider	
Poor short-term memory	Health Care Proxy	Yes (Mary)

Betty's Financials

Income	
Social Security	$1,615
Pension	$1,000
RMD Dividends/Interest from Brokerage	$385 $500
Total Income	$3,500/month

Assets	
Home	$350,000 value (Exempt – In Medicaid Asset Protection Trust from 2019)
Brokerage Account	$300,000.00
IRA	$75,000 (EXEMPT)
Checking	$10,000
Savings	$40,000
Car	Exempt
TOTAL NON-EXEMPT ASSETS	$350,000.00

Step 1: Consult with Care Manager Suzanne

- Betty's family hired an aide for 8 hours a day

- Family members volunteer to rotate staying overnight for bathroom needs

- Running out of money, time and ability to keep the discharge plan intact going.

- At the advice of a friend who went through a similar experience, they went to Pierro, Connor & Strauss Law Group to discuss long term chronic care options

Frank E. Hemming III, Esq.

Senior Associate Attorney

PIERRO, CONNOR & STRAUSS, LLC
Trusted Counsel

Medicaid Eligibility 2021

Monthly Income	
Individual (at home)	$884 (+$20)[1]
Couple (both at home)	$1,300 (+$20)[1]
Minimum Monthly Maintenance Needs Allowance (MMMNA)[2]	$3,259.50
Resources	
Individual	$15,900
Couple (both at home)	$23,400
Comm. Spouse ResourceAllowance	$74,820 (or the spousal share of 1/2 combined resources up to a maximum of $130,380)

1-The first $20 of monthly income per household will not be counted when determining the eligibility of those Medicaid applicants who are aged, blind, or disabled. Income includes monies coming in each month such as Social Security, pension, rent payments, and disability payments

2 – If Community Spouse makes less than $3,259.50 of their own income, they will receive a portion of their spouse's to reach $3,259.50

Exempt Assets

Some assets that are exempt:

- $15,900
- Pre-paid burial
- Income producing property – business assets
- Life insurance – face value less than $1,500!
- IRA in "Periodic Payment Status"- *major exception*
- One Car

NON-EXEMPT ASSETS= EVERYTHING ELSE!

Betty's Home ($906,000 limit)

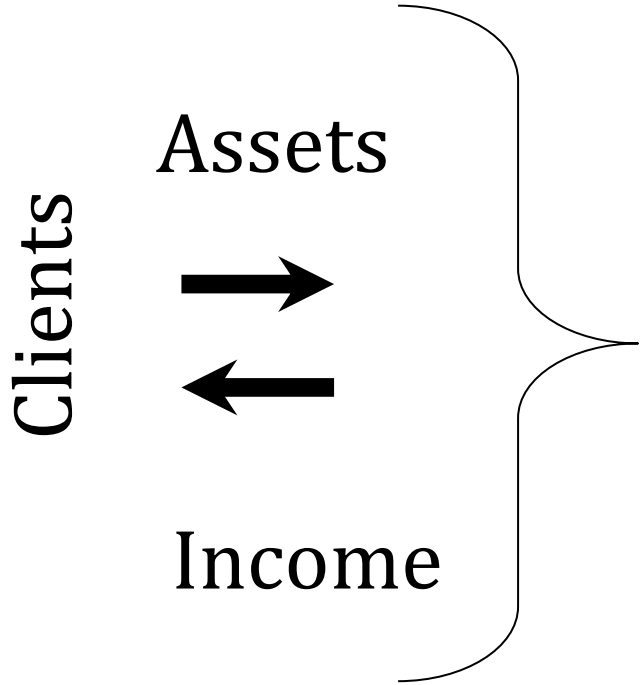
Some assets that are exempt:

- Exempt if Betty or spouse or minor or disabled child lives there
- Transfer exemptions
- Intent to return home
- Liens + Estate Recovery

Current Plan to Achieve Community Medicaid Eligibility

- Fund Medicaid Asset Protection Trust (MAPT)
  - Plan remains possible due to COVID emergency and NY's failure to implement new Community Medicaid eligibility rules passed in October 2020
  - If Betty didn't have a MAPT already, then one would be created and funded to create eligibility
- Create and fund Pooled Income Trust for excess monthly income

Medicaid Asset Protection Trust



- Trustee – manages trust assets
- Beneficiaries
  - Client – income for life and right to use real property
  - Heirs = Remaindermen - inherit when trust ends

Medicaid Asset Protection Trust

Home
Bank Accounts
Stocks & Bonds
Annuities
Life Insurance
Business
Real Estate

MEDICAID ASSET PROTECTION SLIDE

- Income is yours if you want it.
- Principal can NOT be given back to you directly.

Medicaid Asset Protection Trust

Security Features

- Choose initial Trustee, and change at any time
- Choose initial beneficiaries, and change at any time
- With the consent of all beneficiaries, in some jurisdictions the trust can be "amended or revoked"

KEEP OUT

Cash
Bank Acct.
IRA, 401(k)

Medicaid Asset Protection Trust

Advantages:

- Probate avoidance
- Ability to distribute assets outright or in further trust
- Ability to hire and fire trustees
- Access to income and assets within the trust, just has to be done properly
- Ability to revoke an irrevocable trust with consent of beneficiaries
- **Ability to qualify for Community Medicaid immediately, until January 1, 2022**

New Rules Taking Effect on January 1, 2022

- The law imposes a "Medicaid lookback" for transfers after **October 1, 2020** for Community Medicaid
- Starting **January 1, 2022,** there will be a 15-month lookback done for every community application (audit of all financial activity from January 1, 2022 back to October 1, 2020)
    - If transfers/gifts are found within the lookback period, penalties will be assessed and the applicant will not be eligible for Medicaid for a period of time.

This is the system currently used for nursing home applications, except for a period of 5 years/60 months

Plan to Create Eligibility for Community Medicaid Starting January 1, 2022

- Promissory Note and Gift Strategy (also known as "Rule of Halves" planning
  - A Gift and loan are made of roughly 50% of countable assets.
  - The promissory note has been ruled by the Courts to be a **non-countable asset**, just income (used to pay for homecare expenses)
  - The loan payments are calculated to private pay for home care while the penalty period runs- a **complex calculation**

2021 Regional Rates

Region	Counties	2021	2020	2019
New York City	Bronx, Kings (Brooklyn), NY (Manhattan), Queens, Richmond (Staten Island)	**$13,037**	$12,844	$12,419
Long Island	Nassau, Suffolk	**$13,834**	$13,407	$13,407
Northern Metropolitan	Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	**$13,206**	$12,805	$12,636
Western (Buffalo)	Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**$11,054**	$10,720	$10,556
Northeastern (Albany)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**$11,689**	$11,295	$11,280
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	**$13,020**	$12,460	$12,342
Central (Syracuse/Utica)	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	**$10,857**	$10,451	$10,068

Using the Promissory Note/Gift Strategy for Betty

Betty has **$3,500/month of income**, **$350,000 of non-exempt assets**
If Betty requires 24/7 care at home, she has a monthly home care cost of $18,000.00 per month ($25.00 per hour x 24 hours per day = $600.00 per day, $18,000.00 per month)

Her family pre-pays her funeral (could pay for others), buys her a television, clothes, and pays legal fees- **a total spend down of $20,000.00.**

Betty **gifts $146,083.86 to her Medicaid Asset Protection Trust**, and **loans $170,416.14 to George and Mary,** all on January 25, 2022

Promissory Note Example, Continued

Home Care Monthly Cost -Income		$18,000 - $3,500
Needed from Assets/ Month		$14,500/mo.
Non-Exempt Assets -Spend-Down -Amount Left with Vera		$350,000 - $20,000 - $13,500 (slightly less than $15,900)
At Risk Capital		$316,500

Example (Cont.)

Gift of $146,083.86 = Transfer

$146,083.86 / $11,689= 12.5 month penalty

Loan of $170,416.14 = Note payments of $14,300/month for 12 months

Apply for Medicaid February 1,2022
>Penalty runs 2/1/22- 1/31/23 (partial penalty for February, 2023)

>Note pays 2/1/22- 1/31/23

Medicaid Eligible February 1, 2023

What has Betty Saved?

Trust: House ($350,000) and $146,083.86

Amount left with Betty - $13,500.00

Pre-Paid Contract - $10,000.00

IRA - $75,000.00

Total - $594,583.86

Nadia Arginteanu, Esq.

Director of Legal Affairs
The Arc New York

NYSARC TRUST SERVICES

Pooled Supplemental Needs Trust (SNT)

- A pooled supplemental needs trust is a special type of trust in which a not-for-profit trustee, like NYSARC, agrees to hold assets for the benefit of a person with disabilities to preserve that person's eligibility for government benefits and protect excess funds to improve their quality of life
- Federal and New York State law both permit the use of a pooled SNT by persons with disabilities for the purpose of determining Medicaid eligibility by permitting the sheltering of excess income and/or resources
- Funds in a trust can be used to provide for quality of life purchases that a person's benefits do not provide

Benefits of a Pooled Trust

- Qualify and maintain eligibility for Community Medicaid to get health care benefits and long-term care services, like home care, without a complete loss of resources and financial independence
- Utilize excess funds for living expenses and to enhance quality of life
- Maintain comfort and independence in the community - get needed care at home and avoid a nursing home
- Helps people transition home following short-term rehabilitation
- Benefits can provide helpful relief for family caregivers

Using a Pooled Trust for Income Spend-Down

"Income received by an individual and placed into a pooled SNT in the same month will be disregarded for Medicaid eligibility purposes."

2021 NY Medicaid Income Limits	
Individual	$884/month (+$20)
Couple	$1,300/month (+$20)
2021 NY Medicaid Resource Limits	
Individual	$15,900
Couple	$23,400

Examples of Monthly Income: Social Security; Pension; IRA Distributions

Betty: Using a Pooled Trust for Income Spend-Down

After the monthly administrative fee, Betty will have around $1,000 in her trust account to pay bills and other expenses

Betty's total monthly income:	**$3,500**
Medicaid Income Limit:	-$904
Excess monthly income (spend-down)*	= $2,596
Administrative fee	-$240
Funds left in the trust to pay bills	$2,356

*Excess monthly income is determined by Medicaid

Trust Administration

- **All disbursements must be for sole benefit of the trust Beneficiary**
- Disbursements must be substantiated by supporting documentation
- Disbursements can only be paid directly to third parties
- Account terminates upon passing of the trust Beneficiary and no disbursements can be made after death in accordance with Federal SSA POMS policy

Types of Disbursement Requests

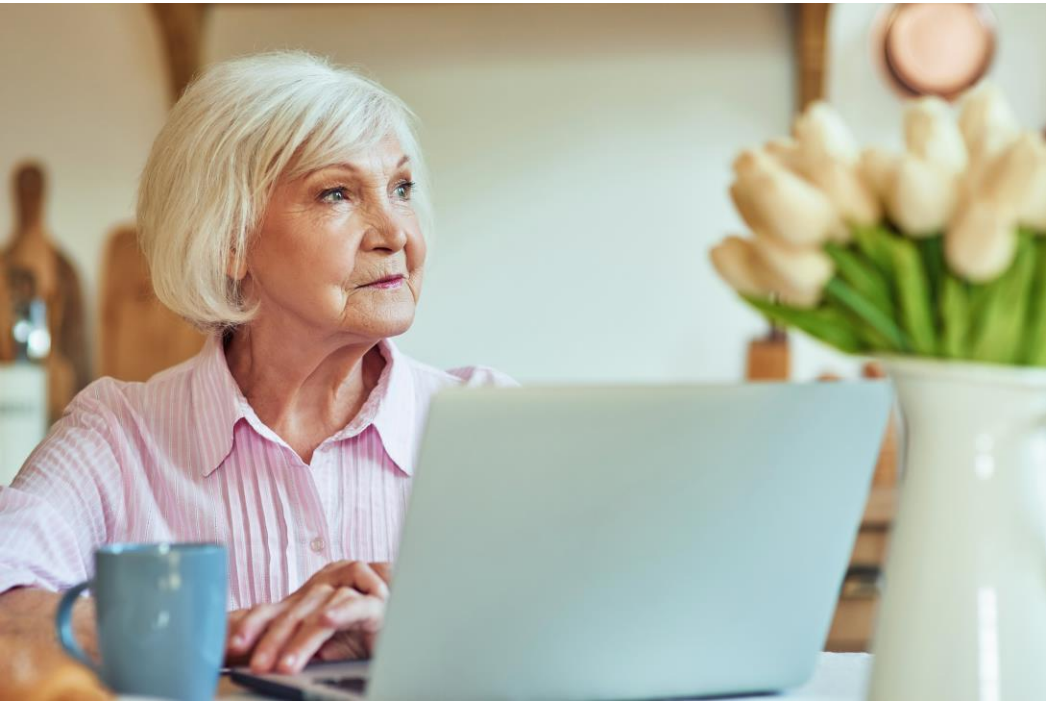
- Submit a bill/receipt to pay a third party directly
  - Rent/Mortgage, Utility Bill, Loan Payment, Insurance Premium, Newspaper/Magazine subscription, etc.
- Submit a receipt to reimburse an individual
  - Groceries, clothing, or other store purchases
- Make purchases using a credit card
  - Submit Credit Card bill and itemized receipts for purchases the trust will pay
- Quote/Invoice for service or purchase
  - Assistive technologies, furniture, computer, home repairs, etc.

What Can Your Trust Pay For?

For a person receiving Community Medicaid, the trust typically pays for living expenses, such as:

- Rent or mortgage, property maintenance, and taxes
- Utility bills, cable, phone, etc.
- Transportation/Vehicle expenses/Insurance (owned by Beneficiary)
- Groceries, clothing, and other personal needs
- Uncovered Medical Expenses/OTC items
- Additional hours for home health aids not covered by Medicaid
- Irrevocable pre-need funeral arrangement
- Entertainment/Recreation

Impact of 2022 Rules



For Pooled Trusts, new rules likely will have Medicaid recipient spend their entire monthly deposit within the month it's made.

Betty would have to spend approx. $2400/month.

She could use this money to fund her everyday living expenses.

Frank Melia

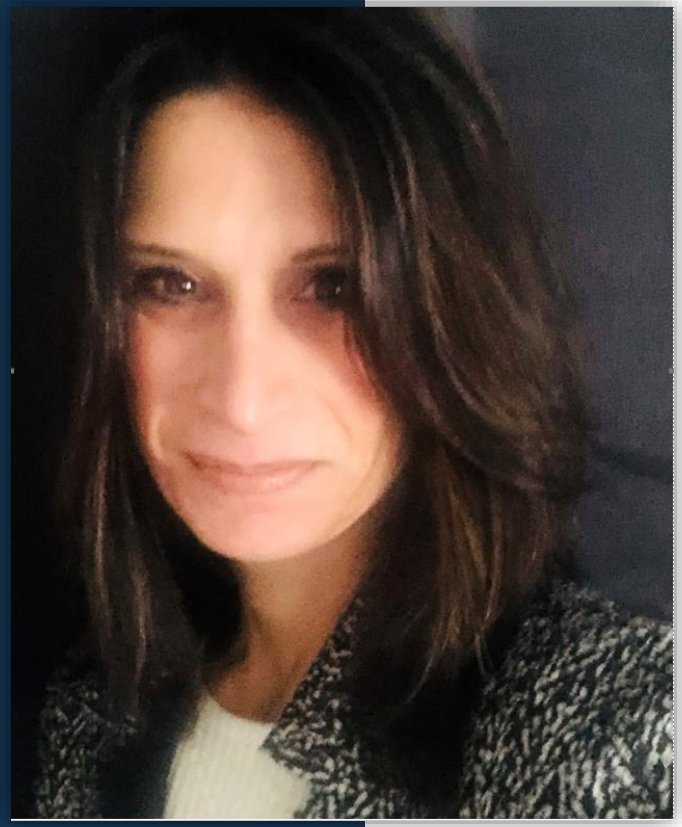
VP of Lending,
Quontic Bank

We Offer Mortgage Programs for Properties in a M.A.P.T.

- A+ Federally Chartered Bank based in NYC
- Up to 75% financing available (IRREV TRUST)
- Escrows included (30 yr. Fixed & H.E.C.M.)
- 5/6 ARM, 15 & 30 yr. Fixed, L.O.C.-HECM

Betty:
H.E.C.M. – Long Term Care Planning

- Income requirements - APPROVED
- Approximately $210,000 available in L.O.C.
- Draws are available 24/7
- Proceeds for LTC costs (trust checking account)
- LOC grows by 5% per year
- POA's allowed-Guardianships allowed



Suzanne Paolucci

Owner,
NY Care Consultants

Medicaid Medical Eligibility for Betty Carter

First Step: Financial Approval – accomplished by Frank and Nadia.

Thankfully, Betty was financially approved in one month.

Second Step: Medical Eligibility

Medicaid Medical Eligibility for Betty Carter (Continued)

Betty's family meet with the Care Coordinator who helped them understand the confusing array of steps

First was the Conflict Free Assessment:

- What does that even mean?
- The Assessment called the UAS-NY had the following noted:

- **At the end of the First Assessment, it was determined that Betty qualified for Community Based Long Term Care Services.**

Medicaid Medical Eligibility for Betty Carter (Continued)

- Determining # of hours: second assessment
- Only 5 hours of daily care - a shock!
- How can Betty get more than 5 hours? Appeal!

(We'll cover this in the next session)

Nora Baratto

Director of
Client Services

EVERHOME
CARE ADVISORS

FAST Forward 2022: New Medicaid Rules

"Betty" comes to us for planning in February 2022, *after new rules kick in*,
How many months until she qualifies for Medicaid??

New 30-Month Lookback starting Jan. 1, 2022

- Penalty begins to run when the applicant is "otherwise eligible" to receive services were it not for the penalty period, and actually applies

  After meeting with Elder Law Attorney, it is determined

- Betty would apply as of Feb 1, 2022, with a 12.5-month penalty
- Funds are sheltered to pay for care during the penalty period. Betty will have approximately $14,300/month to pay for needed care

Referral is made to Aging Life Care Coordinator to assist family with care decisions

Importance of Utilizing an Experienced Advocate

ALCA 8 knowledge areas

An Aging Life Care Coordinator Role

- Assessing care needs
- Connecting local resources
- Assisting with family needs
- Evaluating housing needs
- Assist with financial management
- Deal with crises
- Advocacy

Care Management of the Present and Future

Summary:
How will Betty's Care Plan Be Different?

Panel Discussion

How did we help Betty under the current rules?

How is the total Plan different next year?

Did we accomplish her goals:

-Stay at Home
-Qualify for Medicaid
-Preserve as many assets as possible
-Create a home care plan that works for Betty

Fair Hearings and Appeals: Winning Strategies

Peter J. Strauss, Esq.,
Senior Partner, Pierro,
Connor & Strauss

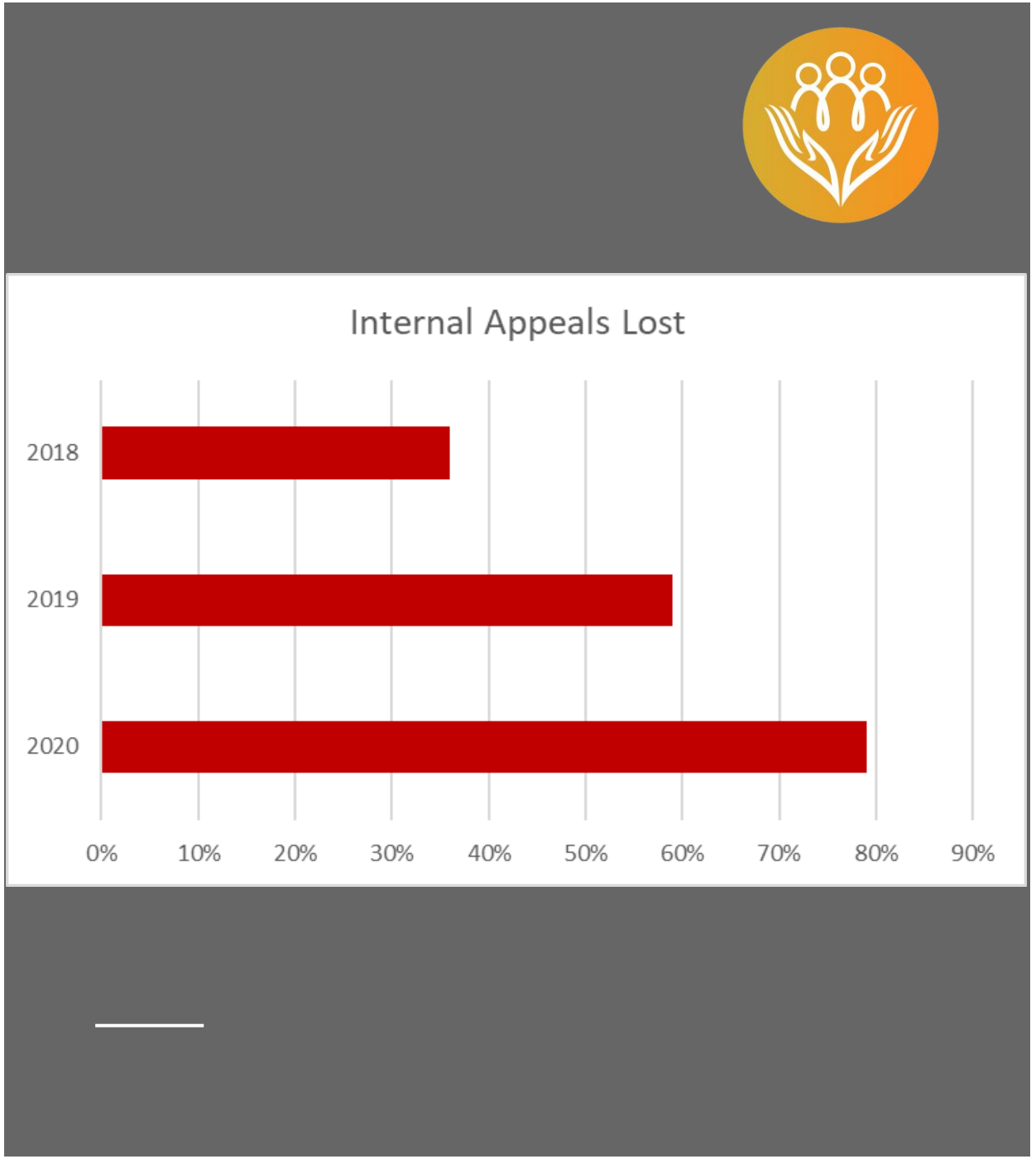
Frank E. Hemming III
Senior Associate
Attorney, Pierro, Connor
& Strauss

Suzanne Paolucci, LCSW
Owner, NY Care
Consultants

Valerie Bogart, Director
Evelyn Frank Legal
Resources Program,
New York Legal
Assistance Group
(NYLAG)

It’s Getting Harder to Win Internal Appeals

The enrollee is being forced to exhaust all measures of the appeal process (Internal/External)



WHY?

The Facts

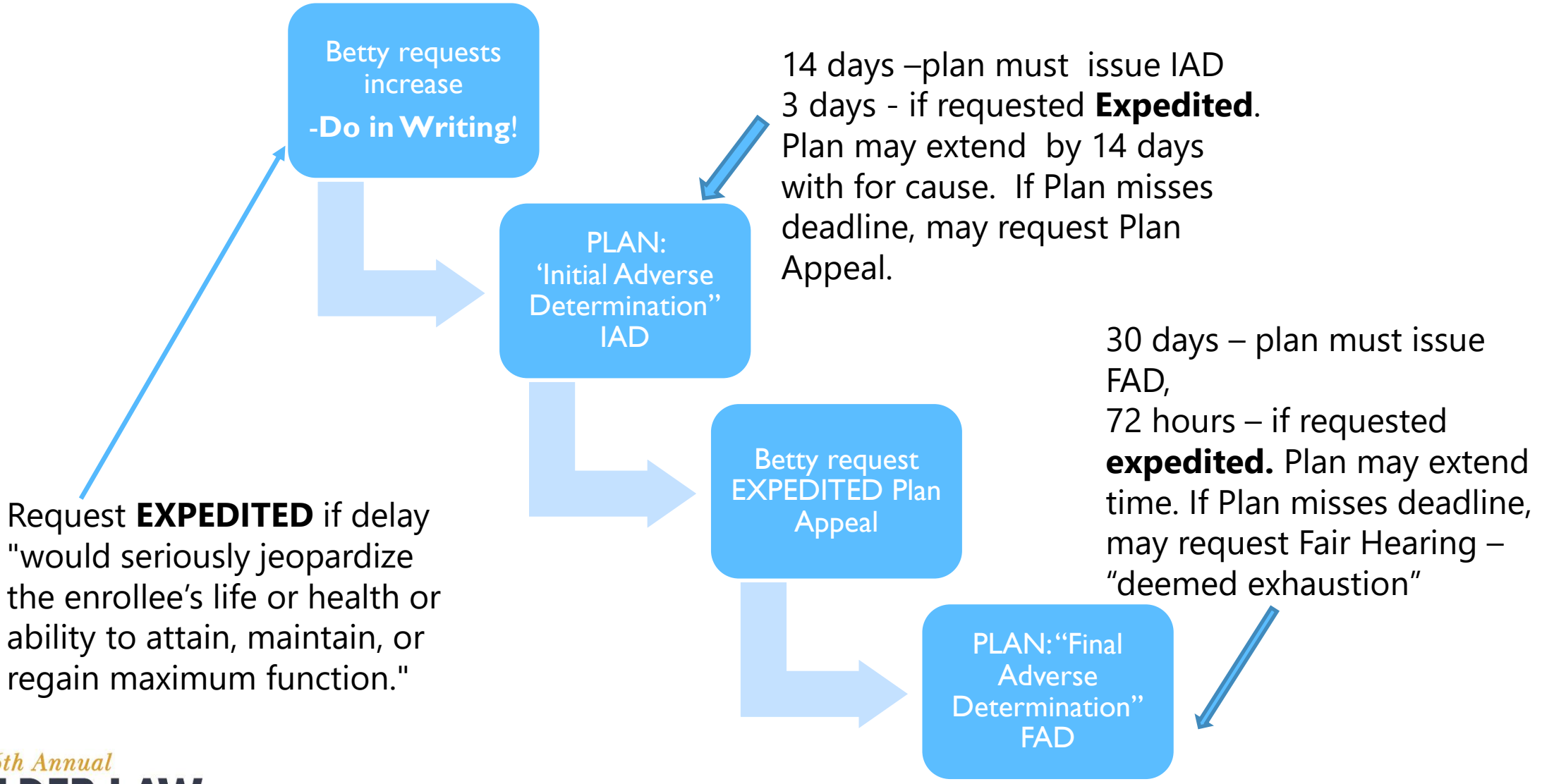
Managed Care Providers are paid a set rate for all enrollees no matter how much care is needed.

The Department of Health consistently will not intervene in clinical decisions.

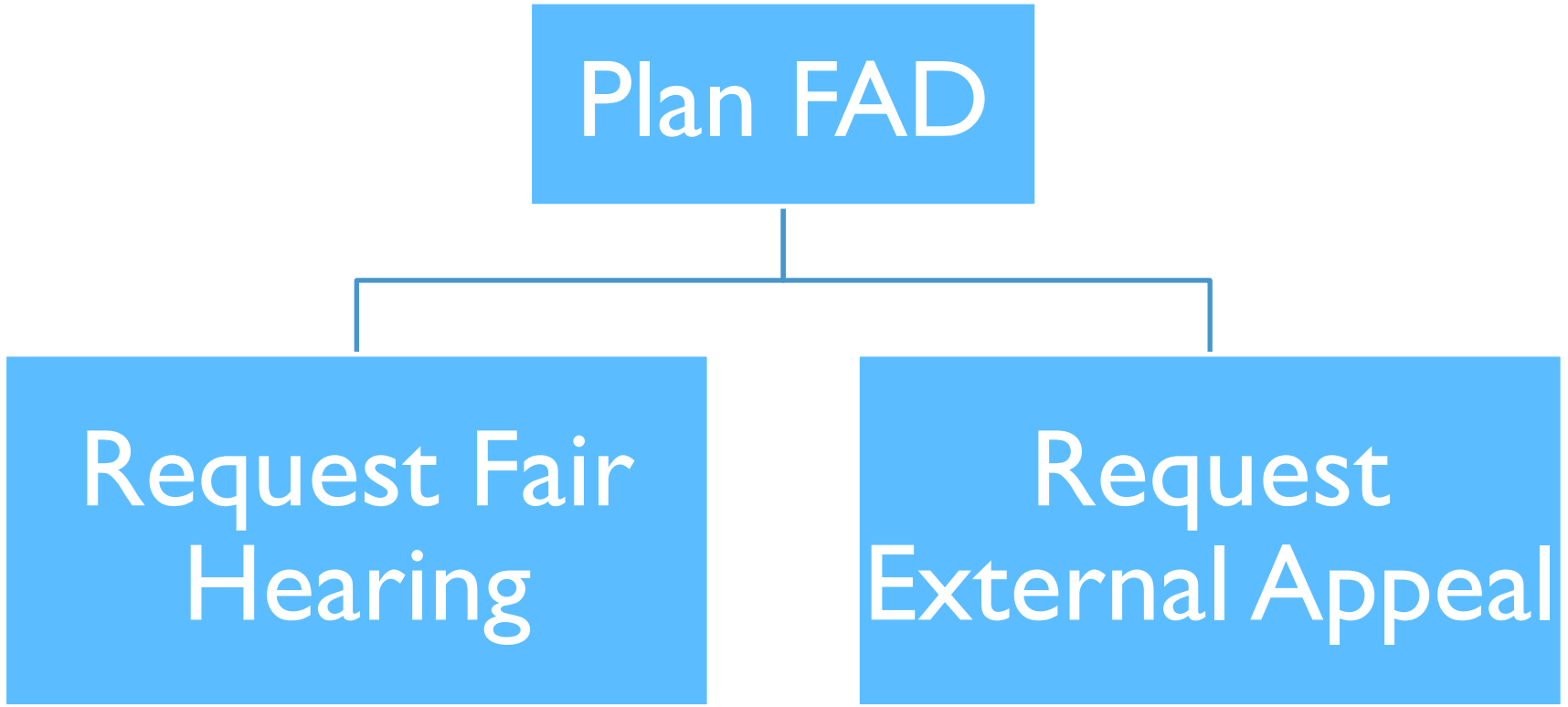
Members do not have rights until the first day of enrollment.

Enrollees are required to exhaust the appeal process.

What is the Appeals Process? Part 1



What is the Appeals Process – Part 2



May do both – Request FH.. While pending, request expedited External Appeal. If lose - may still request Fair Hearing

From NYS Dept. Financial Services. If EXPEDITED -decision in 3 days!

See http://www.wnylc.com/health/entry/228/, http://www.wnylc.com/health/entry/184/

Does Patient Centered Care exist in a climate of managed cost?

Medicaid Managed Care: Fact or Fiction

True or False?

1. Managed Care companies are paid a set rate for enrollees regardless of the level of care.

True

Medicaid Managed Care: Fact or Fiction

True or False?

2. The Managed care company determines if an enrollee is eligible for community based services.

False

Medicaid Managed Care: Fact or Fiction

True or False?

3. The UAS-NY Assessment "tasking tool" determines hours of care.

False

Medicaid Managed Care: Fact or Fiction

True or False?

4. An individual needs to be bed bound in order to qualify for 24-hour care.

False

24-Hour Care Standard in NYS – State Regulation

Available if because of medical condition needs daily assistance with toileting, walking, transferring, turning or positioning:

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

GIS 15 MA/024 (12/2015), 18 NYCRR 505.14(a), (b)(3)(ii)(b),
MLTC Policy 15.09
https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm

Medicaid Managed Care: Fact or Fiction

True or False?

5. Family members living in the same home are not required to provide care.

True

12 OHIP-ADM-01; GIS 97 MA/033

Medicaid Managed Care: Fact or Fiction

True or False?

6. Technology may be used in place of personal care assistance.

True

Medicaid Managed Care: Fact or Fiction

True or False?

7. Safety and supervision as a standalone task is not covered under managed care.

But…"must reflect sufficient time for… safety monitoring, supervision or cognitive prompting for the performance of … particular IADLs or ADLs. https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-07.htm

True

Medicaid Managed Care: Fact or Fiction

True or False?

8. Skilled nursing services are not covered under managed care.

False

Medicaid Managed Care: Fact or Fiction

True or False?

9. Individuals with dementia as their primary diagnosis are not eligible for services.

False

Medicaid Managed Care: Fact or Fiction

True or False?

10. Managed care can be more restrictive than fee for service.

False

Real Life Cases: Pierro, Connor & Strauss

Case of Mrs. S

Local DSS "maximized" her monthly IRA RMD payment

- IRS Life Expect. Table - $5,140.00 per month
- Social Security Life Expect. Table - $10,569.42
  - Difference - $5,429.42 **PER MONTH**

Real Life Cases: Pierro, Connor & Strauss

Case of Mrs. P

Local county wanted to count income from Long Term Care Insurance policy in the month the claim was made, rather than the months the funds were received

- Has major impacts on promissory note cases going forward since the cost of care in a home care case is likely to be much less static and fixed than a nursing home case

REMEMBER:

Betty was only granted five hours.

- What happens next?
- What will Betty most likely face at the internal appeal level?
- What will Betty and her family experience at the external appeal / fair hearing?

PANEL DISCUSSION

Q & A

SESSION II
FRIDAY, JUNE 4
8:30am-12:00pm

Senator Kirsten Gillibrand
U.S. Senate Special Committee on Aging
"Welcome and Remarks" (video)

PAYING FOR LONG-TERM CARE: HOW CAN NEW YORK LEAD THE WAY?

- Washington and State Lawmakers: Long-Term Care Updates
- The Nursing Home Dilemma
- State Agency Leader: Impacts of Covid on Aging in New York
- Insurance Options for LTC
- Holy Grail: Public-Private Financing

NEW! "OPEN FORUM" BREAK-OUT SESSIONS IN ZOOM

12:00-12:30pm

1. Private Insurance Options for LTC
2. Technology Solutions for LTC
3. Public Policy: Medicaid, Medicare & Alternative Solutions