February 10, 2020

Ms. Lana Earle, Director
NYS DOH Division of Long Term Care
Office of Health Insurance Programs
Corning Tower
Albany, NY 12237

By email to lana.earle@health.ny.gov

Dear Ms. Earle:

We write to express grave concern about aspects of implementation of the nursing home carve-out, with potential violations of the ADA and Olmstead. We understand that many of the tens of thousands of MLTC members in nursing homes may intend to remain in nursing homes permanently and are unlikely to be negatively impacted by disenrollment.[1] However, for those who hope to and can return home the content of the disenrollment notice and procedures are seriously inadequate to protect their rights. We understand the state has an interest in quickly implementing the policy given its projected cost savings. However, the state's need for efficiency must not outweigh the rights of disabled New Yorkers to live in the community. We ask that DOH's notices and policies around the nursing home benefit limitation recognize that MLTC plans have a financial incentive to disenroll high cost members, leading to the unnecessary institutionalization of individuals who can be served in the community.

This letter outlines our serious concerns and recommendations to mitigate the potential harm to Medicaid recipients. Those members who had previously received MLTC services in the community, as opposed to those required to enroll in a plan after admission to the nursing home, have additional rights, outlined in Sec. 2.C. below.

1. Opportunity to Request an Assessment for Possible Safe Discharge

The CMS Special Terms & Conditions approving the disenrollment of long-term nursing home residents from MLTC plan states:

[1] DOH has not provided the number of people being disenrolled in and outside of New York City, which presumably increased since 2018 when DOH stated there were 23,000 MLTC members in nursing homes.

" ii. **Should an individual prefer discharge—and an assessment of the individual's medical needs indicates they may be safely discharged to the community—they may remain enrolled in their MLTC plan, while residing in the nursing home on a temporary basis for more than three months, until their discharge plans are resolved and the individual is transitioned out of the nursing home**."

CMS Letter and Special Terms & Conditions [ST&C], amended Dec. 19, 2019, at page 28 (copy attached hereto). The disenrollment notice[2] implies that the individual does NOT prefer discharge and has been assessed as unable to be safely discharged to the community. Without first giving the individual an opportunity to express a preference to return to the community, and to request an assessment of whether they may be safely discharged, it is premature to disenroll them. The State has skipped this crucial step; disenrolling members from the MLTC plans before an opportunity to request an assessment for community care is a recipe for potential Olmstead violations. Similarly, the paragraph in the notice titled, "*Who determines that I am in a long-term nursing home stay*?" implies that the consumer has participated in a decision along with their doctor and the nursing home that the nursing home stay will be long term. There is no basis for that assumption.

The consumer must first be given notice of the opportunity to express her preference to return to the community and ask to be assessed. An adverse determination from that assessment would then trigger a notice (the content of which is discussed below) and ultimately disenrollment.

2. Title and Content of Disenrollment Notice are Inadequate

We are disappointed that DOH did not consult with advocates in drafting these notices. We ask for changes in this notice before it is sent out to upstate members in February and then in NYC in March, and to additional members on an ongoing basis.

A. Title of Notice is Misleading

The title of the notice does not clearly alert members of the actual planned disenrollment, so will deter individuals from requesting a fair hearing. The title, "Important Notice About Your Enrollment in MLTC" sounds more like an informational notice than an actual Notice of Disenrollment.

[2] The final notice does not appear to be posted by DOH, but is available at http://www.wnylc.com/health/download/717/.

B. Notice Lacks Any Explanation of the Basis of the Determination that the Consumer is Not Expected to Return Home, and of the Right to Appeal this Determination

The notices do not alert members of their right to challenge the determination that the nursing home stay is long-term and that they are not expected to return home. The Special Terms & Conditions language quoted on page 2 above entitles members to remain in a plan beyond three months if they prefer discharge and may be safely discharged to the community. ST&C p. 28. This language provides a clear exception to the three-month limit and must be stated in the notice. The notice implies that the sole basis for requesting a fair hearing is if the member was not in fact in the nursing home for three months. The omission of the right to remain in the plan for longer than three months if safe discharge is possible deters members from requesting a fair hearing.

Moreover, the notice fails to inform the member of the basis for the implicit finding that they do *not* prefer discharge and that they may *not* be safely discharged to the community and also fails to inform them of their right to a Fair Hearing if they disagree. This renders the notice inadequate under basic due process standards.

In addition, an Administrative Law Judge at a hearing would infer from the notice that the sole hearable issue is whether the individual was in the nursing home for 3+ months, and may not allow evidence that the consumer can safely be discharged home. Since the notice lacks any specific basis for the plan's implicit determination that the member cannot be safely discharged home, the plan will presumably not be required to substantiate this finding at the hearing or provide supporting documents to the consumer as the "evidence packet" prior to the hearing. Without these documents, the consumer cannot prepare for the hearing.

C. For those MLTC Members who Had Received Community-Based Services from the Plan Prior to being Admitted to the Nursing Home, this Notice — or a Separate "IAD" from the Plan — Must Also Explain Grounds for Discontinuing the Previously Authorized Services

The notice is inadequate to alert those individuals who before entering the nursing home had received community-based services from the MLTC plan that the plan is also discontinuing those services and the reason why. The Second Circuit Court of Appeals in *Granato v. Bane* held in 1996 that refusal to reinstate personal care services after a hospital stay is equivalent to a discontinuance of these services,

which the recipient is entitled to appeal with notice and "aid continuing" rights.[3] Under these principles, this notice – if not a separate Initial Adverse Determination from the plan – should include a specific determination by the plan to terminate and not reinstate the previously authorized services, and that the consumer cannot be safely discharged home. The notice must specify the change in the consumer's condition that now renders them ineligible for the services.

Consider the following example that illustrates the potential Olmstead violations.

Martha was authorized by the MLTC plan for 24/7 live-in care before she had a heart attack and was hospitalized. She is ready to go home from rehab in the 3rd month, but the plan has refused to reinstate services. Because there is no formal "active discharge plan," she receives the Disenrollment notice after 3 months. The plan has thus avoided its duty under DOH MLTC Policy 16.06[4] to provide notice that specifies why she cannot be safely discharged under the prior care plan. Her right to challenge termination of previously authorized services has been violated, leading to unwanted institutionalization.

D. If DOH Does Not Send a Preliminary Notice of the Right to Request an Assessment to Determine if Safe Discharge is Possible, then This Notice Must Offer That Opportunity.

If the preliminary notice of the opportunity to request an assessment for a discharge plan, as described in Point 1 above, is not provided, then this Disenrollment notice must afford that opportunity. If a member requests that assessment, this should stop the disenrollment from going forward. If an adverse determination is made after that assessment, then appropriate notice must be given of the findings from that assessment, that complies with Policy 16.06 and the other points made here.

E. Lack of Information on How to Request Services to Return to the Community

The CMS Cover Letter enclosing the Special Terms and Conditions states, "*Nursing home residents will be allowed to re-enroll in an MLTC and return to the community* ***without***

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[3] This principle has been implemented in state directives NYS DSS 99 OCC-LCM-2 (Apr. 20, 1999), reaffirming 96-MA-023 - New Notice, Aid-Continuing and Related Procedures Applicable to Hospitalized MA Recipients Who Received Personal Care Services Immediately Prior to Hospitalization (*Granato v. Bane*; *McCoy v. Schimke*; *Burland v. Dowling*). Managed care plans must make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a) (4)(i).

[4] DOH MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services.*

***requiring a CFEEC, if such movement is within 6 months of the … disenrollment*."** ST&C p. 28 (emphasis added). However, the notice does not explain how a member who has been disenrolled may request re-enrollment within 6 months, or how they may request a conflict free assessment to enroll in MLTC after 6 months. The notice should also inform the consumer about the procedure to request expedited home care services from their local district if they have an "immediate need" for these services to return to the community. The lack of any language on the opportunity to request services to return home raises serious concerns about compliance with the ADA and Olmstead.

3. The Notice should be Sent to the Consumer's Designated Representative and to the Consumer's Addresses both in the Nursing Home and Community.

New York Medicaid Choice (NYMC) should send the disenrollment notices to the consumer both at the nursing home and their home in the community, and to their designated representative known to the nursing home or MLTC plan. Notices solely sent to the consumer at the nursing home may not be seen in time by an involved family member who may visit only weekly, or they may get lost. Sending the notice to the member's address in the community, if any, and to their designated representative makes receipt more likely.[5] The MLTC plans also should have an involved family member on record who should receive the notice.

4. DOH has Defined Too Restrictively Which Members Will Not be Disenrolled because They Have an "Active Discharge Plan."

The Dear Administrator Letter (DAL) dated Jan. 21, 2020 to nursing home administrators is unduly restrictive on defining who will NOT receive the notice because they have an "active discharge plan."[6] The DAL gave the nursing homes only one week to identify members (1) actively being assessed by the Open Doors program, or (2) those with an active transition plan in place with "all the required elements" – though those elements are not defined, or (3) those with an expected discharge date of 3 months or less, a discharge plan in place that could not be improved by being referred to Open Doors. Only those members will not receive disenrollment notices.

Even if nursing homes could identify these members in such a short time, this definition leaves out many people who prefer to be and could safely be discharged with a package of services authorized by the plan. The letter gives no opportunity for

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[5] 10 NYCRR 415.2(f)(definition of "designated representative").

[6] The DAL does not appear to be posted on DOH website, but is available at http://www.wnylc.com/health/download/718/.

individuals to self-identify as preferring to be discharged home and no opportunity to request an assessment as to whether they can be safely discharged home. DOH is relying solely on information from the plans and nursing homes, which each have a conflict of interest in making this determination. Open Doors has limited capacity to work with all nursing home residents seeking to return home, and many consumers are working with family or other advocates to arrange for discharge.

At a minimum, the disenrollment notice should *not* be sent to:

- Anyone with a pending request to the plan to reinstate or increase prior home care or other community-based services;
- Anyone with a pending plan appeal, or request for a fair hearing or external appeal of a denial to reinstate/increase prior services;
- Anyone who has made known their preference to return home, who should be given an opportunity to request an assessment of their medical needs to determine if they may be safely discharged to the community. Only if that assessment determines that they cannot be safely discharged to the community should they receive the notice with the improvements requested above.
- Anyone who has requested "Community Budgeting" sometimes known as Rent Retention budgeting, in order to be able to keep enough income to pay rent while they are in a nursing home.[7]
- Anyone whose nursing home services are still covered by Medicare, given that Medicare is generally a short-term rehabilitation benefit, and that further rehabilitation may make a safe discharge possible.

As stated above, if a member who did receive the notice requests an assessment to determine whether a safe discharge plan is possible, the disenrollment must be stopped.

5. The Disenrollment Must be Suspended if a Request for Prior Approval or Concurrent Review, Appeal, or Fair Hearing Request is Pending.

Inevitably, members will receive the disenrollment notices who have pending requests with their plans to reinstate or increase services, or who have appealed a denial or reduction of services. In such cases, Maximus should immediately suspend the disenrollment. The member would be deprived of any relief they might win in the pending request or appeal if they have been disenrolled from the plan.

[7] 18 NYCRR § 360-1.4(k)

6. Prospective Disenrollment Procedures Are Inadequate.

The DAL says plans will identify members for prospective disenrollment after March 23, 2020 and refer to NYMC. Any member with a pending request for reinstatement of or increase in services, appeal or fair hearing must be excluded from this group. Since the plan has little incentive to identify these individuals, the member must receive notice first from the plan – with appeal rights -- with its determination that they cannot be safely discharged home if the prior level of services are reinstated, or with any additional services in the benefit package. This is essentially a notice of discontinuance, with rights under Policy 16.06. See fn 4, *infra*. Only if no appeal is filed from that notice should the case be referred to NYMC for disenrollment. Requiring the nursing home to give a copy of the LDSS-3559 to the resident, as stated in the DAL, is not a substitute for notice from the plan. The resident cannot appeal a 3559 form indicating permanent placement.

Further, nursing homes must be reminded to request community budgeting for those with a reasonable expectation to return home. Anyone with this budgeting or who has requested it should not receive a disenrollment notice.

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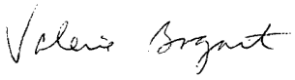
In summary we ask for the following:

1. Consumers first be given notice of the opportunity to express their preference to return to the community and ask to be assessed;
2. Changes to the content of the notice as outlined above;
3. Expand the categories of people who do NOT receive a notice and who will not be disenrolled;
4. Notices sent to consumer designated representative and to the consumer's addresses both in the nursing home and community;
5. Changes to disenrollment process, which should be outlined in an MLTC Policy, including but not limited to suspending disenrollment if the consumer contacts the plan, DOH, NY Medicaid Choice or the nursing home to request an assessment for possible discharge, or if the consumer has a request or appeal pending with the plan to reinstate or increase community-based services in order to return to the community. If the member was already disenrolled, enrollment should be reinstated pending outcome of the assessment or appeal process.

We ask the State to hold off on sending the disenrollment notices until these changes are made. We request an additional opportunity to meet with DOH to discuss the policies and procedures for implementing this major change in the MLTC program.

Thank you.

Very truly yours,



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encl.

Cc: Lisa Sbrana

the State's Independent Entity as described and included in the approved Children's waiver. All HCBS benefits are listed in the approved Children's waiver or the approved State Plan for CFCO. All reimbursement for Children's Waiver HCBS will be non-risk for the first 24 months subject to the non-risk UPL at 42 CFR 447.362. The MCO must pay the FFS fee schedule for non-risk services as long as the HCBS are non-risk (i.e., 24 months). There are no co-payments for Children's waiver services.

b. **Managed Long Term Care.** State plan benefits are delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out of the MLTC contract and delivered directly by the state on a fee-for-service basis. All MLTC benefits are listed in Attachment B.

   i. For those individuals receiving a nursing home benefit in the partially capitated MLTC plan they will be limited to three months for those enrollees who have been designated as Long-Term Nursing Home Stays (LTNHS) in a skilled nursing or residential health care facility as of the effective date of this amendment. After three months the individual will be involuntarily disenrolled from the partially capitated MLTC plan and payment for nursing home services will be covered by Medicaid fee for service for individuals who qualify for institutional Medicaid coverage.

   ii. Should an individual prefer discharge—and an assessment of the individual's medical needs indicates they may be safely discharged to the community—they may remain enrolled in their MLTC plan, while residing in the nursing home on a temporary basis for more than three months, until their discharge plans are resolved and the individual is transitioned out of the nursing home.

c. **Health and Recovery Plans (HARP).** State plan and demonstration benefits that are identical to MMMC with an additional component that provides BH HCBS for SMI and SUD needs will be provided by the HARPs. Long term care services (in excess of 120 days) or permanent placement in a Nursing facility, however, are not provided by HARPs. There are no co-payments for HARP services. All BH HCBS benefits are listed in Attachment D. BH HCBS for HARP enrollees meeting targeting, risk, and need-based functional criteria are only provided under the demonstration. The state must update the Medicaid state plan for rehabilitation and other mental health and substance use disorder services as identified through a companion letter to TN 10-38 as well as substance use disorder demonstration services not described in the current state plan. HIV SNPs also provide BH HCBS to enrollees meeting targeting, risk, and needs-based criteria. All reimbursement for BH HCBS in HARPs and HIV SNPs will be non-risk.

   i. **HARPs Services Tiers.** HARPs enrollees receive BH HCBS services under the following tier structure in accordance with their person-centered plan of care. HARP enrollees are permitted to appeal any service denial decisions.

      1. Tier 1 BH HCBS services include:

         a. Peer supports