C-PR DE

COALITION TO PROTECT THE RIGHTS OF NEW YORK'S DUALLY ELIGIBLE

**Issues and Concerns Related to the Carve-in of the Nursing Home Benefit into Mainstream Managed Care (MMC) and Managed Long Term Care (MLTC)**

**SUMMARY**

SECTION I -- Who is to be Considered "Permanently Placed" Requiring Mandatory Enrollment in MMC or MLTC?

RECOMMENDATIONS:

1. We request that DOH clarify that the LDSS eligibility determination after a "lookback" submission should not trigger mandatory managed care enrollment without a separate, appealable determination based on a medical and functional assessment that the placement is permanent and that community-based services cannot maintain health and safety in the home.

2. We request that DOH clarify that while there is a requirement to file the LDSS 3559, filing the form does not mean the placement is permanent.

3. We request that DOH provide clearer procedures for assigning responsibility for submitting the 5-year lookback application for people already enrolled in MMC or MLTC plans, including requests for non-chronic or community budgeting.

SECTION II - Other Transition Issues

1. Issues Related to Hospital-to-Nursing Home Transitions in MLTC
    a. Contradictory language regarding MLTC coverage of out-of-network nursing home stays:

    b. Transfers between plans (applies to MLTC and MMC):

2. Transfer to NH outside of District of Fiscal Responsibility (DFR):

3. Notice, Fair hearing and Aid Continuing issues
        a. Recommendation for long-term placement:

        b. Community to Nursing Home transition
        .

c. Hospital to nursing home transition or nursing home short-term stay to long-term stay transition:

d. Plan decision to transfer member to a different Nursing Home:

e. Plan decision to deny Nursing Home placement after a short-term stay:

f. Nursing Home resident right to notice and appeal rights if involuntarily discharged from nursing home:

4. Olmstead implications of erroneous assumption that every nursing home resident is in permanent absence status:

    a. We request that DOH incorporate more accurate information regarding the 29-day Short-term rehab benefit into the nursing home transition policy.
    b. We request that DOH expand the 29-day rehab benefit to 90 days, or at a minimum, not include days fully covered by Medicare in the 29-day count.
    c. We request that DOH draft procedures that assign responsibility for requesting Non-Chronic Care Budgeting (Community Budgeting).
    d. We request that DOH make either nursing homes or managed care plans responsible for filing certifications with the Social Security Administration (SSA) in an effort to guarantee that individuals can retain their SSI benefits.
    e. We request that DOH inform plans, nursing homes and LDSS offices of their responsibilities regarding ensuring that individuals are budgeted for the MLTC Housing Disregard upon discharge to the community.

5. Plans' Duty to Assess for Potential Discharge Back to Community and *Olmstead* Concerns

6. Grandfathered Populations – Clarification Needed

7. Networks:

8. Provider Education:

9. Spousal Impoverishment Budgeting:

10. Barriers to Discharge to Community for Individuals who were not in MLTC or MMC Plans
11. Clarification on when CFEEC required for nursing home residents seeking to enroll in MLTC

## SECTION I.

## Who is to be Considered "Permanently Placed" Requiring Mandatory Enrollment in MMC or MLTC?

The New York State Department of Health (DOH) nursing home transition policy casts a wide net to mandate managed care enrollment for virtually everyone admitted to a nursing home, without explicitly discerning between those who are "permanently placed" in a nursing home and those admitted for a short-term stay. This guidance presumes there is some clear determination that an individual is now "permanently placed" in a nursing home or is in need of permanent placement. However, in practice there is not always a clear determination of "permanent placement." Many, if not most people admitted to nursing homes will return to the community after a short-term stay. At the time of admission to the nursing home, it is commonly unknown whether the stay will ultimately be short or long-term. A recent study by the United Hospital Fund (UHF) found a dramatic increase—168 percent—in short-term nursing home admissions in New York from 2000 to 2010.[1] During the same ten year period, the number of short-term residents increased by 79 percent. "The ratio of short-stay patients to long-stay residents doubled over the decade from about 1:2 in 2000 to almost 1:1 in 2010."[2]

For people not already enrolled in a managed care or MLTC plan, the date a placement becomes "permanent" is significant because the individual must now enroll in a managed care/MLTC plan in addition to being approved for institutional care with a 5-year lookback period.

For people who are already enrolled in a managed care or MLTC plan, a plan's decision that a "permanent placement" of a member is medically necessary triggers serious due process concerns. It likely means that the plan is terminating home care or other community-based services based on a determination that community-based services cannot reasonably maintain the member's health and safety. Such a determination must be made with advance written notice to the member, appeal rights and right to receive the home care services pending the hearing. DOH guidance omits any reference to these notice requirements.[3]

---

[1] Research on nursing home trends define short-term patients as those whose last MDS assessment for the calendar year reflected an actual or projected Medicare stay of 90 days or less, compared to long-stay patients whose last assessment for the calendar year did not include a Medicare short stay or an admission with a projected discharge date within 90 days. Thomas H. Dennison**,** *New York's Nursing Homes: Shifting Roles and New Challenges*, United Hospital Fund of New York, available at https://www.uhfnyc.org/publications/880922 **(**Aug. 5, 2013)("UHF NH Study")(page 5).

[2] Id. at 6

[3] If home care services had previously been provided and the plan now determines not to reinstate these services, then plan must provide notice of discontinuance of home care services with the right to reinstate them as Aid Continuing, pursuant to *Granato v Bane* and NYS DSS 99 OCC-LCM-2 (Apr. 20, 1999), reaffirming effectiveness of 96-MA-023 .

The confusion arises from terminology. Terms like “long term placement,” “permanent placement,” “chronic care,” “custodial care” are used interchangeably even though they have different meanings.

**RECOMMENDATIONS:**

1. **We request that DOH clarify that the LDSS eligibility determination after a “lookback” submission should not trigger mandatory managed care enrollment without a separate, appealable determination based on a medical and functional assessment that the placement is permanent and that community-based services cannot maintain health and safety in the home.**

Medicaid eligibility rules require submission of an institutional Medicaid application with the 5-year “lookback” even for a temporary NH stay, for Medicaid to pay beyond a 29-day admission. Many of these stays may be short-term (the UHF nursing home study classified short-term stays as less than 90 days).[4] A Medicaid lookback determination is a purely financial decision regarding asset transfers. It has nothing to do with a decision that permanent placement is required as made by a medical team, individual and family.[5] Yet the Department’s policy uses the local DSS lookback determination as a proxy for a determination that a placement is permanent. It triggers the mandatory managed care enrollment process, in which NY Medicaid Choice sends the 60-day choice notice and then auto-assigns members to a plan 60 days later.

The lookback determination, however, does not necessarily indicate that a placement is “permanent.” Where there is a reasonable expectation to return home, “community” or “non-chronic care” budgeting rules are used that allow a nursing home resident to retain more income than the institutional Personal Needs Allowance of $50 to maintain

[4] Thomas H. Dennison, New York's Nursing Homes: Shifting Roles and New Challenges, United Hospital Fund of New York, available at https://www.uhfnyc.org/publications/880922 (Aug. 5, 2013)(“UHF NH Study”).

[5] The March 2015 (updated) FAQ Q69 gives an incorrect answer indicative of the problem of conflating the Medicaid requirements for payment of nursing home care, whether short-term or long-term, with the concept of true “permanent placement.”

> Q. If a consumer is admitted to a nursing home for a short term stay following an inpatient hospital stay, is an eligibility determination by the LDSS including a 60-month lookback, required?
>
> A. No, plans are required to cover short-term stays. There are no changes to the eligibility rules that districts will use to determine eligibility for Medicaid coverage of long-term nursing home care (permanent placement) including when the 60-month transfer of assets look back period applies….”

This answer is incorrect. It is true that plans are required to cover short-term stays, but the eligibility rules still require a 60-month lookback submission if the stay is longer than 29 days, even though still a short-term stay.

the home --for six months and even an indefinite period.[6] This "community budgeting" applies even after the lookback determination is made. Since the lookback determination is not a proxy for a determination that a placement is permanent, the mandatory enrollment process should not begin until a separate appealable determination is made that a placement is permanent.

**2. We request that DOH clarify that while there is a requirement to file the LDSS 3559, filing the form does not mean the placement is permanent.**
Mainstream plans are entitled to a separate rate cell to cover the higher cost of nursing home care. The DOH policy requiring nursing homes to notify the local district of social services (LDSS) with LDSS-3559 or its local equivalent within 48 hours of a nursing home admission is presumably intended to notify the LDSS to make the eMedNY code entries necessary to trigger this rate increase. However, this rate cell applies for short-term and long-term NH placements alike.[7] Therefore, the form is not a proxy for a determination of permanent placement.

**3. We request that DOH provide clearer procedures for assigning responsibility for submitting the 5-year lookback application for people already enrolled in MMC or MLTC plans, including requests for non-chronic or community budgeting.**

The fact that the MMC or MLTC plan is now paying the nursing home for care upon admission is a sea change from decades of past practice. This triggers the need for clearer procedures delineating responsibility for submitting the 5-year lookback application. In the past, an individual admitted to a nursing home who either had no Medicaid coverage or who had fee-for-service (FFS) Community Medicaid had to file an Institutional Medicaid application, or the nursing home would not be paid at all. This created an incentive for nursing homes to assist new residents and their families with the application in order to ensure it was filed within three months of the admission. Currently, MMC and MLTC plans must pay the nursing home starting on the date of admission of a managed care enrollee. Since the nursing home is being paid, we believe it no longer has the incentive to ensure that the Institutional Medicaid application is filed. MLTC plans likewise have no real incentive to file this application. In our experience, only MMC plans have an incentive to report the admission to the LDSS,

[6] We are pleased to see that in the FAQ June 2015 Q25, DOH explains that "non-chronic budgeting" allows individuals who are expected to return home to retain the regular Medicaid income level, with no set durational limit.

[7] The LDSS-3559 "RHCF Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status" is not attached to any guidance so cannot be commented on. We understand the New York City form is the MAP-2159i (4/3/2015) (attached to HRA MICSA Medicaid Alert – Transition of Long Term Nursing Home Benefit into Medicaid Managed Care, available at http://www.wnylc.com/health/download/544/, This form is called "Notice of Permanent Placement - Medicaid Managed Care." Again, this title illustrates the conflation of terms, using the term "permanent placement" solely because institutional budgeting is required or to trigger the MMC rate cell, which both may apply even for a short-term placement.

since that triggers an increase in their rates (the report is just the LDSS 3559 form, not the full 5-year lookback).

Because the landscape has changed, it is no longer enough for DOH to simply state that the member still has responsibility for filing the lookback application, as before. As a practical matter, the member may be unaware that this application is needed, unless they have representation, and even then, we have seen confusion when plans or nursing homes insist that the lookback application isn't necessary or even permitted. In the cases where there would be a penalty period, this confusion causes problems as the penalty period does not start running on a timely basis. But even where there is no penalty, it is in the State's interest to establish procedures that ensure compliance with federal Medicaid rules regarding chronic care budgeting; the nursing home, plan, and/or LDSS must have responsibility for notifying the resident of the requirement to file the lookback application and for assisting the member both with preparing and submitting it. This includes responsibility for requesting non-chronic care or community budgeting. See Section II. 3.c.on page 9 below.

## SECTION II.
## Other Transition Issues

1. **Issues Related to Hospital-to-Nursing Home Transitions in MLTC**

   DOH policy released in February 2015[8]centered on MMC plans, but did not address issues unique to MLTC population, for whom Medicare is usually the primary payor of an initial part of a long-term nursing home stay, or for an entire short-term nursing home stay.

   a. **Contradictory language regarding MLTC coverage of out-of-network nursing home stays:**
   We are pleased to see DOH clarify that "Plans are required to cover coinsurance of a Medicare-covered stay in a nursing home even if the member is in an out-of-network nursing home."[9] However, there is still contradictory language. The requirement that an MLTC plan cover Medicare coinsurance in an out-of-network (OON) nursing home implies that the MLTC member has the right to select an OON nursing home when discharged from a hospital for Medicare-covered rehab. However, 15 OHIP/ADM-01 and other guidance state "…consumers entering a nursing home for long-term placement are required to remain or enroll in a managed care plan, either MMCP or MLTCP… or obtain approval from the plan to enter the out of network nursing home."[10] We request that DOH clarify whether this was intended to be so restrictive for MLTC. We believe the contradictory

[8] Referenced as Feb. 2015 Policy, available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf

[9] DOH FAQ June 2015 Q31. Thank you for confirming continuation of the policy per DOH Q&A Aug. 16, 2012 - Question 42 on page 7. See also March 2015 FAQ Q57.

[10] ADM pp. 2, 3.

language is in part the result of the guidance conflating MMC and MLTC when they are very different in this context.

b. **Transfers between plans (applies to MLTC and MMC):**
Related to the point raised in the previous section is the individual's right to change plans at any time to one that includes her/his preferred nursing home in its network. Where a member of Plan A enters a nursing home outside of Plan A's network, the member must change plans to one that has the nursing home in its network. 15 OHIP/ADM-01 now clarifies that Plan A is responsible for authorizing the placement and "is responsible for payment to the nursing home until the new plan enrollment becomes effective."[11] However, this policy still leaves critical gaps:

1) Is Plan A required to authorize the OON placement and pay for it pending transfer to Plan B? The FAQ June 2015 says the plan "may" approve OON placement. Q24. What if the individual did not realize the nursing home was OON? Or if the hospital discharge planner did not verify this or inform the nursing home what plan the individual was in?

2) How and by whom is the individual—or her/his designated representative—informed that s/he needs to change plans in order to have the nursing home care covered? If notice is given, who is required to give that notice—the plan, the nursing home, or NY Medicaid Choice? If no notice is given, we believe the individual should not be held liable for care s/he does not realize is not being covered. Otherwise, how does the individual know to change plans?

3) How long does Plan A have to pay for the OON nursing home while the individual transfers to a different plan? The time period should be extended where the member was not notified of the need to change plans. Also, if the change in plans must be locked in by the 18th of the month, several months can go by before the transfer is effective.

These procedures have to be fleshed out and must be tailored for MLTC members who have a right to choose a Medicare provider for rehabilitation, even though that provider might be outside the MLTC plan's network. Since DOH has clearly stated that an MLTC plan must pay Medicare coinsurance for an OON nursing home during a Medicare stay, there should also be clear rules for notifying the member that s/he must transfer to a different plan if s/he wants to stay in that nursing home once the Medicare-covered stay is over. The rules must specify who is responsible for that notice (the nursing home or the plan), must explain how to transfer to a different plan, and should ensure that Plan A covers the care until the transfer is effective.

[11] ADM p. 6.

2. **Transfer to NH outside of District of Fiscal Responsibility (DFR):**
   The ADM at page 3 limits choice of plan to ones that operate both in the original DFR and the new district where the preferred nursing home is located. The ADM says "the transfer to the new nursing home will coincide with the effective date of the plan enrollment." ADM p. 3. The expectation that the transfer to the second nursing home can be timed to be on the first of the month of enrollment in the new plan is unrealistic, especially if the member is entering the nursing home from a hospital stay. Hospitals will not keep a patient until the first of the next month if ready for discharge. Even where a member is in a nursing home and moving to a different one, the transfer cannot always be timed for the first of the month, especially when that date is on a weekend or holiday.

   EXAMPLE: New York Legal Assistance Group (NYLAG) currently has a case where the member is in the hospital and has chosen a nursing home outside of New York City. He has transferred to a new plan that operates in the county where he is moving and covers the nursing home he has chosen, but the date of discharge from the hospital cannot be delayed until the first of the month. As such, his current plan should be required to cover the nursing home OON until the effective date of the new plan– it should not be discretionary. Otherwise, he really does not have the flexibility of changing plans as DOH Policy ensures.

3. **Notice, Fair hearing and Aid Continuing issues**

   A plan does not have the authority to place a member in a nursing home against her/his will: only a state court in an Article 81 guardianship proceeding has authority to order placement. DOH Policy refers to notice and appeal rights indirectly, and only regarding a plan's decision that nursing home placement is medically necessary. However, notice, appeal and Aid Continuing rights are required at various transition points:

   a. **Recommendation for long-term placement:**
      DOH 2/2015 Policy Section I.1. "Recommendation for long term placement" does not seem to mention notice to member with hearing and appeal rights. One of the few references to notice and hearing rights is if the plan recommends that the member be discharged from the nursing home. Jan 2015 Q&A #53. It is just as important to also have clear notice and appeal procedures for the initial nursing home placement.

   b. **Community to Nursing Home transition**:
      If a plan determines that long-term care services provided in the community can no longer reasonably maintain a member's health and safety, notice of discontinuance of the home care and other services and of the proposed plan to provide services in a nursing home must be provided with aid continuing rights that continue home care services through the fair hearing process. .

   c. **Hospital to nursing home transition or nursing home short-term stay to long-term stay transition:**
      If home care services had previously been provided and the plan now determines not to reinstate these services, but instead transfer a person to a nursing home from a hospital, or from a short-term to a long-term nursing

home stay, then the plan must provide notice of discontinuance of home care services with the right to reinstate them as aid continuing, pursuant to Granato v Bane and NYS DSS 99 OCC-LCM-2 (Apr. 20, 1999), reaffirming effectiveness of 96-MA-023.

d. **Plan decision to transfer member to a different Nursing Home:** This is the sole time member appeal rights are mentioned in the Feb. 2015 Policy (p. 10), but there is still no specific mention of notice to both member and designated representative.

e. **Plan decision to deny Nursing Home placement after a short-term stay:** if a plan authorizes a discharge plan that is considered inadequate (e.g. has inadequate amount of home care services) what notice is the plan required to give the member, and what are the appeal rights? Does the plan pay for the nursing home stay while discharge is being contested, or until a discharge?

f. **Nursing Home resident right to notice and appeal rights if involuntarily discharged from nursing home:**
Jan 2015 Q&A #72 mentions these rights under 10 NYCRR 415.3, but does not clarify whether the plan or nursing home or both are responsible for notices. How will that system now work with plan responsible for care? If the plan wants the individual to remain in the nursing home, but the nursing home wants to discharge the individual, what happens? A decision to discharge an individual from a nursing home involuntarily—whether made by the plan or the nursing home—must comply with longstanding federal and state law and regulations that prescribe specific notice and hearing requirements and limit grounds for discharge.[12] If a plan, rather than the nursing home, makes the decision to discharge the resident, the plan must still ensure compliance with these notice and hearing rights.

4. **<u>Olmstead</u> implications of erroneous assumption that every nursing home resident is in permanent absence status**:
Both the nursing home and the plan must take steps to ensure the member can retain sufficient income to maintain and return to his or her home.

   **a. We request that DOH incorporate more accurate information regarding the 29-day Short-term rehab benefit into the nursing home transition policy.**
   The new 15 OHIP/ADM-01 at page 3 makes passing mention to the 29-day benefit, but the statement is not very clear. This ADM section states, "For Medicaid recipients who were not enrolled in mainstream managed care who received more than 29 days of short-term rehabilitation services prior to a change in status to permanent placement, a transfer of assets lookback would have already occurred for Medicaid coverage beyond day 29." In our experience, this statement is not very realistic; the documents for the five-year lookback take months to compile, submit and then be processed by the LDSS. It is not instantaneous. Since Medicaid can be retroactive for up to

[12] See 10 NYCRR 415.3(g).

three months, these documents are often compiled over the first three months of a nursing home admission and then submitted in time to be retroactively effective to the admission date. The 29-day period has long since lapsed by then.

Nevertheless, this is an important benefit under state law that entitles one to 29 days of nursing home care using Community Medicaid without requiring a five-year lookback.[13] For individuals without Medicare but who have community Medicaid, the initial 29-day stay is fully covered by Community Medicaid without requiring a five-year lookback application. No decision for permanent placement, or application with a five-year lookback, should be done prior to the 29th day of admission. During this time, regular "community" budgeting is used, allowing an individual to retain $845 of her/his monthly income to maintain her/his home.

**b. We request that DOH expand the 29-day rehab benefit to 90 days, or at a minimum, not include days fully covered by Medicare in the 29-day count.**

The UHF Nursing Home study cited above classifies short-term patients as those whose last Minimum Data Set assessment for the calendar year reflected an actual or projected Medicare stay of 90 days or less, compared to long-stay patients whose last assessment for the calendar year did not include a Medicare short stay or an admission with a projected discharge date within 90 days.[14] Since UHF found that nearly half of all residents fall within this short-term stay definition, it would greatly reduce administrative costs of the LDSS, as well as those of plans and nursing homes, to expand the period of nursing home coverage in the community benefit to 90 days. This change would obviate the need for the lookback submission for at least half of all people admitted to nursing homes since they return home within three months. Alternately, Medicare-covered days should not count toward the 29-day period covered by community Medicaid. Since Medicare often covers in full the first 20 days of rehabilitation, and often more, this limits dually-eligible individuals to only nine days of Medicaid coverage without requiring the lookback and institutional budgeting. We request that DOH change this policy so that Medicaid will cover 29 days of nursing home care without counting any days Medicare pays in full.

**c. We request that DOH draft procedures that assign responsibility for requesting Non-Chronic Care Budgeting (Community Budgeting).**

Federal and state regulations provide that the presumption that every nursing home placement is "permanent" can be overcome by "adequate medical evidence" that the resident expects to return home.[15] This allows for retention of income in order to maintain the home; the allowance ensures the individual's ability to pay rent or other expenses to maintain the home for a period of 6 months, subject to extension. This is an important right but adds

[13] DOH 04 OMM/ADM-6; GIS 05 MA 004.
[14] See supra n 1.
[15] 42 CFR 435.832 (a)(3), 18 NYCRR § 360-1.4(k)

more confusion—though an individual may not be "permanently" placed for purposes of using non-chronic care budgeting, she/he would still require a 5-year lookback after the initial 29-day period expires.

We are pleased to see that in the FAQ June 2015 Q25, DOH explains that "non-chronic budgeting" allows individuals who are expected to return home to retain the regular Medicaid income level, with no set durational limit. However, neither 15 OHIP/ADM-01, nor any other guidance, states clear procedures and responsibilities on the part of the plan and nursing home to request this budgeting as part of the Medicaid application for institutional care. Nursing homes and managed care plans need instruction regarding the forms and procedures to be used. Importantly, this budgeting will apply to both MMC and MLTC—to anyone who receives any income other than Supplemental Security Income (SSI).

We have long witnessed that nursing homes fail to request community budgeting when submitting Institutional Medicaid applications, even when an individual has expressed a desire to return home and is actively seeking community placement as expressed, for example, through an NHTD application. We believe the transition of the nursing home benefit to managed care provides an opportunity to make the plans responsible for submitting the form in cases where returning home is reasonably expected. The 2015 Nursing Home ADM and other directives extensively discuss determination and collection of Net Available Monthly Income (NAMI). NAMI calculation changes dramatically with non-chronic care budgeting, and as such, it is important that those individuals who can benefit from chronic care budgeting are able to do so.

d. **We request that DOH make either nursing homes or managed care plans responsible for filing certifications with the Social Security Administration (SSA) in an effort to guarantee that individuals can retain their SSI benefits.**
The Revised March 2015 FAQ (updated June 18, 2015), is the first mention in any DOH guidance of the SSA procedure that allows continuation of SSI benefits for 90 days when the recipient is in a hospital and/or nursing home. This procedure allows the SSI recipient to retain crucial income to maintain her/his home. However, the SSA procedure requires very specific certifications to be filed with the SSA (including one from the physician) assuring that the stay is expected to be less than 90 days.

The DOH guidance places no responsibility for filing the requisite certifications with the SSA on either the nursing home or the plan. The guidance only states that "local SSA offices encourage nursing homes to timely report temporary or permanent placements," and that "the SSI recipient or ... representative should notify SSA of an admission to a nursing home." Q133. The required forms must be submitted to the Social Security office before the 90th day of the institutionalization or before the discharge home,

whichever is earlier. If submitted, SSI benefits may continue for three months. These benefits are called "Temporary Institutionalization" benefits.[16] Over 300,000 MMC members in New York State, and some MLTC members, rely on SSI benefits to pay their rent and other housing costs. Part of plans' care management should include obtaining and filing these forms for both MMC and MLTC members who receive SSI. Whether the MMC/MLTC plan fulfills this duty or delegates it to the nursing home must be made clear in contracts. In absence of any such contractual language, we request that DOH clarify that the plans have this responsibility. Consumer advocates drafted and provided to DOH a model Fact Sheet to SSI recipients with a model form that DOH can use to require plans and nursing homes to prepare and file with the SSA.

e. **We request that DOH inform plans, nursing homes and LDSS offices of their responsibilities regarding ensuring that individuals are budgeted for the MLTC Housing Disregard upon discharge to the community.** Plans, nursing homes and LDSS offices must ensure that a nursing home resident entitled to this disregard upon discharge to the community has it budgeted.[17]

5. **Plans' Duty to Assess for Potential Discharge Back to Community and *Olmstead* Concerns**

The DOH Policy dated Feb. 2015 states that the "nursing home, hospital and the MCO will respond to an enrollee's request for services in a less restrictive location in a timely manner and decisions regarding the enrollees' care should not be based on financial incentives." DOH Policy Feb. 2015 p. 10, sec II.1(g). However, it is not enough for plans to simply respond in a timely manner to a member's request for assessment for services in order to return to the community, nor is it enough for the plan to only perform regular six-month Uniform Assessment System (UAS) assessment or assess if the individual experiences a significant change, as stated in Jan 2015 Q&A # 49-51. Rather, we suggest DOH implement the following in order to clarify plans' duties to assess for an individual's potential discharge back to the community:

a. The plan should have the duty to assess the member for potential discharge at critical transition points:

   1) End of 29-day short-term rehabilitation period;

   2) End of Medicare-covered rehabilitation period, if any; and

   3) End of 6-month community budgeting period (see section 3b above), and if, that period extended, at the end of any extension period.

[16] See Social Security Administration, POMS Section SI 00520.140, available at http://policy.ssa.gov/poms.nsf/lnx/0500520140

[17] See **MLTC Policy 13.02: MLTC Housing Disregard**.

b. The plans' assessments should be conducted in advance of these critical transition points to allow for arrangement of services upon discharge.

c. The plan should also have the duty to assess the member for potential discharge when the member's responses to MDS 3.0 section Q questions indicate the member's interest in talking to someone about the possibility of returning to the community.

d. Plans should consider the availability of the Housing Disregard[18] as well as Spousal Impoverishment budgeting when performing assessments for potential discharge to the community. Since lack of affordable housing is a huge factor in preventing discharge to the community, plans assessing for potential discharge must consider these favorable budgeting methodologies that may make discharge possible. Again, plan and provider education is critical.

e. Plans should give homeless individuals special considerations, and should not be permitted to discharge homeless individuals into homeless shelters. The Feb. 2015 Policy at pg. 10 states that special consideration should be given for enrollees who are homeless during discharge planning, but the suggested engagement of the LDSS in arranging a safe location for discharge is not enough. We encourage DOH to explore additional opportunities for providing plans and LDSS with guidance around safe discharge for homeless individuals.

f. DOH should require plans to facilitate application to the Olmstead Housing Subsidy Program when it is launched. That program, which is currently in the Request for Application phase, will provide rental subsidies and transitional housing support services for Medicaid beneficiaries "who are homeless or unstably housed, and who have spent at least one hundred and twenty (120) consecutive days in a nursing home over the most recent two year period [with preference] given to Medicaid enrollees who are currently residing in a nursing home…" [19]

**6. Grandfathered Populations:**

Who is in the grandfathered class of individuals in nursing homes who are currently excluded from and, when voluntary enrollment begins, will be exempt from enrollment into MMC or MLTC? Are the transition dates for each region also the grandfathering cutoffs?

It is our understanding that people whose need for long-term placement is "established" prior to the transition date are grandfathered. It is also our understanding that this is true regardless of whether the person's long-term nursing home care was being paid by FFS Medicaid, private pay, long-term care insurance or otherwise, as per the March 2015 FAQ #81. However, what is meant by

[18] **MLTC Policy 13.02: MLTC Housing Disregard**
[19] MRT Supportive Housing Olmstead Housing Subsidy Program, https://www.grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx?NavItem1=2

"established"? Is the need for long term care "established" when the nursing home determines the individual needs long-term care regardless of payor? Or does "established" mean the submission of an institutional Medicaid application, the approval of an institutional Medicaid application, or the end of a penalty period? Or are there multiple events that trigger establishment of the need for long-term care?

We request that DOH clarify that no one admitted after the transition date is required to choose a plan until after they have been determined eligible for institutional Medicaid, after the expiration of the 29-day rehab benefit and, if applicable, after "community budgeting" periods of six months or more are no longer being used.

7. **Networks:**

According to the January 2015 Q&A # 34, "Each facility [is] expected to contract with at least one MMCP." Is this true for MLTC too? And is every specialty nursing home, such as those that specialize in ventilator-dependent care or Traumatic Brain Injury (TBI), required to contract with every MMC and MLTC plan in that county and in neighboring counties that have no such specialty nursing homes? If not, then we believe there are counties where the network requirements for specialty nursing homes are currently not being met.

**8. Provider Education:**

Nursing homes and plans alike need to be trained on the complex rules regarding Institutional Medicaid application procedures, including the "community budgeting" rights mentioned above and the procedures for ensuring that SSI benefits are retained.

**9. Spousal Impoverishment Budgeting:**

We understand that spousal impoverishment or "post eligibility" budgeting applies to institutionalized spouses who are enrolled in MMC or MLTC and have a community spouse, but that it does not apply to institutionalized spouses whose eligibility is determined under MAGI rules (January 2015 Q&A # 13; January PPT). However, we request additional clarification from DOH regarding the following:

a. Individuals who change from MAGI to non-MAGI while institutionalized must be re-budgeted using spousal impoverishment rules; how will this be carried out?

b. How will DOH ensure that budgeting for married individuals with spouses in MLTC (who have utilized spousal impovershment budgeting prior to nursing home admission) will (1) continue during a nursing home stay and (2) continue once discharged home with MLTC?

c. How will DOH ensure that those in MLTC who were not utilizing spousal impoverishment budgeting prior to entering a nursing home will have this budgeting while in the nursing home and upon discharge to an MLTC plan, without having to request it?

10. **Barriers to Discharge to Community for Individuals who were not in MLTC or MMC Plans :**
    a. Individuals "grandfathered" in who will remain in FFS nursing home care will continue to experience barriers we have already seen in returning to the community. Because enrollment in an MMC or MLTC plan must be arranged for the first of the month, timing must be carefully arranged for the LDSS to "convert" the Medicaid from institutional to community Medicaid as of the first of the month. In addition, the MMC or MLTC plan should assess the individual as eligible for enrollment, conduct a home visit arranged by a caregiver, and work with the nursing home to prepare a discharge plan, also for the first of the month.

    b. Because it is often not possible to arrange for a discharge to occur on the same day enrollment begins, some flexibility is needed to permit the MLTC plan to arrange for the discharge home within the week following enrollment. This would allow the MLTC plan time to arrange for the services to be ready upon discharge. We recognize that this can involve complications with the Medicaid codes – institutional vs. community – and requires the MLTC plan to pay the nursing home for the days until the discharge. We also recognize that there are no procedures set up for this, so we request assistance from DOH as we are met with pushback from plans and nursing homes, as well as from the LDSS that change the codes.

11. **Clarification on when CFEEC required for nursing home residents seeking to enroll in MLTC.** Since October 1, 2015, the "grandfathered" nursing home residents who were exempt from mandatory enrollment in MLTC are now permitted to enroll in MLTC voluntarily. Is a CFEEC required for these enrollments? Does it matter whether these residents now receive institutional Medicaid?

Thank you for the opportunity to submit these questions and concerns. We look forward to discussing these issues with NYS DOH.

Contact person for CPRNYDE:

Krystal Scott
Medicare Rights Center
kscott@medicarerights.org
(212) 204-6219

Dated: October 22, 2015