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Supplemental Materials for a Practical Review of the Managed Long-Term Care Medicaid (MLTC) Medicaid Home Care Application Process

Submitted by:
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NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NEW YORK STATE INCOME AND RESOURCE STANDARDS FOR NON-MAGI POPULATION
EFFECTIVE JANUARY 1, 2017

HOUSE HOLD SIZE	MEDICAID INCOME LEVEL		100% FPL		120% FPL		133% FPL		135% FPL		150% FPL		185% FPL		200% FPL		250% FPL		RESOURCES	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY		
ONE	9,900	825	11,880	990	14,256	1,188	15,801	1,317	16,038	1,337	17,820	1,485	21,978	1,832	23,760	1,980	29,700	2,475	14,850	1
TWO	14,500	1,209	16,020	1,335	19,224	1,602	21,307	1,776	21,627	1,803	24,030	2,003	29,637	2,470	32,040	2,670	40,050	3,338	21,750	2
THREE	16,675	1,390	20,160	1,680			26,813	2,235			30,240	2,520	37,296	3,108	40,320	3,360				3
FOUR	18,850	1,571	24,300	2,025			32,319	2,694			36,450	3,038	44,955	3,747	48,600	4,050				4
FIVE	21,025	1,753	28,440	2,370			37,826	3,153			42,660	3,555	52,614	4,385	56,880	4,740				5
SIX	23,200	1,934	32,580	2,715			43,332	3,611			48,870	4,073	60,273	5,023	65,160	5,430				6
SEVEN	25,375	2,115	36,730	3,061			48,851	4,071			55,095	4,592	67,951	5,663	73,460	6,122				7
EIGHT	27,550	2,296	40,890	3,408			54,384	4,532			61,335	5,112	75,647	6,304	81,780	6,815				8
NINE	29,725	2,478	45,050	3,755			59,917	4,994			67,575	5,632	83,343	6,946	90,100	7,509				9
TEN	31,900	2,659	49,210	4,101			65,450	5,455			73,815	6,152	91,039	7,587	98,420	8,202				10
EACH ADD'L PERSON	2,175	182	4,160	347			5,533	462			6,240	520	7,696	642	8,320	694				+

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	$3,022.50	$120,900
Institutionalized Spouse	$50	$14,850
Family Member Allowance	$2,003 (150% of FPL for 2) is used in the FMA formula the maximum allowance is $668.	N/A

SPECIAL STANDARDS FOR HOUSING EXPENSES					
REGION	Amount	REGION	Amount	REGION	Amount
Central	$412	Northeastern	$471	Northern Metropolitan	$892
Rochester	$419	Long Island	$1,285		
Western	$367	New York City	$1,171		

*In determining the community resource allowance on and after January 1, 2016, the community spouse is permitted to retain resources in an amount equal to the greater of the following $74,820 or the amount of the spousal share up to $120,900. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

Revised December 6, 2016

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NON-MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
UNDER 21, ADC-RELATED	MEDICAID LEVEL	825	1,209	NO RESOURCE TEST		
SSI-RELATED	MEDICAID LEVEL	825	1,209	14,850	21,750	Household size is always one or two.
Qualified Medicare Beneficiary (QMB)	100%FPL	990	1,335	NO RESOURCE TEST		Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible.
COBRA CONTINUATION COVERAGE	100%FPL	990	1,335	4,000	6,000	A/R may be eligible for Medicaid to pay the COBRA premium.
AIDS INSURANCE	185%FPL	1,832	2,470	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation.
QUALIFIED DISABLED & WORKING INDIVIDUAL	200%FPL	1,980	2,670	4,000	6,000	Medicaid will pay Medicare Part A premium.
SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMBS)	OVER 100% BUT AT OR BELOW 120% FPL	990	1,335	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
		1,188	1,602			
QUALIFIED INDIVIDUALS (QI-1)	BETWEEN 120% BUT	1,188	1,602	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
	LESS THAN 135% FPL	1,337	1,803			
MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)	250%	2,475	3,338	20,000	30,000	Countable retirement accounts are disregarded as resources effective 10/01/11.

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New York State Income Standards for MAGI Population Effective January 1, 2017														
House Hold	LIF LEVEL		100% FPL		110% FPL		138% FPL		154% FPL		155% FPL		223% FPL	
Size	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY
One	11,948	996	11,880	990	13,068	1,089	16,395	1,367	18,296	1,525	18,414	1,535	26,493	2,208
Two	15,170	1,265	16,020	1,335	17,622	1,469	22,108	1,843	24,671	2,056	24,831	2,070	35,725	2,978
Three	18,289	1,525	20,160	1,680	22,176	1,848	27,821	2,319	31,047	2,588	31,248	2,604	44,957	3,747
Four	21,426	1,786	24,300	2,025	26,730	2,228	33,534	2,795	37,422	3,119	37,665	3,139	54,189	4,516
Five	24,653	2,055	28,440	2,370	31,284	2,607	39,248	3,271	43,798	3,650	44,082	3,674	63,422	5,286
Six	27,249	2,271	32,580	2,715	35,838	2,987	44,961	3,747	50,174	4,182	50,499	4,209	72,654	6,055
Seven	29,935	2,495	36,730	3,061	40,403	3,367	50,688	4,224	56,565	4,714	56,932	4,745	81,908	6,826
Eight	33,122	2,761	40,890	3,408	44,979	3,749	56,429	4,703	62,971	5,248	63,380	5,282	91,185	7,599
Nine	35,340	2,945	45,050	3,755	49,555	4,130	62,169	5,181	69,377	5,782	69,828	5,819	100,462	8,372
Ten	37,559	3,130	49,210	4,101	54,131	4,511	67,910	5,660	75,784	6,316	76,276	6,357	109,739	9,145
Each Add't Person	2,220	185	4,160	347	4,576	382	5,741	479	6,407	534	6,448	538	9,277	774

Revised October 19, 2016

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE 1	HOUSEHOLD SIZE 2	RESOURCE LEVEL 1	RESOURCE LEVEL 2	SPECIAL NOTES
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN	223% FPL	N/A	2,978	NO RESOURCE TEST		Qualified provider makes the presumptive eligibility determination. Cannot spenddown to become eligible for presumptive eligibility.
PREGNANT WOMEN	223% FPL	N/A	2,978	NO RESOURCE TEST		A woman determined eligible for Medicaid for any time during her pregnancy remains eligible for Medicaid coverage until the last day of the month in which the 60th day from the date the pregnancy ends occurs, regardless of any change in income or household size composition. It the income is above 223% FPL the A/R must spenddown to the Medicaid income level. The baby will have guaranteed eligibility for one year.
CHILDREN UNDER ONE	223% FPL	2,208	2,978	NO RESOURCE TEST		If the income is above 223% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level. One year guaranteed eligibility if mother is in receipt of Medicaid on delivery. Eligibility can be determined in the 3 months retro to obtain the one year extension.
CHILDREN AGE 1 THROUGH 5	154% FPL	1,525	2,056	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
CHILDREN AGE 6 THROUGH 18	110% FPL	1,089	1,469	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
	154% FPL	1,525	2,056			
PARENTS/CARETAKER RELATIVES	138% FPL	1,367	1,843	NO RESOURCE TEST		If income is above 138% FPL the A/R may apply for APTC or if chooses to spenddown, must spenddown to the Medicaid Level.
19 AND 20 YEAR OLDS LIVING WITH PARENTS	138% FPL	1,367	1,843	NO RESOURCE TEST		If income is above 155% FPL the A/R can apply for APTC or if chooses to spenddown, must spenddown to Medicaid level.
	155% FPL	1,535	2,070			
SINGLE/CHILDLESS COUPLES AND 19 AND 20 YEARS LIVING ALONE	100% FPL	990	1,335	NO RESOURCE TEST		S/CCs cannot spenddown , but can apply for APTC. 19 and 20 year olds if income over 138% may apply for APTC or if chooses to spenddown, must spenddown to the Medicaid level.
	138% FPL	1,367	1,843			
FAMILY PLANNING PROGRAM	223% FPL	2,208	2,978	NO RESOURCE TEST		Eligibility determined using only applicant's income.

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2017 Medicaid Levels and Other Updates
EFFECTIVE DATE:	January 1, 2017
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the levels and figures used in determining Medicaid eligibility effective January 1, 2017.

Due to a 0.3 percent cost of living adjustment (COLA) for Social Security Administration (SSA) payments effective January 1, 2017, several figures used in determining Medicaid eligibility must be updated. Since the increase to the Supplemental Security Income (SSI) benefit levels was relatively small, the Medically Needy Income and Resource Levels will remain the same.

Due to the low COLA and a statutory "hold harmless" provision designed to ensure that a beneficiary's Social Security benefit is not lower in January than it was in December due solely to the increase in Medicare Part B premiums, Medicare Part B premiums will vary depending on the amount of an individual's Social Security benefit in 2017. Medicare Part B premiums will increase by the amount of the individual's Social Security COLA. The net result of the COLA increase for many Medicaid recipients will be a $0 change in net available monthly income.

Since information concerning the manner in which Medicare Part B premiums would be impacted by the COLA was not received in time to make the necessary changes for the scheduled Mass Re-Budgeting (MRB) upstate, it was decided not to perform the MRB. While the MRB will not occur, the MBL tables and figures will be updated to reflect the 2017 figures. The updated MBL tables for upstate will be available December 5, 2016 and for New York City on December 9, 2016.

A chart with the new Medicaid levels is attached. MBL will be programmed to use these figures when a "From" date of January 1, 2017, or greater is entered.

Note: Budgets with a "From" date of January 1, 2017, or later, that utilize an FPL, must be calculated with the 2016 Social Security benefit amount and Medicare Part B premium until the 2017 FPLs are available on MBL. Upstate districts should separately identify these cases for re-budgeting once the 2017 FPLs are available as these cases will not be included in Phase Two of Mass Re-budgeting. In New York City, the 2016 Social Security benefit amounts and Part B premium should be used until Phase Two of Mass Re-budgeting. Upstate districts are instructed to update Social Security benefit amounts and Medicare Part B premiums for budgets that do not utilize a FPL at next contact or recertification, whichever occurs first.

The following figures are effective January 1, 2017.

1. Medically Needy Income and Resources Levels.

HOUSEHOLD SIZE	MEDICALLY NEEDY INCOME LEVEL		RESOURCES
	ANNUAL	MONTHLY	
ONE	9,900	825	14,850
TWO	14,500	1,209	21,750
THREE	16,675	1,390	
FOUR	18,850	1,571	
FIVE	21,025	1,753	
SIX	23,200	1,934	
SEVEN	25,375	2,115	
EIGHT	27,550	2,296	
NINE	29,725	2,478	
TEN	31,900	2,659	
EACH ADD'L PERSON	2,175	182	

2. The Supplemental Security Income federal benefit rate (FBR) for an individual living alone is $735/single and $1,103/couple.
3. The allocation amount is $384, the difference between the Medicaid income level for a household of two and one.
4. The 249e factors are .968 and .159.
5. The SSI resource levels remain $2,000 for individuals and $3,000 for couples.
6. The State Supplement is $87 for an individual and $104 for a couple living alone.
7. The Medicare Part A Hospital Insurance Base Premium is $227/month for people having 30-39 work quarters and $413/month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters. The standard Medicare Part B monthly premium for beneficiaries with income less than or equal to $85,000 is $134.
8. The Maximum federal Community Spouse Resource Allowance is $120,900.
9. The Minimum State Community Spouse Resource Allowance is $74,820.
10. The community spouse Minimum Monthly Maintenance Needs Allowance (MMMNA) is $3,022.50.
11. Maximum Family Member Allowance is $668 until the FPLs for 2017 are published in the Federal Register.
12. Family Member Allowance formula number remains $2,003 until the FPLs for 2017 are published in the Federal Register.
13. Personal Needs allowance for certain waiver participants subject to spousal impoverishment budgeting is $384.
14. Substantial Gainful Activity (SGA) is: Non-Blind $1,170/month, Blind $1,950/month and Trial Work Period (TWP) $840/month.
15. SSI-related student earned income disregard limit of $1,790/monthly up to a maximum of $7,200/annually.
16. The home equity limit for Medicaid coverage of nursing facility services and community-based long-term care is $840,000.
17. The special income standard for housing expenses that is available to certain individuals who enroll in the Managed Long Term Care program (See 12 OHIP/ADM-5 for further information) vary by region. For 2017, the amounts are: Northeastern $471; Central $412; Rochester $419; Western $367; Northern Metropolitan $892; Long Island $1,285; and New York City $1,171.

Please direct any questions to the Local District Support Unit at 518-474-8887 for Upstate and 212-417-4500 for NYC.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services

Date of Issuance: November 17, 2016

On December 30, 2015, the Department notified all managed long term care ("MLTC") plans of recent changes to the Department's regulations governing personal care services ("PCS") and consumer directed personal assistance ("CDPAS"), including revised regulatory provisions governing notices that deny PCS or CDPAS or propose to reduce or discontinue PCS or CDPAS. (See MLTC Policy 15.09 at http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm.).

The purpose of this directive is to provide further guidance to MLTC plans concerning appropriate reasons and notice language to be used when proposing to reduce or discontinue PCS or CDPAS. In particular, it addresses notices that propose to reduce or discontinue PCS or CDPAS for either of the following reasons: a change in the enrollee's medical or mental condition or social circumstances; or a mistake that occurred in the previous authorization or reauthorization.

A MLTC plan may not reduce or discontinue an enrollee's PCS or CDPAS unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi), for PCS, and 18 NYCRR §§ 505.28(h)(5)(ii)(a) through (f), for CDPAS. Two such examples are discussed in greater detail below. The MLTC plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering the facts of the individual enrollee's circumstances and thus cannot reduce services as part of an "across-the-board" action that does not consider each individual enrollee's particular circumstances and need for assistance.

The general purpose of these requirements is to assure that the plan's notice accurately advises the enrollee, in plain comprehensible language, ***what*** the plan is proposing to change with regard to the enrollee's PCS or CDPAS and ***why*** the plan is proposing to make that change. The more specificity the plan's notice provides with regard to the specific change in the enrollee's services, the reason for the change, and why the prior services are no longer needed, the better able the plan will be to defend its proposed reduction or discontinuance at any fair hearing, at which the plan bears the burden of proof to support its proposed action (i.e. the plan must establish that its proposed reduction or discontinuance is correct).

A. Change in Enrollee's Medical or Mental Condition or Social Circumstances

In such a case, the Plan's notice must indicate:

- The enrollee's medical or mental condition or social circumstances have changed and the plan determines that the services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. If the reason for the proposed reduction or discontinuance is a change in one or more such conditions or circumstances, the plan's notice must not simply recite the underlined language in the previous sentence, which would impermissibly make it the enrollee's responsibility to figure out which particular condition or circumstance had changed. Such boilerplate recitations are inadequate. Instead, the plan's notice must:

  1) state the enrollee's particular condition or circumstance - whether medical condition, mental condition, or social circumstance – that has changed since the last assessment or authorization;

  2) identify the specific change that has occurred in that particular medical or mental condition or social circumstance since the last assessment or authorization; and

  3) state why the services should be reduced or discontinued as a result of that change in the enrollee's medical or mental condition or social circumstances.

  Example of a change in medical condition: The plan authorized an enrollee for personal care services. At the time of the assessment, the enrollee was recuperating from hip replacement surgery. As the enrollee recovered from her surgery, her medical condition improved. Specifically, the enrollee's hip has now healed sufficiently that she is now able to walk 30 feet alone. The physician's order documented this improvement in her medical condition. Due to the improvement in her medical condition, she no longer needs the previously authorized level and amount of assistance with personal care services. Accordingly, the enrollee no longer needs help ambulating inside her apartment.

  Example of a change in social circumstances: The plan had authorized an enrollee for Level II personal care services, support with dressing. At the time of the initial authorization, the enrollee lived in her longtime residence with no family or friends who could help dress and undress. Her sister then moved next door and agreed to help with this task. Due to the change in the enrollee's social supports, she no longer needs the previously authorized amount of assistance for dressing and undressing.

B. Mistake

In such a case, the Plan's notice must indicate:

- A mistake occurred in the previous PCS or CDPAS authorization or reauthorization. The plan's notice must identify the specific mistake that occurred in the previous assessment or reauthorization and explain why the prior services are not needed as a result of the mistake.

  Plans must adhere to the following guidelines when proposing to reduce or discontinue services based on a mistake that occurred in the previous assessment or reassessment:

  1) A mistake in a prior authorization or reauthorization is a material error that occurred when the prior authorization was made. An error is a material error when it affected the PCS or CDPAS that were authorized at that time.

     Example of a mistake: The plan authorized, among other services, assistance with the Level I task of doing the enrollee's laundry. This authorization, however, was based on an erroneous understanding that the enrollee's apartment building did not have laundry facilities and that the aide would need to go off-site to do the enrollee's laundry. During a subsequent assessment, it was determined that the aide did, in fact, have access to a washer and dryer in the basement of the enrollee's apartment building. The plan thus proposed to reduce the time needed for the aide to perform the enrollee's laundry to correct the prior mistake and reflect that less time is needed to complete this task than was previously thought.

  2) This particular reason for reducing or discontinuing services is intended to allow an MLTC to rectify a material error made in a previous authorization for a particular enrollee. It must not be expanded beyond that narrow application or otherwise used as a reason to reduce services across-the-board or reduce services for a particular enrollee without a legitimate reason as described in this policy directive. For example:

     - A MLTC plan must not implement a new task-based assessment tool that contains time or frequency guidelines for tasks that are lower than the time or frequency guidelines that were contained in the plan's previous task-based assessment tool, and then reduce services to an individual or across-the-board on the basis that a "mistake" occurred in the previous authorization.

- A MLTC plan must not reduce services when implementing a new task-based assessment tool, if those services were properly contained in the former task-based assessment tool, on the basis that a "mistake" occurred in the previous authorization.

3) A prior authorization for PCS or CDPAS is *not* a mistake if it was based on the UAS-NY assessment that was conducted at that time but, based on the subsequent UAS-NY assessment, the enrollee is determined to need fewer hours of PCS or CDPAS than were previously authorized.

In such a case, a subsequent assessment might support the plan's determination to reduce or discontinue services for one of the reasons enumerated in NYCRR §§ 505.14(b)(5)(v)(c)(2)(i)-(vi) for PCS and 18 NYCRR §§ 505.28(h)(5)(ii)(a)-(f) for CDPAS. For example:

- There has been an improvement in the enrollee's medical condition since the prior authorization. In such a case, the MLTC plan's notice must identify the specific improvement in the enrollee's medical condition and explain why the prior services should be reduced as a result of that change, as set forth above.

Plans are reminded that enrollees are entitled to timely (i.e. 10 day prior notice) and adequate notice whenever plans propose to reduce or discontinue PCS or CDPAS or other services. All partially capitated plans must also use the State-mandated fair hearing notices. In additions, plans must comply promptly with all aid-continuing directives issued by the NYS Office of Temporary and Disability Assistance.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services

Date of Issuance: November 17, 2016

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.

If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring,

supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates.

NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night**.** A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link:

http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at mltcworkgroup@health.ny.gov.

MLTC Policy 16.08

- Policy is also available in Portable Document Format (PDF)

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.08: Conflict Free Evaluation and Enrollment Center (CFEEC) Update to Expiration of Evaluations

Date of Issuance: December 16, 2016

The purpose of this policy is to inform all Managed Long Term Care (MLTC) plans that the Department of Health (the Department) has extended the amount of time a consumer's CFEEC evaluation for Community Based Long Term Care (CBLTC) services remains valid.

When the Department implemented CFEEC, we incorporated the requirement that any individual voluntarily seeking CBLTC services could not be enrolled into an MLTC plan until the CFEEC conducted an evaluation determining CBLTC eligibility. At that time, and in accordance with the September 29, 2014 frequently asked questions, a consumer's CFEEC evaluation was only valid for sixty (60) days.

Effective immediately, the CFEEC evaluation for CBLTC eligibility is valid for seventy-five (75) days. After such time, a new evaluation will be required if the consumer does not select an MLTC plan but continues to seek CBLTC.

This change only applies to the expiration of the consumer's CFEEC evaluation and in no way impacts the MLTC plan's assessment period.

Should you have questions regarding this information, please email the following address: CF.Evaluation.Center@health.ny.gov

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

May 2015, revised Dec. 2016

Explanation of the CFEEC and MLTC Evaluation Process for New Applicants

PART 1 – REQUEST CONFLICT FREE "CFEEC" ASSESSMENT

Now that your client was approved for Community Medicaid with or without a spend down and your client has a CIN #, you or the family has to arrange for the client to be evaluated through the Conflict Free Evaluation and Enrollment Center (CFEEC), run by New York Medicaid Choice or Maximus, a state contractor. Website: https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care. The purpose of this evaluation is for the nurse to determine that your client meets the eligibility criteria for enrollment into a Managed Long term Care.

You may schedule an evaluation before you have been approved for Medicaid but remember that the CFEEC evaluation is only valid for 75 days (increased from 60 days on Dec. 16, 2016). See NYS MLTC Policy 16.08, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-08.htm. If you are not enrolled in an MLTC plan within 75 days of your CFEEC evaluation, then you will have to have another CFEEC evaluation.

What does CFEEC evaluate?

- That you require at least 120 days of Community Based Long Term Care Services (CBLTC = Personal care services, CDPAP, Private Duty Nursing etc.).
- The CFEEC evaluation will not determine the number of hours that you qualify for. That step comes later.

REQUEST CFEEC phone 1-855-222-8350 Monday – Friday 8:30 am to 8:00 pm Saturday 10:00 am to 6:00 pm.

- When you call this phone number to arrange for the evaluation through CFEEC, please have the following information about your client:
  - Full name, address, DOB, SSN, Medicaid number, phone number.

Once you make it through all the prompts, you will speak to a representative at CFEEC and schedule the nurse's evaluation. The CFEEC representative will ask you and/or remind you of the following:

1. The evaluation will be about three hours long.
2. The evaluation can be done either in the morning or in the afternoon
3. Weekend appointments are available but have more limited availability
4. Provide instructions for getting to the apartment (nearest subway, doorbell working, any other tips to ensuring access to the apartment/home)

5. Have your health insurance cards available to show the nurse on the day of the evaluation
6. Have all medications accessible to show the nurse
7. Have the name and phone number of your primary care physician
8. Provide the name and phone number of the individual who should receive a reminder call the day before the evaluation

During the actual evaluation, it will be important for someone who knows the client to be present because it is critical for someone to explain to the nurse the ways in which the client requires assistance with ADLs (activities of daily living).

1. Bathing, grooming, dressing, meal preparation, reheating, chores,
2. assistance with ambulation (use of a cane or walker, indoor and outdoor)
3. transfers (getting up/down from a seated position, getting up/down from a laying position),
4. toileting (use of diapers or liners any incontinence of bowel or urine)
5. You want to mention if the client needs reminder, prompting/cueing to perform any of the tasks indicated above). For example, the client can get into the bath tub, but does not wash himself properly, leaves soap in his/her hair if you do not assist him, can't regulate temperature of the water, needs to be reminded etc. (Not sure if this applies etc.)

At the end of the evaluation, the nurse will tell you if you passed the "test" (meaning that you were found eligible for MLTC enrollment). The nurse will also ask you if you have selected an MLTC plan for the next evaluation. If you know the name of the MLTC plan, tell the nurse and then the nurse can help you arrange the second evaluation with the MLTC plan of your choice. (**better to have a plan in mind, but not required)**

If you do not have an MLTC plan in mind, then you can call back the CFEEC 1-855-222-8350 and they can advise you on which plans to contact for evaluations. There are many plans so it is not feasible to call all of them. You may also call the MLTC plans directly.

Resources for Additional Information on CFEEC:

- New York Health Access http://www.wnylc.com/health/news/41/
- NYS Department of Health http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
- New York Medicaid Choice https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care

PART 2: MLTC Evaluation:
(only after CFEEC says you were found eligible for MLTC enrollment)

The second evaluation is conducted by one or more MLTC plans. You can schedule multiple appointments with different MLTC plans. The reason why you would have more than one plan evaluate you is because you want to ensure that you enroll in an MLTC plan that approves you for the services that you need. You have no obligation to sign enrollment paperwork with the MLTC plan at the time of the evaluation. You can shop around until you choose a plan that meets your needs.

We recommend that you enroll with the first MLTC plan that visits your client:

1. if this plan approves your client for the hours that he/she needs and
2. if your client receives dental, audiology, podiatry, and/or optometry services, then make sure that the MLTC plan you choose has the client's providers within its network

We see no reason to shop around if you were approved for the hours/services you were requesting and as applicable, if the MLTC plan works with your providers within those specialties. Remember that you would like to be enrolled in an MLTC as soon as possible so that you can begin to receive long term care services.

You must be enrolled and the plan must submit your enrollment paperwork by the 19th of the month for services to start on the 1st of the following month.

The MLTC evaluation will also be like the evaluation conducted by the CFEEC. You will have to provide the MLTC plan nurse with your health insurance cards, medications, and information about your physician. You will also have to highlight and discuss with the MLTC plan's nurse the ADL needs of your client (see above section on ADL needs, page #2).

Additional Resources:

- Here is a list of MLTC plans
  http://www.wnylc.com/health/entry/114/#List%20of%20Plans
- Services provided by the MLTC plan
  http://www.wnylc.com/health/entry/114/#MLTC%20service%20package

What is MLTC?

An introduction to Managed Long Term Care by the Independent Consumer Advocacy Network

Community Service Society | Fighting Poverty Strengthening New York

ICAN
Independent Consumer Advocacy Network

How to use this brochure

You can read this brochure from the beginning if you don't know anything about managed long term care.

You can also use the Table of Contents to skip straight to your question.

If there's anything you don't understand or want more information about, you can always call ICAN at **(844) 614-8800**.

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ICAN
Independent
Consumer Advocacy
Network

Health insurance pays for medical care like doctors, hospitals and drugs.

But most health insurance doesn't pay for **long term care.**

What is MLTC?

MLTC stands for **Managed Long Term Care**.

Long term care means services that help you with your daily activities. Examples are home care attendants, day care programs, and nursing homes. You might need long term care services if you need another person to help you clean your home, get dressed, or take a shower.

Many New Yorkers who need long term care get it through Medicaid. And most people with Medicaid must get their long term care through an MLTC program.

The "M" in MLTC stands for managed. MLTC is a type of health insurance called managed care. You must join a plan offered by a private health insurance company to get Medicaid to pay for your long term care. Medicaid pays these companies to provide long term care to their members.

In order for the plan to pay for your care, you must go to providers in the plan's network.

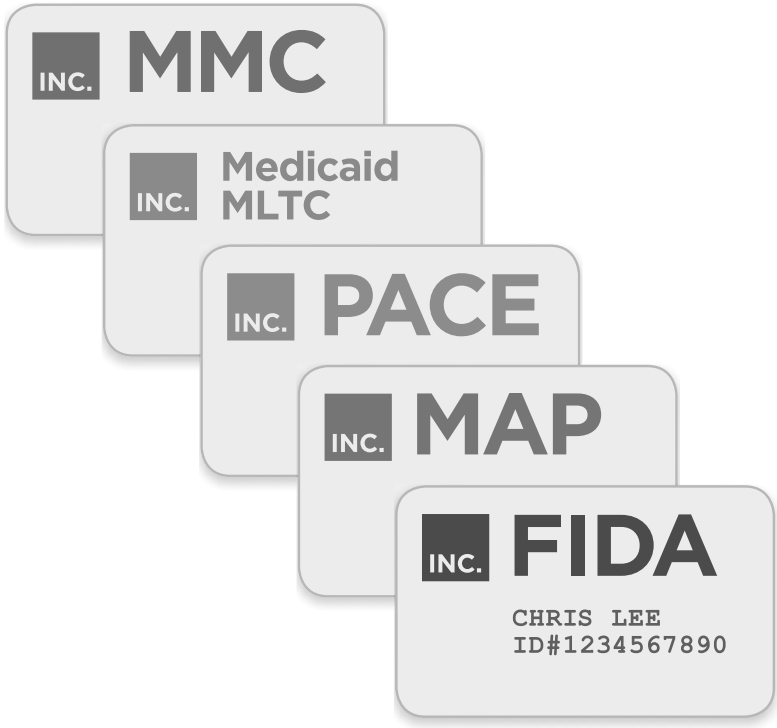
All of the five MLTC programs described below cover services like home care, adult day care, nursing home care, medical supplies, and transportation services. However, availability of other long term care services varies among the five programs.

When you join an MLTC plan, you will get a **Care Manager**.

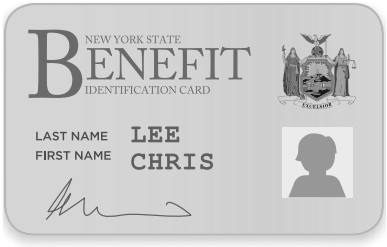
This person will visit you at least twice a year and help you get the care you need. You can call your care manager whenever you have questions or problems.

What kinds of MLTC plans are there?

There are **five** different kinds of Medicaid health insurance that include long term care. Each kind of plan may cover different services. But all plans of the same kind must cover the same services. Which kind is right for you depends on whether you also have Medicare.



If you have Medicaid but don't have Medicare:



you probably get your Medicaid health insurance through a **Mainstream Medicaid Managed Care (MMC)** plan.

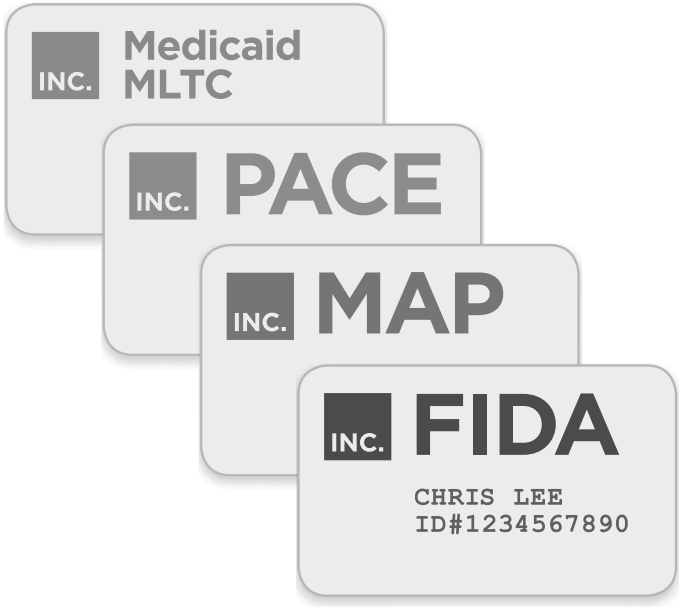
Mainstream Medicaid Managed Care (MMC)

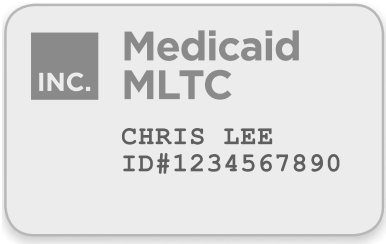
These plans cover all of your doctors, hospitals, medications, and also your long term care services. You generally do not need a separate MLTC plan to get long term care services.

If you have Medicaid only and need long term care, the rest of this brochure does not apply to you. Call ICAN for help (see p.18).

If you have Medicare and Medicaid:

then you can choose from the following four kinds of plan:





Medicaid MLTC

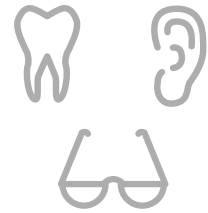
Most people with MLTC have this kind of plan, also called “partial-capitation MLTC.” It is called “partial” because it only covers part of your health care.

You would still have traditional Medicare and Medicaid for your doctors, hospitals, and other medical care.

Medicaid MLTC plans cover long term care and a few other services. With this type of plan, you would use your Medicare health insurance for your medical care. You could continue to see the same doctors you see now, because your Medicare health insurance would not change.

Here are some of the services covered by Medicaid MLTC:

- Home care
(including personal care, home health aide, and Consumer Directed Personal Assistance)
- Adult day care
- Private duty nursing
- Physical/Occupational/Speech therapy
- Transportation to medical appointments
- Home delivered meals
- Medical equipment and supplies
- Hearing aids and audiology
- Eyeglasses and vision care
- Dental care
- Podiatry
- Nursing home

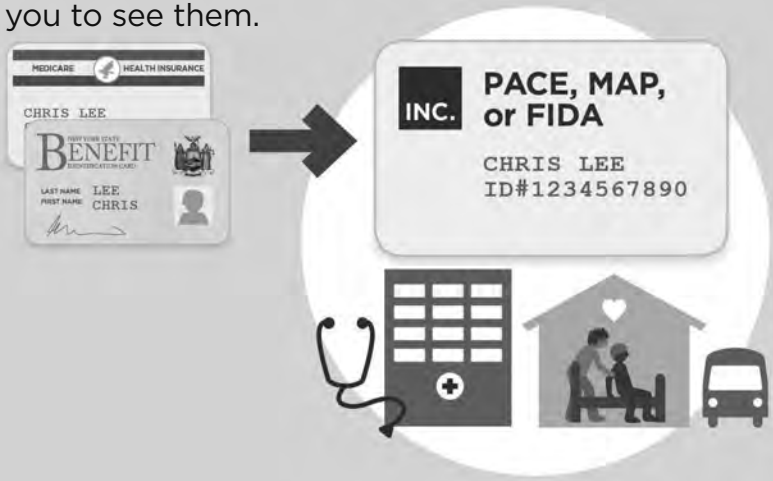


Fully-Capitated Plans

The following three types of plan include all of the same services as Medicaid MLTC. But they **also** include all of your Medicare benefits.

They are sometimes called **fully-capitated** plans, because they are paid to provide both your Medicare and Medicaid benefits. With these plans, you would no longer use your Medicare card to get medical care. Everything would be through your plan. These plans are more convenient because you have only one insurance plan to worry about.

However, you need to make sure your doctors take the plan before you join. You also need to make sure that the hospitals, pharmacies, and other providers you use are in the plan's **network**. If your provider is not in the plan's network, then your insurance will not pay for you to see them.



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

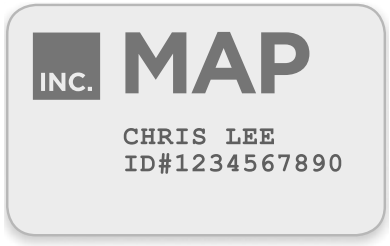
PACE combines Medicare, Medicaid and long term care services under one plan.

You have to be at least 55 years old to join PACE.

If you join a PACE, you must go to a center in your neighborhood to get most of your care.

The PACE center includes doctors and nurses who coordinate your care, as well as adult day care, meals, and other services.

PACE is not available everywhere in the State. But it is a great option for people who live near a PACE center.

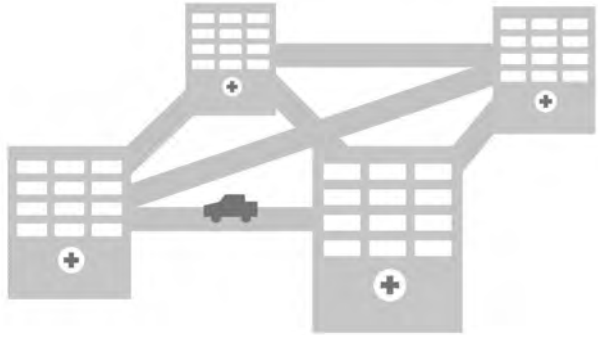


Medicaid Advantage Plus (MAP)

Medicaid Advantage Plus is like a Medicare Advantage[1] plan combined with an MLTC plan. Like PACE, MAP includes all Medicare, Medicaid and long term care services.

Age requirements vary among plans from 18+ to 65+.

Unlike PACE, there is no center you need to go to for your doctors and other care.



1. Medicare Advantage is a way to get your Medicare health insurance through a private managed care plan. Some Medicare beneficiaries choose to enroll in these plans.

Fully Integrated Duals Advantage (FIDA)

FIDA is a new type of health insurance that provides better coordination for people with Medicare and Medicaid.

Like PACE and MAP, FIDA combines all of your Medicare, Medicaid and long term care services into one plan.

In FIDA, you would be part of a **team** that can help you make decisions about your health care. Depending on your personal preferences, this team can include any family members or friends who help you, your doctor, and your care manager at the plan.

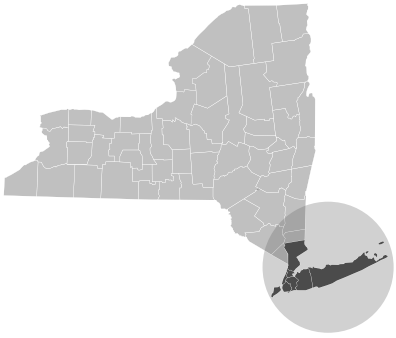
This team helps get you the services you need and makes sure all the parts of your health care are working together smoothly.

FIDA also covers some special services, like home modifications, non-medical transportation, house calls by doctors, and services to help you move out of a nursing home into the community.

Some FIDA plans even give you a card you can use to buy over-the-counter items from the drug store.

If you want to have your Medicare and Medicaid benefits combined, FIDA is probably your best option.

FIDA is only available in New York City, Nassau, Suffolk, and Westchester.[2]



To learn more about FIDA, see our brochure called "**Is FIDA right for me?**"

There is also a special FIDA plan for people with intellectual or developmental disabilities, called FIDA-IDD. To learn more, see our brochure called "**A Plan for Me: FIDA-IDD**."

2. As of June 2016, FIDA is not yet available in Suffolk and Westchester counties.

Who must join an MLTC plan?

You must join a Plan if you answer "yes" to all of these questions:

Are you currently enrolled in Medicare?	☐ yes ☐ no
Are you currently enrolled in Medicaid?	☐ yes ☐ no
Do you need long-term home care, adult day health care, nursing home, or other long term care?	☐ yes ☐ no
Are you age 21 or older?	☐ yes ☐ no

If you answered "yes" to all of the questions, then you must choose a plan.[3] You can choose a Medicaid MLTC, PACE, MAP or FIDA plan.

You will only be able to receive long term care services by joining a plan.

If you are already **receiving** Medicaid long term care services, you may already have been switched into an MLTC plan.

If you are **applying** for Medicaid long term care, you must choose an MLTC plan once you are approved for Medicaid.

3. There are a small number of exemptions, even if you answered "yes" to all of these questions. Call ICAN at (844) 614-8800 to find out more.

ICAN can help you.

We can:

- **Answer your questions** about Managed Long Term Care plans.
- **Give you advice** about your plan options.
- **Help you enroll** in an MLTC 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.**

Call **844-614-8800**.

If you are hearing or speech impaired, you can use the NY Relay service by dialing **711**.

Email **ICAN@cssny.org**.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Consumer Advocacy
Network

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ICAN is a program of Community Service Society of New York, funded by New York State. The opinions, results, findings and/or interpretations of data contained in this brochure are the responsibility of CSS and do not necessarily represent the opinions, interpretations or policy of the State. Design by Imaginary Office. Updated July 2016.

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

December 15, 2016

Temporary Non-Immigrants

The following ALERT is to advise Hospitals, Community Based organizations and Providers of instructions received from New York State in Administrative directive 16 MA-002, Changes in Medicaid Coverage for Temporary Non-Immigrants. These changes are effective immediately.

Temporary non-immigrants are individuals who are allowed to enter the United States temporarily for a specific purpose and for a specific period of time. They are commonly referred to as short-term visa holders (e.g., tourists, students and visitors for the purpose of business). MAP-3123, **Residency Review Worksheet** has been created for use in determining whether or not a Temporary Non-Immigrant has met the SDOH-defined residency requirement for full Medicaid evaluation.

Prior to this recent change in State policy, Temporary Non-Immigrants could only be evaluated for Treatment of Emergency Medical Condition (07 Coverage). However, based upon new policy, **these individuals may now be eligible for full Medicaid coverage if they have established residency.**

Effective immediately, as a condition of Medicaid eligibility, Temporary Non-Immigrants are required to complete and return the attached MAP-3123, along with any documentation required as a result of the responses that they provided. If an application for someone meeting this criteria is received without this form, staff will **defer applications and renewal applications for these non-immigrants who fail to complete MAP-3123.** At renewal, all consumers with 07 coverage will be deferred for completion of MAP-3123 to ensure that recipients who only have coverage for emergency services are given the opportunity complete the Residency Review Worksheet and be evaluated for additional coverage.

Consumers will be given 15 days to provide proof of residency pursuant to the answers they provided on the MAP-3123. If they fail to return the MAP-3123 in response to the deferral notice, the case will be denied or closed for failure to respond.

Consumers returning completed MAP-3123 forms with "No" responses to all questions will be deemed as failing the New York State Residency test and are eligible only for evaluation for Emergency Medicaid (07 Coverage).

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

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Steven Banks, *Commissioner* ♦ **Karen Lane,** *Executive Deputy Commissioner* ♦ **Maria Ortiz-Quezada**, *Director of EIS*

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

October 21, 2016

Clarification on Institutional Medicaid for PRUCOL Individuals

An individual's status as "PRUCOL" should not be used as a factor in determining the need for nursing home services nor in nursing home admittance. The term "Permanently Residing Under the Color of Law" (PRUCOL) is a public benefit eligibility status.

HRA determines an individual's PRUCOL eligibility as part of the Medicaid eligibility process. An individual, otherwise eligible and determined to be PRUCOL, is eligible for Medicaid regardless of level of service or the category of assistance. MAGI and non-MAGI individuals determined to be PRUCOL are eligible for the same Medicaid coverage as citizens.

Eligible PRUCOL individuals will receive Medicaid coverage for all care and services including long term nursing home care. In addition, lack of a green card or social security number is **not** a basis to deny admittance to a nursing home or long term care services. Admittance to a nursing home or long term care services must be based on need and Medicaid eligibility, not immigration status.

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Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

September 23, 2016

Submission of Foreign Passports to Determine Immigrant Eligibility

When submitting copies of foreign passports as proof of immigration status for any consumer who is not a U.S. citizen, it is very important that you include copies of all pages with any markings: passport stamps, Visas, annotations, etc. This information is needed to properly determine Medicaid eligibility. HRA will review all markings in foreign passports to make an immigrant eligibility determination.

When copying pages of a foreign passport, please pay particular attention to the copy/scanning quality. Stamp on foreign passports are often difficult to copy. It may be necessary to choose the darken option on the copier to ensure the information is readable.

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Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

November 23, 2016

Applying for Entitlement and Benefits

This Alert is to inform Client Representatives, Providers, Hospitals, Managed Long Term Care (MLTC) Plans, Nursing Homes of instructions provided by New York State of Health in GIS 16 MA/12 regarding entitlements or other benefits for which an applicant/recipient may reasonably appear to be eligible, but for which s/he has not applied.

Applicants/recipients (A/Rs) who are eligible for or reasonably appear to meet the eligibility criteria for an entitlement benefit which would reduce or eliminate the need for assistance and care, are required to apply for and fully utilize such benefits as a condition of Medicaid eligibility. Entitlement benefits include Unemployment Insurance Benefits (UIB), Social Security Retirement, and Survivors and Disability Insurance (RSDI). For example, if someone has zero income ($0.00) but also discloses that s/he has a work history and recently lost a job, requiring the A/R to apply for UIB would be appropriate. If an A/R indicates zero income and s/he is disabled and unable to work and has a work history, applying for Social Security Disability benefits would be an appropriate referral.

With the increase in the retirement age for full Social Security retirement benefits, many individuals are delaying retirement and continue to work full time. When an A/R is still working full time, they **are not required to apply for Social Security Retirement benefits as a condition of eligibility**. However, if an A/R is not working full-time, they are required to apply when they become eligible at age 62. A/R's can attest whether s/he works part-time or full-time. This policy is applicable to all Medicaid programs.

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Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

October 19, 2016

Immediate Need for Personal Care or Consumer Directed Personal Assistance Services

The purpose of this Alert is to inform Medicaid providers, community based organizations and others assisting Medicaid clients of the procedure for requesting Immediate Need Personal Care or Consumer Directed Personal Assistance Services.

I. Consumer with Immediate Need for Home Care Services

In order to be considered a consumer with an Immediate Need for Home Care Services, the consumer must meet the following conditions:

a. Have an immediate need for Personal Care or Consumer Directed Personal Assistance Services;

b. Have no informal caregivers available, able or willing to provide personal care services;

c. Have no home care agency providing needed assistance;

d. Does not have third party insurance or Medicare benefits available to pay for needed assistance;

e. Does not have adaptive or specialized equipment or supplies in use to meet, or has adaptive or specialized equipment or supplies that cannot meet, the person's need for assistance.

A consumer must attest to meeting these conditions by completing and signing the OHIP-0103, **Immediate Need for Personal Care Services/Consumer Directed Personal Care Services: Informational Notice and Attestation Form**.

II. Submission of an Immediate Needs Request

A new transmittal, HCSP-3052, **Immediate Need Transmittal to the Home Care Services Program** has been developed to facilitate Immediate Needs Requests. Required documents vary depending on whether or not the consumer is already in receipt of Medicaid with coverage for long term care, needs

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to upgrade their Medicaid coverage to include long term care or needs to apply for Medicaid. These requirements are detailed on the transmittal.

A. Documents to be Submitted

All consumers:

1) Attestation of Immediate Need (OHIP- 0103);
2) Medical Request for Home Care (HCSP-M11q). If the M-11q is not readily available a physician's order may be submitted for purposes of determining if the consumer has an immediate need for an expedited Medicaid eligibility determination. A M-11q is required to begin the expedited immediate need home care service assessment and determination;
3) Authorization for Release of Health Information Pursuant to HIPAA (OCA-960). This is needed to be able to discuss case with person(s) other than the client)
4) Optional (but strongly recommended) – A cover letter that includes an explanation of the immediate need, the status of consumer's current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), etc.

Consumers with active Medicaid coverage that needs to be upgraded to include community based long term care, also must submit:

1) A completed Access NY Supplement A (DOH-4495A)*

*** Note:** For purposes of the eligibility determination, a consumer who would otherwise be required to document his or her accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts.

Consumers without active Medicaid also must submit:

1) A completed Access NY Insurance Application (DOH-4220)
2) A completed Access NY Supplement A (DOH 4495A)*

*** Note:** For purposes of the eligibility determination, a consumer who would otherwise be required to document his or her accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts.

Consumers with Medicaid coverage on the Health Exchange (NY State of Health):

The consumer/representative must contact NY State of Health (855-355-5777 or via email (hxfacility@health.ny.us) to have the Medicaid transferred to HRA. For these consumers the OHIP-0103, **Immediate Need for Personal Care Services/Consumer Directed Personal Care Services: Informational Notice and Attestation Form** and the M-11Q, **Medical Request for Home Care** or physician's order for personal care, must be sent to HRA.

Where to Submit

1) Mail to: HRA HCSP – Attention: Immediate Needs Liaison
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

2) Deliver to: HRA HCSP – Attention: Immediate Needs Liaison
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

3) eFax to: 917-639-0665

III. Processing of Immediate Needs Cases:

The Immediate Need Request packages are logged in and date stamped to establish date of receipt. The expedited processing begins the first calendar day after receipt of the documents. The first calendar day will be referred to as day one (1).

Medicaid Determination

1. Within four (4) calendar days after day one (1), the HCSP Medicaid Eligibility Unit (MEU) will review the submitted documents for completeness to determine if a Medicaid eligibility review can proceed.

   a. If review of the Medicaid Application, Supplement A and supporting documents determines that the package is incomplete, a written notice will be sent to the applicant explaining that the Medicaid processing is deferred. The notice will state what information and/or supporting documents are missing. It will also provide a response due date.

   b. If the Medicaid Application and Supplement A are determined to be complete and all of the required supporting documents are submitted, a Medicaid determination will be made by the seventh day (7th) calendar day after day one (1).

Service Authorization Review

1. On day one (1), the Medical Request for Home Care (M11-q) and cover letter, if applicable, will be scanned and registered in the Long Term Care Web (LTCW) system and reviewed for completeness, accuracy and compliance with NYSDOH regulations.

2. Concurrently, the process of scheduling a home visit will be initiated upon verification of a complete Medicaid Application or conversion request for Medicaid with coverage for Long Term Care.

3. If the HCSP-M11q is found to be complete, accurate and compliant with regulations, a home visit with the applicant will be scheduled. The service authorization review will be completed prior to the twelfth (12^{th}) day from day four.

4. If the HCSP-M11q is found to be incomplete, not accurate or non-compliant with regulations, it will be rejected. A written notice will be sent to the applicant / family / representative stating the reason for the HCSP M11q's rejection. A new Immediate Need request can be submitted with a Attestation form and properly completed M11-q

5. If the applicant is approved for services, the case will be assigned by the 12^{th} day from day four to a HRA contracted License Home Care Services Agency or Fiscal Intermediary as appropriate.

6. If the applicant is not approved for services, a written notice will be sent to the applicant / representative indicating the reason for denial of services.

More information is available in the New York State Department of Health's ADM: 16 OHIP/ADM-02 Immediate Need for Personal Care Service and Consumer Directed Personal Assistance Services.

Please note that in addition to posting the new transmittal (HCSP-3052) and OHIP -0103 forms on MARC, these forms have also been added to HRA's internet site (Long Term Care) page (http://www1.nyc.gov/site/hra/help/long-term-care.page) to help ensure these forms are readily available.

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PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

IMMEDIATE NEED FOR PERSONAL CARE SERVICES/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES: INFORMATIONAL NOTICE AND ATTESTATION FORM

If you think you have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), such as housekeeping, meal preparation, bathing, or toileting, your eligibility for these services may be processed more quickly if you meet the following conditions:

- You have no informal caregivers available, able and willing to provide or continue to provide care;
- You are not receiving needed help from a home care services agency;
- You have no adaptive or specialized equipment or supplies in use to meet your needs; and
- You have no third party insurance or Medicare benefits available to pay for needed help.

If you don't already have Medicaid coverage, and you meet the above conditions, you may ask to have your Medicaid application processed more quickly by sending in: a completed Access NY Health Insurance Application (DOH-4220); the Access NY Supplement A (DOH-4495A or DOH-5178A), if needed; a physician's order for services; and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that does not include coverage for community-based long term care services, you must send in a completed Access NY Supplement A (DOH-4495A or DOH-5178A), a physician's order for services and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that includes coverage for community-based long term care services, you must send in a physician's order for services and a signed *"Attestation of Immediate Need."

If you don't already have Medicaid coverage or you have Medicaid coverage that does not include coverage for community-based long term care services: All of the required forms (see the appropriate list, above) must be sent in to your local social services office or, if you live in NYC, to the Human Resources Administration (HRA). As soon as possible after receiving all of these forms, the social services office/HRA will then check to make sure that you have sent in all the information necessary to determine your Medicaid eligibility. If more information is needed, they must send you a letter, by no later than four days after receiving these required forms, to request the missing information. This letter will tell you what documents or information you need to send in and the date by which you must send it. By no later than 7 days after the social service office/HRA receives the necessary information, they must let you know if you are eligible for Medicaid. By no later than 12 days after receiving all the necessary information, the social services office/HRA will also determine whether you could get PCS or CDPAS if you are found eligible for Medicaid. You cannot get this home care from Medicaid unless you are found eligible for Medicaid. If you are found eligible for Medicaid and PCS or CDPAS, the social services office/HRA will let you know and you will get the home care as quickly as possible.

If you already have Medicaid coverage that includes coverage for community-based long term care services: The physician's order and the signed Attestation of Immediate Need must be sent to your local social services office or HRA. By no later than 12 days after receiving these required forms, the social services office/HRA will determine whether you can get PCS or CDPAS. If you are found eligible for PCS or CDPAS, the social services official/HRA will let you know and you will get the home care as quickly as possible.

The necessary forms may be obtained from your local department of social services or are available to be printed from the Department of Health's website at: http://www.health.ny.gov/health_care/medicaid/#apply

*Found on the back side of this page.

Attestation of Immediate Need
for
Personal Care Services/Consumer Directed Personal Assistance Services

I, _____ attest that I am in need of immediate Personal Care Services
(Name)
or Consumer Directed Personal Assistance Services.

I also attest that:

- no voluntary informal caregivers are available, able and willing to provide or continue to provide needed assistance to me;
- no home care services agency is providing needed assistance to me;
- adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers or wheelchairs, are not in use to meet, or cannot meet, my need for assistance; and
- third party insurance or Medicare benefits are not available to pay for needed assistance.

I certify that the information on this form is correct and complete to the best of my knowledge.

X _____ _____

SIGNATURE OF APPLICANT/ REPRESENTATIVE **DATE SIGNED**

Individuals Receiving Long Term Care Services in a Nursing Home or Hospital Setting

If you are receiving long term care services in a nursing home or a hospital setting and intend to return home, you may have your eligibility for Personal Care Services or Consumer Directed Personal Assistance Services processed more quickly. Follow the directions on the previous page and fill in the information requested below.

I am in a nursing home or a hospital setting and have a date set to return home on _____.
DATE

Contact me or my legal representative by calling_____.

IMMEDIATE NEED TRANSMITTAL TO THE HOME CARE SERVICES PROGRAM

Human Resources Administration
Department of Social Services

HCSP-3052 (E) 09/19/2016

DATE: _____ CONSUMER'S NAME:_____ LAST 4 DIGITS OF CONSUMER'S SSN: _____

From
NAME OF SUBMIITING ORGANIZATION
STREET ADDRESS
CITY, STATE, ZIP CODE

To:
HOME CARE SERVICES PROGRAM – IMMEDIATE NEEDS
785 ATLANTIC AVENUE, 7th Floor
BROOKLYN, NY 11238

I am submitting this application package on behalf of the above named consumer for processing as an "Immediate Need" for home care services. S/he wishes to be enrolled in the following program (check one):

☐ Personal Care (PCS) ☐ Consumer Directed Personal Assistance (CDPAS)

I understand that the documentation listed in the table(s) below is **required** for this request to be processed. All are attached and appear to be fully completed.

For **all** Immediate Need Requests

OHIP-0103, **Attestation of Immediate Need**	HCSP M-11q, **Medical Request for Home Care**	OCA-960, **Authorization for Release of Health Information Pursuant to HIPAA**

Also required, in addition to the three items listed above, **if** the consumer already has Medicaid coverage, but it does not include long term care coverage

DOH-4495A, **Access NY Supplement A**	All necessary proofs that apply to this supplemental form **only**, as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Also, required in addition to everything listed in both tables above, **if** the consumer does not already have Medicaid coverage at all

DOH-4220, **Access NY Insurance Application**	All necessary proofs as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Though not required, I understand that submission of a cover letter that includes an explanation of the immediate need, the status of consumer's current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), is strongly recommended.

☐ I have attached a cover letter ☐ I have not submitted a cover letter

Print Name:	Sign Name:	Telephone Number:

Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

11/18/2016

RE: Estate of:
Date of Death:
Recovery Case #:

Dear [redacted]:

Health Management Systems, Inc. (HMS) is the estate recovery contractor of the New York Office of the Medicaid Inspector General. On behalf of the New York State Medicaid Program, we would like to express our sincere condolences for your recent loss. You have received this notice because our records indicate that you are the primary contact for the estate of the deceased Medicaid recipient named above. If this is not correct, please contact the HMS Estate & Casualty Recovery Unit as soon as possible.

Otherwise, it is important that you please read the enclosed "Notice Of Intent To File A Claim Against The Estate" which explains the federal law which requires States to recover costs of certain medical services from the estates of Medicaid recipients. We would also appreciate your notifying any family members or heirs who may be affected by the attached information.

Please contact the HMS Estate & Casualty Recovery Unit regarding this notice at your earliest convenience by calling toll-free at 1-877-331-1460 for further explanation and information. You may also submit this form electronically at submissions.hms.com. For additional information regarding the contract between Health Management Systems, Inc. and the New York Office of the Medicaid Inspector General, please visit www.omig.ny.gov/images/stories/TPL_Summary_for_Website.pdf.

Sincerely,

HMS, Inc.
Estate & Casualty Recovery Unit

NOTICE OF INTENT TO FILE A CLAIM AGAINST THE ESTATE

Notification has been received from federal and state data systems that the named Medicaid recipient is deceased. Our records show that the State of New York provided payment for certain Medicaid covered services for the benefit of the decedent on or after reaching the age of 55. Upon request, we can provide the authorized representative with a detailed list of services billed to Medicaid which are subject to recovery.

In accordance with the estate recovery mandate of the Social Security Act (42 U.S.C. § 1396p), the New York State Medicaid Program is required by federal law to recover the costs of Medicaid services provided, from the estates of Medicaid recipients who were age 55 and older when they received the services. These costs may only be recovered from the decedent's estate in an amount not to exceed the actual Medicaid costs, or the value of the estate's assets, whichever is less. Health Management Systems, Inc., as agent for the Office of the Medicaid Inspector General is responsible for processing the recovery.

Within the next few weeks, you will receive a letter presenting a Medicaid estate recovery claim. This letter will provide the amount of the claim, the payment dates of recoverable services, and payment instructions. As appropriate, the claim may also be filed as a preferred claim pursuant to New York Social Services Law Sections 104 and 369, and New York Surrogate's Court Procedure Act Section 1811 for repayment of medical assistance payments made by the State to or for the benefit of the decedent. Please note that this claim is against the estate of Beverly Berger, and not the personal representative, family members, or heirs.

In some cases, the New York State Medicaid Program will release the estate claim if there is a surviving spouse or an exempt child. An exempt child is either a minor child under the age of 21 or a child of any age who is certified blind or certified disabled. So that we may determine whether an exemption should be applied, we ask that you please complete and return the attached Medicaid Estate Recovery Questionnaire with two weeks of receipt of this notice. **The questionnaire must be completely filled out with all requested documentation and faxed to 877-476-9126 or mailed in the envelope provided.**

If no recovery exemptions apply, but an heir can demonstrate collection of the State's claim would result in a qualified undue hardship, the New York State Medicaid Program may still waive the estate claim. Undue hardship may exist when:

- the estate asset subject to recovery is the sole income-producing asset of the beneficiaries, such as a family farm or family business, and income produced by the asset is limited;
- the estate asset subject to recovery is a home of modest value and the home is the primary residence of the beneficiary; or
- the beneficiary can demonstrate that there are other compelling circumstances.

Undue hardship will not be found to exist based solely on the inability of any of the beneficiaries to maintain a pre-existing lifestyle, or if the alleged hardship is the result of Medicaid or estate planning methods involving divestiture of assets.

To apply for a hardship waiver, please call our office and request the appropriate application forms. All requests for Hardship Waiver Applications must be made to our office **no later than 15 days** from the date of this notice. The actual Hardship Waiver Application must be completed and received no later than 60 days from the date of the request. Undue hardship waiver determinations are evaluated on a case-by-case basis and will be made within 40 days of the receipt of the Application for Hardship Waiver and all required supporting documentation. If no exemptions or approved hardship conditions exist, the State will pursue appropriate recovery measures. For questions regarding this notice, call (877) 331-1460.

An individual who receives this notice and the information contained herein, and who is not a Certified Person as defined in 15 C.F.R. § 1110.2, shall not (i) disclose any information regarding the deceased individual, as contained in this notice, including but not limited to the date of death, to any person other than a person who (a) has a legitimate fraud prevention interest or a legitimate business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty, (b) has systems, facilities, and procedures in place to safeguard such information, and experience in maintaining the confidentiality, security, and appropriate use of such information, pursuant to requirements similar to the requirements of section 6103(p)(4) of the Internal Revenue Code of 1986, and (c) agrees to satisfy such similar requirements; (ii) disclose any information regarding the deceased individual, as contained in this notice, including but not limited to the date of death, to any person who uses the information for any purpose other than a legitimate fraud prevention interest or a legitimate business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty; or (iii) disclose any information regarding the deceased individual, as contained in this notice, including but not limited to the date of death, to any person who further discloses the information to any person other than a person who meets the requirements set forth in item (i)(a)-(b) herein. An individual who receives this notice, and the information regarding the deceased individual contained herein, who further discloses or uses such information in any manner prohibited herein or otherwise prohibited under 15 CFR Part 1110, Certification Program for Access to the Death Master File, shall be subject to the penalty provisions set forth at 15 C.F.R. § 1110.200, and shall pay to the General Fund of the United States Department of the Treasury a penalty of $1,000 for each such disclosure or use, up to a maximum of $250,000 in penalties per calendar year.

NEW YORK ESTATE RECOVERY QUESTIONNAIRE

1. NEW YORK MEDICAID MEMBER'S INFORMATION:

Name: _____

Birth Date: _____

Date of Death: 09/19/2016

2. STATUTORY CLAIM EXEMPTION:

Is there any surviving spouse? If yes, please provide the following information along with a copy of the Deceased Member's Death Certificate. ☐YES ☐NO

Name of Surviving Spouse: _____

Address: _____

City, State Zip _____

Phone: _____

Social Security Number: _____

3. STATUTORY CLAIM EXEMPTION:

Is there a child under the age of 21, or surviving child of any age who is blind or certified as disabled? If yes, please provide the following information along with proof of age, relationship, and disability (Birth Certificate, Benefit Award Letter, and a copy of the most recent federal income tax return).

☐YES ☐NO

Name of Child: _____

Address: _____

City, State Zip _____

Birth Date: _____

Social Security Number: _____

4. STATUTORY CLAIM EXEMPTION:

If the decedent was an American Indian, Alaska Native, or if he had retained government reparation payments at the time of death, the estate might qualify for an exemption. Please contact us at our toll-free number (877) 331-1460 for more information.

[redacted]

5. ASSET INFORMATION:
Did the decedent own a home or other real property at the time of death? ☐YES ☐NO

If yes, please complete the following

Homestead:
Property Address:

_____

Approximate Fair Market Value: _____

County Where Recorded: _____

List any mortgages or liens against the property:

_____

Other Real Property:
Property Address:

_____

Approximate Fair Market Value: _____

County Where Recorded: _____

List any mortgages or liens against the property:

_____

Does the estate contain any personal property? (Bank accounts, vehicle, jewelry, furniture, other personal items of value). If yes, please complete the following. ☐YES ☐NO

Bank Name: _____

Acct#: _____ Balance: _____

Identify any additional Personal Property: _____

_____

_____

6. CONTACT INFORMATION: ☐**Attorney** ☐**Personal Representative** ☐**Guardian**

Name: _____

Address: _____

City, State Zip _____

Phone: _____

Has there been or do you anticipate any third party lawsuits filed on behalf of this Estate? ☐YES ☐NO

Has there been (or will there be) a petition for probate of the estate, or any other document relating to the transfer of property due to the decedent's death? ☐YES ☐NO

Has there been or do you anticipate a filing for an affidavit of heirship or small estate affidavit?

☐YES ☐NO

If yes to any of these, please complete the following information:

Case Number:_____

Date filed: _____County Court:_____

7. ESTATE ADMINISTRATION

Did the decedent have a will? ☐YES ☐NO

If yes and no statutory exemptions exist, please enclose a copy of the will when you return this questionnaire.

8. OTHER INFORMATION

If there are additional circumstances and/or information related to this claim, please include this information in the following section or provide attachments:

_____

_____

_____

_____

_____

Please complete all requested information within two weeks and return this form to:

HMS ESTATE & CASUALTY RECOVERY UNIT
P.O. BOX 167887
IRVING, TX 75016-9971
(877) 331-1460 – TOLL FREE NUMBER
(877) 476-9126 – FAX NUMBER
submissions.hms.com

Preparer Name: _____

Preparer Signature: _____

Date Prepared: _____

Misrepresentation, falsification or submission and/or filing of false statements with a governmental entity for the purpose of achieving financial gain may be punishable by criminal, civil and administrative action, fine and/or imprisonment under Federal Law.

NOTES