Nursing Homes: From Admission to Discharge

Thursday, September 15, 2016

Albany Marriott
Albany, NY

CLE Course Materials and NotePad®

Complete course materials distributed in electronic format online in advance of the program.

Sponsored by the

New York State Bar Association and The Committee on Legal Aid

This program is offered for education purposes. The views and opinions of the faculty expressed during this program are those of the presenters and authors of the materials. Further, the statements made by the faculty during this program do not constitute legal advice.

Lawyer Assistance Program 800.255.0569

NYSBA

Q. What is LAP?

A. The Lawyer Assistance Program is a program of the New York State Bar Association established to help attorneys, judges, and law students in New York State (NYSBA members and non-members) who are affected by alcoholism, drug abuse, gambling, depression, other mental health issues, or debilitating stress.

Q. What services does LAP provide?

A. Services are **free** and include:

- Early identification of impairment
- Intervention and motivation to seek help
- Assessment, evaluation and development of an appropriate treatment plan
- Referral to community resources, self-help groups, inpatient treatment, outpatient counseling, and rehabilitation services
- Referral to a trained peer assistant – attorneys who have faced their own difficulties and volunteer to assist a struggling colleague by providing support, understanding, guidance, and good listening
- Information and consultation for those (family, firm, and judges) concerned about an attorney
- Training programs on recognizing, preventing, and dealing with addiction, stress, depression, and other mental health issues

Q. Are LAP services confidential?

A. Absolutely, this wouldn't work any other way. In fact your confidentiality is guaranteed and protected under Section 499 of the Judiciary Law. Confidentiality is the hallmark of the program and the reason it has remained viable for almost 20 years.

Judiciary Law Section 499 Lawyer Assistance Committees Chapter 327 of the Laws of 1993

Confidential information privileged. The confidential relations and communications between a member or authorized agent of a lawyer assistance committee sponsored by a state or local bar association and any person, firm or corporation communicating with such a committee, its members or authorized agents shall be deemed to be privileged on the same basis as those provided by law between attorney and client. Such privileges may be waived only by the person, firm or corporation who has furnished information to the committee.

Q. How do I access LAP services?

A. LAP services are accessed voluntarily by calling **800.255.0569** or connecting to our website **www.nysba.org/lap**

Q. What can I expect when I contact LAP?

A. You can expect to speak to a Lawyer Assistance professional who has extensive experience with the issues and with the lawyer population. You can expect the undivided attention you deserve to share what's on your mind and to explore options for addressing your concerns. You will receive referrals, suggestions, and support. The LAP professional will ask your permission to check in with you in the weeks following your initial call to the LAP office.

Q. Can I expect resolution of my problem?

A. The LAP instills hope through the peer assistant volunteers, many of whom have triumphed over their own significant personal problems. Also there is evidence that appropriate treatment and support is effective in most cases of mental health problems. For example, a combination of medication and therapy effectively treats depression in 85% of the cases.

Personal Inventory

Personal problems such as alcoholism, substance abuse, depression and stress affect one's ability to practice law. Take time to review the following questions and consider whether you or a colleague would benefit from the available Lawyer Assistance Program services. If you answer "yes" to any of these questions, you may need help.

1. **Are my associates, clients or family saying that my behavior has changed or that I don't seem myself?**
2. **Is it difficult for me to maintain a routine and stay on top of responsibilities?**
3. **Have I experienced memory problems or an inability to concentrate?**
4. **Am I having difficulty managing emotions such as anger and sadness?**
5. **Have I missed appointments or appearances or failed to return phone calls? Am I keeping up with correspondence?**
6. **Have my sleeping and eating habits changed?**
7. **Am I experiencing a pattern of relationship problems with significant people in my life (spouse/parent, children, partners/associates)?**
8. **Does my family have a history of alcoholism, substance abuse or depression?**
9. **Do I drink or take drugs to deal with my problems?**
10. **In the last few months, have I had more drinks or drugs than I intended, or felt that I should cut back or quit, but could not?**
11. **Is gambling making me careless of my financial responsibilities?**
12. **Do I feel so stressed, burned out and depressed that I have thoughts of suicide?**

There Is Hope

CONTACT LAP TODAY FOR FREE CONFIDENTIAL ASSISTANCE AND SUPPORT

The sooner the better!

Patricia Spataro, LAP Director

1.800.255.0569

New York State Bar Association

FORM FOR VERIFICATION OF PRESENCE AT THIS PROGRAM

Pursuant to the Rules pertaining to the Mandatory Continuing Legal Education Program for Attorneys in the State of New York, as an Accredited Provider of CLE programs, we are required to carefully monitor attendance at our programs to ensure that certificates of attendance are issued for the correct number of credit hours in relation to each attendee's actual presence during the program. Each person may only turn in his or her form-you may not turn in a form for someone else. Also, if you leave the program at some point prior to its conclusion, you should check out at the registration desk. Unless you do so, we may have to assume that you were absent for a longer period than you may have been, and you will not receive the proper number of credits.

Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees: please complete, sign and return this form along with your evaluation, to the registration staff **before you leave** the program.

You MUST turn in this form at the end of the program for your MCLE credit.

Nursing Homes: From Admission To Discharge, Thursday, September 15, 2016
New York State Bar Association's Committee on Legal Aid, Albany Marriott, Albany, NY

Name:
(Please print)

I certify that I was present for the entire presentation of this program

Signature: Date:

Speaking Credit: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

NEW YORK STATE BAR ASSOCIATION

Live Program Evaluation (Attending In Person)
Please complete the following program evaluation. We rely on your assessment to strengthen teaching methods and improve the programs we provide. The New York State Bar Association is committed to providing high quality continuing legal education courses and your feedback is important to us.

Program Name: Nursing Homes: From Admission to Discharge

Program Code: THLLH1

Program Location: Albany Marriott - Albany, NY

Program Date: September 15, 2016

1. What is your overall evaluation of this program? Please include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional Comments____

____

2. Please rate each Speaker's Presentation based on **CONTENT** and **ABILITY** and include any additional comments.

	CONTENT				ABILITY			
	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
Marie T. Vaz	☐	☐	☐	☐	☐	☐	☐	☐
Daniel A. Ross	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
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(please turn over)

Additional comments (CONTENT)

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Additional comments (ABILITY)

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3. Please rate the program materials and include any additional comments.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Additional comments

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4. Do you think any portions of the program should be **EXPANDED** or **SHORTENED**? Please include any additional comments.
☐ Yes – Expanded ☐ Yes – Shortened ☐ No – Fine as is

Additional comments

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5. Please rate the following aspects of the program: **REGISTRATION**; **ORGANIZATION**; **ADMINISTRATION**; **MEETING SITE** (if applicable), and include any additional comments.

	Please rate the following:				
	Excellent	Good	Fair	Poor	N/A
Registration	☐	☐	☐	☐	☐
Organization	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐
Meeting Site (if applicable)	☐	☐	☐	☐	☐

Additional comments

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6. How did you learn about this program?
☐ Ad in legal publication ☐ NYSBA web site ☐ Brochure or Postcard
☐ Social Media (Facebook / Google) ☐ Email ☐ Word of mouth

7. Please give us your suggestions for new programs or topics you would like to see offered

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NEW YORK STATE BAR ASSOCIATION
One Elk Street, Albany, NY 12207
Phone: 518-463-3200 | Secure Fax: 518.463.5993

Workshop Title:

Nursing Homes: From Admission to Discharge

Brief Description:

This session will provide an overview of the nursing home admissions process, Medicaid managed care enrollment policies for nursing home residents, public benefits budgeting methodologies for people in nursing homes, nursing home quality of care and resident's rights, and nursing home discharge planning in New York State.

Timed Agenda:

1.25 hour presentation

Nursing Home Admissions- *10 minutes*
Nursing Home Placement and Medicaid Managed Care Enrollment- *5 minutes*
Nursing Home Placement and Public Benefits Entitlements- *10 minutes*
Nursing Home Quality of Care- *10 minutes*
Nursing Home Residents' Rights- *20 minutes*
Nursing Home Discharge Planning- *15 minutes*
Q&A- *5 minutes*

Panel Bios:

Marie T. Vaz, Esq., New York Legal Assistance Group- *Marie has been a Staff Attorney in the Evelyn Frank Legal Resources Program at NYLAG since 2012. Marie specializes in Medicaid and Medicare eligibility and services, emphasizing the needs of low-income people seeking long-term care services. She graduated from Fordham Law School in 2011 as a Stein Scholar in Public Interest Law and Ethics. Marie interned during and after law school in Medical-Legal Partnership programs at Manhattan Legal Services and Legal Services NYC-Bronx and for Georgia Legal Services. She also represented and coordinated services for children with severe medical conditions and/or developmental disabilities at SKIP of New York. Marie graduated in 2004 from Emory University with a B.A. in Sociology.*

Daniel A. Ross, Esq., MFY Legal Services, Inc.- *Dan is a staff attorney at MFY Legal Services, Inc., where he represents residents of nursing homes and adult homes in individual and class-action matters related to health care, housing, and public benefits. Previously, Dan was a staff attorney at the Vera Institute of Justice's Guardianship Project, which works to allow incapacitated adults to age in place or return to their homes from nursing homes and hospitals. As a Disability Rights Fellow at Brown, Goldstein & Levy, he represented people who had been denied educational and employment opportunities due to the use of inaccessible technology in*

schools, offices, and other places of public accommodation. Dan graduated from Vassar College (A.B.) and the University of Virginia (M.A., history, J.D.).

NEW YORK LEGAL ASSISTANCE GROUP

EVELYN FRANK LEGAL RESOURCES PROGRAM

Nursing Homes

From Admission to Discharge

New York State Bar Association

Partnership Conference September 2016

Prepared by the **Evelyn Frank Legal Resources Program**

Valerie J. Bogart, Esq.
Director

Marie T. Vaz, Esq.
Staff Attorney

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I. “Nursing Home” Defined:

An institution that is commonly called a **“nursing home”** must meet certain Federal and New York State requirements to operate or to receive payment from Medicare and Medicaid. Some examples of how a “nursing home” or parts of a nursing home can be defined within those laws and ensuing regulations are:

A. Section 1819 of the Social Security Act defines a **“Skilled Nursing Facility”** as an institution (or a distinct part of an institution) which is primarily engaged in providing to residents: skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; and is not primarily for the care and treatment of mental diseases; and meets certain enumerated criteria. 42 U.S.C. § 1395i–3. This definition is primarily used for Medicare purposes by the Centers for Medicare and Medicaid Services (“**CMS**”).

B. Section 1919 of the Social Security Act defines a **“Nursing Facility”** as an institution (or a distinct part of an institution) which is primarily engaged in providing to residents: skilled nursing care and related services for residents who require medical or nursing care; rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; and is not primarily for the care and treatment of mental diseases; and meets certain

enumerated criteria. 42 U.S.C. § 1396r. This definition is primarily used for Medicaid purposes by CMS.

C. N.Y. Public Health Law § 2801 defines a **"Nursing Home"** or **"Residential Health Care Facility"** as a facility providing nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related services. This definition is used by the N.Y. State Department of Health ("**DOH**") in overseeing the operation of nursing homes and providing State Medicaid payments to nursing homes.

1. A "Nursing Home" or "Residential Health Care Facility" is further described in State regulation as providing lodging for 24 or more consecutive hours to three or more residents who need regular nursing services or other professional services but who shall not need the services of a general hospital. 10 N.Y.C.R.R. § 415.2.

II. Nursing Home Admissions:

An individual can be admitted to a nursing home from either their home in the community or from a hospital. Some forms involved in the admissions process are:

A. For patients who require placement or continued stay in a nursing home or health-related facility, the "Hospital/Community PRI" or the "**PRI**," as appropriate, shall be completed by a registered professional nurse. 10 N.Y.C.R.R. § 400.11(a)(1) (PRI = Patient Review Instrument). Instructions for completing a "PRI"/required content of a "PRI" are found at 10 N.Y.C.R.R. § 400.13.

B. For patients who require placement or continued stay in a nursing home or a health-related facility, the "**SCREEN**" form shall be completed by a professional with demonstrated skills in assessing psychosocial situations, including but not limited to social work and discharge planning professionals. *Id*. (SCREEN = Patient Screening Instrument). The "SCREEN" form content and location are found at 10 N.Y.C.R.R. § 400.12.

C. Upon admission and periodically thereafter the facility shall conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Based on the results of these assessments, the facility shall develop and keep current an individualized comprehensive **plan of care** to meet each resident's needs. 10 N.Y.C.R.R. § 415.11.

III. Paying for a Nursing Home Stay: Options other than Medicaid

A nursing home can charge a costly daily rate so maximizing insurance coverage options, rather than paying privately, is important for patients.

A. **Medicare:** Individuals who are enrolled in Medicare have two options to receive their Medicare coverage: **Original Medicare** and **Medicare Advantage**. Original Medicare is the fee-for-service program offered from the Federal government. Original Medicare consists of **Part A** (hospital) and **Part B** (outpatient medical) services. Medicare Advantage is an insurance plan offered by private companies that contract with the Medicare program. Oftentimes called **Part C**, Medicare Advantage plans must cover the

same Part A and B services offered in Original Medicare but can have provider network restrictions and different cost-sharing than Original Medicare. 42 U.S.C. § 1395 et seq.; 42 C.F.R. § 422 et seq.

1. Medicare beneficiaries choose between Original Medicare and Medicare Advantage based on a number of different factors specific to coverage of their own health care needs, particularly provider networks, prescription drug formularies, and out of pocket costs. Individuals can use guides such as the CMS annual publication "Medicare & You" (available at https://www.medicare.gov/Pubs/pdf/10050.pdf) and the advice of certified Medicare counselors (contact list per state available at https://www.medicare.gov/contacts/) to make the enrollment decision best for them.
2. A Medicare beneficiary has opportunities to reevaluate their coverage and switch between Original Medicare and Medicare Advantage plans at least once per calendar year, and up to a month by month basis, depending on whether a "Special Enrollment Period" applies based on their individual circumstances. *See, e.g.*, CMS Medicare Managed Care Manual, Chapter 2 - Medicare Advantage Enrollment and Disenrollment (revised May 27, 2016), available at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/; 42 U.S.C. §1395w-21(e).

3. **Part A** of **Original Medicare** covers up to **100 days** of a Skilled Nursing Facility ("**SNF**") stay per benefit period. 42 C.F.R. § 409.61. Days 1 through 20 are covered in full and days 21 through 100 carry a daily copayment amount, which changes per year. 42 C.F.R. § 409.85. In 2016, the **copayment is $161 per day** (https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html). A benefit period begins the day inpatient care starts and ends after being out of a hospital or SNF for 60 days in a row. 42 C.F.R. § 409.60.
4. To qualify for Medicare coverage of a SNF, an individual must meet **certain criteria** (42 C.F.R. § 409.30 et seq.):
    - **a.** They must need skilled nursing care seven days a week or skilled therapy services at least five days a week;
    - **b.** They must be formally admitted as an inpatient to a hospital for at least three consecutive days and entered a Medicare-certified SNF within 30 days of leaving the hospital;
    - **c.** They must be enrolled in Medicare Part A before being discharged from the hospital; and
    - **d.** They must need care that can only be provided in a SNF.
5. Hospitals sometimes keep patients that enter through the emergency room in **"observation status"** which is not a *formal admission as an inpatient* as required for Medicare SNF coverage. N.Y. is one of five states requiring hospitals to inform patients when they are in observation status within 24 hours and of the

consequences of not being admitted as inpatients. N.Y. Pub. Health L. § 2805-w. The Federal Notice of Observation, Treatment and Implication for Care Eligibility Act (enacted August 2015) requires hospitals, by August 2016, to inform Medicare beneficiaries of their outpatient status within 36 hours, or, if sooner, upon discharge. 42 U.S.C. § 1395cc(a)(1). The Center for Medicare Advocacy has "know your rights" information on observation status on their website at http://www.medicareadvocacy.org/medicare-info/observation-status/.

6. Effective January 1, 2016, CMS will allow Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if medical record supports that "…the admitting physician expects the patient to require hospital care that crosses **two midnights**." 42 C.F.R. § 412.3(d) (as amended August 2015).

7. Previously, CMS would deny claims for patients whose conditions were not showing improvement from their SNF care. The settlement in *Jimmo v. Sebelius* clarified that there is no such **"improvement standard"** for Medicare coverage of a SNF stay. *See Jimmo v. Sebelius*, No. 5:11-cv-17, 2011 WL 5104355 (D. Vt. Oct. 25, 2011). The *Jimmo* lawsuit was filed by the Center for Medicare Advocacy and their website contains valuable tips for patients and advocates seeking to challenge the misuse of an "improvement standard" at http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

8. Because **Medicare Advantage** plans must cover the same services as Part A of Original Medicare: A patient who is enrolled in a Medicare Advantage plan can be subject to the same above-listed criteria as in Part A of Original Medicare for their plan to cover their SNF stay, and the plan must cover up to 100 days, at a minimum, if the criteria are met. 42 C.F.R. § 422.101 (allowing Medicare Advantage plans to also offer SNF coverage without a prior hospitalization). The cost sharing a patient faces will differ from Original Medicare and is determined by their plan each year. For example, many Medicare Advantage plans **carry high copays** for the first few days in a SNF and then no copay for the rest of the 100 days. CMS requires that plans publish a Summary of Benefits, which would list the cost sharing for SNF and other covered services, on the plan's website. *See* CMS Medicare Marketing Guidelines (issued June 10, 2016) available at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html.
9. The procedure for **appealing a coverage determination** in Original Medicare is described at 42 C.F.R. § 405.900 et seq. with more information available at https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html. The procedure for appealing a coverage determination in Medicare Advantage is described in 42 C.F.R. § 422.560 et seq. with more information available at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/.

B. <u>Medicare Supplemental Insurance ("Medigaps")</u>: Medicare Supplemental Insurance policies, commonly called "Medigaps," are sold by private health insurance companies to cover some of the expenses of Original Medicare. Medigaps do not assist with the cost sharing of Medicare Advantage. The N.Y. State Department of Financial Services oversees and regulates these Medigap plans. 11 N.Y.C.R.R. § 360.1 et seq. For Medigap policies sold before June 01, 2010, there are fourteen standardized plans A through L. For policies sold on or after June 01, 2010, there are 11 standardized plans A through N. Each standardized Medigap policy must provide the same basic core benefits, such as covering the cost of certain Medicare copayments and deductibles.

1. Nine of the 11 standardized Medigap policies – all except Plans A and B – provide coverage of the Medicare SNF coinsurance. Plans C, D, E, F, M and N provide full SNF coinsurance coverage. Plans K and L cover, respectively, 50% and 75% of the SNF coinsurance. Note that Medigap coverage is limited to Medicare-covered SNF care.

2. Plans also vary regarding coverage of foreign travel emergency care.

3. A chart of the standardized plans and what they each cover is available at http://www.dfs.ny.gov/consumer/medplan/Medsup_coverage.pdf/. For tables comparing plans in N.Y. State *see* http://www.dfs.ny.gov/consumer/caremain.htm.

C. **<u>Retiree/Union Coverage</u>:** Some Medicare beneficiaries might have a supplemental plan through their retiree benefit package or union. Contact the plan or union representative to determine whether SNF is covered.

D. **<u>Medicare Savings Program</u>:** If a Medicare beneficiary is low-income they may qualify for the Medicare Savings Program in which N.Y. State pays for certain Medicare costs. The Medicare Savings Program has three levels each with a different income limit (and no asset limit): **Qualified Medicare Beneficiary ("QMB")**, Specified Low-income Medicare Beneficiary ("SLIMB"), and Qualified Individuals-1 ("QI-1"). *See* N.Y. S.S.L. § 367-a(3).

1. QMB has the lowest income limit of **$990 per month** for a single person and **$1,335 per month** for a couple in 2016. N.Y. State DOH, 2016 Federal Poverty Levels, GIS 16 MA/07 (January 1, 2016). QMB includes coverage for the copay or coinsurance of an Original Medicare or Medicare Advantage approved SNF stay. N.Y. S.S.L. § 367-a(3). The SNF must be enrolled in the N.Y. State Medicaid program in order to receive QMB payment (and most SNFs are). CMS Informational Bulletin, January 6, 2012, available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

a. The amount that QMB will pay towards the copay or coinsurance of a Medicare service depends on the service and whether the beneficiary is

enrolled in Original Medicare or Medicare Advantage. *See* N.Y. S.S.L. § 367-a(1)(d)(iii)-(iv).

b. However, even if QMB does not pay the full amount **a QMB beneficiary cannot be balance billed** by the SNF. Balance billing is banned by section 4714 of the Balanced Budget Act of 1997 (implemented at 42 U.S.C. § 1396a(n)(3)(A) and (B)) and is further discussed in the CMS Informational Bulletin, issued January 6, 2012, titled "*Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs),"* cited to *supra*. The CMS letter states:

> "All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs are prohibited from billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments….QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions."

E. **<u>Long Term Care Insurance</u>:** Long Term Care Insurance is a product which, if certain conditions are met, will pay for all or a portion of nursing home and/or home care expenses. Such policies have been marketed to individuals who do not wish to have their assets depleted should they need long term care. N.Y. Insurance Law and ensuing regulations provide minimum coverage requirements for Long Term Care Insurance policies:

1. Coverage must be for at least 24 months and must be provided as one of three options, with most policies in New York provided under the option of covering all

levels of nursing home care for at least $70-$100 per day. 11 N.Y.C.R.R. § 52.12(a).

2. Policies may exclude people with certain medical conditions from purchasing and may also impose a 6 month pre-existing condition limitation upon effective date of the policy but beyond that period, if the insured needs coverage for a nursing home stay the policy cannot require prior hospitalization or a specified level of care. 11 N.Y.C.R.R. § 52.25(b) and (c). The policy cannot deny a claim for coverage of a nursing home stay based on the insured's medical condition. 11 N.Y.C.R.R. § 52.25(d).

F. **Long-Term Care Partnership Policies:** The N.Y. State Partnership for Long-Term Care is a DOH program combining private long term care insurance and Medicaid coverage. An individual or couple who purchases a Partnership insurance policy can receive extended Medicaid coverage of long-term care, including nursing home care, when their policy runs out and also keep some or all of their assets that are over the Medicaid limit. An Administrative Directive from DOH contains a detailed discussion of the interrelationship of the Medicaid rules and Partnership policies. *See* N.Y. State DOH, Medicaid Extended Coverage for New York State Partnership for Long-Term Care Policyholders, 09 OHIP/ADM-3 (July 8, 2009); N.Y. State DOH webpage, Partnership for Long-Term Care, available at http://www.nyspltc.org/.

1. There are five types of partnership plans offered in N.Y. with the minimum coverage requirements for each explained in 11 N.Y.C.R.R. §§ 39.3 - 39.7; N.Y.

State DOH webpage, Partnership for Long-Term Care, available at http://www.nyspltc.org/. The nursing home coverage amongst the five plans ranges from one and a half years to four years. *Id*. Two companies offer the plans. *Id*.

G. <u>Life Insurance</u>: Some Life Insurance policies offer an accelerated payment of all or part of the death benefit when the insured is expected to remain in a nursing home until death or to cover the cost of the insured's chronic illness. *See* N.Y. Ins. Law § 1113(a)(1).

IV. Medicaid Coverage of a Short-Term Nursing Home Stay (MAGI or non-MAGI):

Some Medicaid applicants/recipients ("A/R") in New York are eligible under rules established by the Medicaid expansion of the **Affordable Care Act** and some Medicaid A/R's are eligible under rules existing prior to the January 1, 2014 expansion. *See* N.Y. S.S.L. § 366; N.Y. State DOH, Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010, 13 OHIP/ADM-03 (September 25, 2013) (how these eligibility categories affect Medicaid coverage of long-term nursing home care is discussed *infra*). We call those A/Rs affected by Medicaid expansion "**MAGI**" eligible (MAGI = Modified Adjusted Gross Income) and those A/R's eligible under the pre-2014 rules "**non-MAGI**." "MAGI" Medicaid A/R's may apply for Medicaid at the local department of social services ("**LDSS**") or through the **N.Y. State of Health** Marketplace, but non-MAGI A/R's may apply solely through the LDSS. *See* N.Y. State DOH, Medicaid Application

and Renewal Processing for Modified Adjusted Gross Income (MAGI) Eligibility Groups, 13 OHIP/ADM-04 (December 3, 2013).

A. **29-Day Short-Term Rehab Stay**: Regardless of what eligibility group they fall in or where they applied, if an individual has been approved for Medicaid for persons living in the community they are entitled to coverage of one period of Certified Home Health Agency ("CHHA") services, up to a maximum of 29 consecutive days in a twelve-month period, and one short-term nursing home admission, up to a maximum of **29 consecutive days** in a twelve-month period.

    1. Medicaid A/R's are entitled to this benefit whether or not they provided proof of their resources at Medicaid application/renewal. N.Y. S.S.L. § 366-a(2)(b); N.Y. State DOH, Resource Documentation Requirements for Medicaid Applicants/Recipients, 04 OMM/ADM-6 (July 20, 2004).

    2. A Medicaid recipient may receive one of each type of service for a total of 58 days in a 12 month period. The 29 days must be consecutive. The Medicaid recipient cannot spread the coverage over two or more nursing home stays in a year. N.Y. State DOH, Start Date for 29 Days of Short-Term Rehabilitation, GIS 05/MA 004 (January 24, 2005). For example, if a patient is sent back to the hospital from a nursing home after only 15 days, the 14 remaining days of the 29 day maximum are lost and cannot be carried over if the patient was then discharged from the hospital back to the nursing home. The individual would not qualify until the next year and would have to provide the five year resource

documentation, discussed *infra*, to receive more nursing home coverage after the hospital stay.

3. The 29 day clock starts running on the first day the patient receives CHHA services or is admitted to a nursing home, regardless of whether the patient has Medicare or other insurance to pay for the early part of the stay. *Id*. For example, a patient is admitted to a nursing home for rehabilitation on November 8. Original Medicare covers November 8 through 27 (20 days) in full. Medicaid coverage for short-term rehabilitation is available starting November 28 through December 6 (the remaining 9 days of the short-term rehabilitation allowance). If the individual was not in receipt of Medicaid upon admission and applied for Community Medicaid coverage hence in order to utilize the short-term rehabilitation benefit, November 8 would still count as day one of the short-term rehabilitation benefit even if the application was filed in December or after.

V. MAGI Medicaid Coverage of a Long-Term Nursing Home Stay:

A. **Who is MAGI?** MAGI Medicaid eligible groups include parents, caretaker relatives, pregnant women, children, and childless adults who are under age 65 and not in receipt of Medicare. *See* N.Y. S.S.L. § 366; N.Y. State DOH, Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010, 13 OHIP/ADM-03 (September 25, 2013). This means that a person who is over 65, even if they are a Medicare beneficiary, can be eligible for MAGI Medicaid if they are the parent or caretaker relative of a child under age 18 or under

age 19 if the child is in school. 42 C.F.R. § 435.4. A disabled person under the age of 65 can be eligible for MAGI Medicaid until they become a Medicare beneficiary, and after if they are a parent or caretaker for a child (see above).

B. MAGI Medicaid eligibility is determined by comparing the Medicaid A/R's modified adjusted gross income ("MAGI"), as defined in the Federal Income Tax Code and the Affordable Care Act, to the applicable percentage of the federal poverty level ("FPL"). *Id*.

> "MAGI-based income" means income calculated using the same methodologies used to determine MAGI under section 36B(d)(2)(B) of the Internal Revenue Code, with the exception of lump sum payments, certain educational scholarships, and certain American Indian and Alaska Native income, as specified by the commissioner of health consistent with federal regulation at 42 C.F.R. § 435.603 or any successor regulation.

N.Y. S.S.L. § 366(1)(a)(7). For example, the MAGI income of a parent, caretaker, or childless adult is compared to **138% FPL** which is **$1,367 per month** in 2016. N.Y. State DOH, 2016 Federal Poverty Levels, GIS 16 MA/07 (January 1, 2016).

C. MAGI Medicaid Coverage of Nursing Home Care

1. A MAGI Medicaid A/R who is **"medically frail"** may receive coverage for medically necessary nursing facility services. The need for nursing facility services qualifies the individual as "medically frail" and no further documentation is required. N.Y. State DOH, Long Term Care Eligibility Rules and Estate Recovery Provisions for MAGI Individuals, GIS 14 MA/016 (January 1, 2014).

2. A MAGI Medicaid A/R who is in a nursing home for more than 29 days can continue to keep all of their income, regardless of the permanence of their stay, as long as their countable income is under the MAGI Medicaid income limit of **138% FPL** for a

household of 1 (regardless of whether the institutionalized A/R has a community spouse, the A/R will be budgeted as a household of 1). In other words, they have **no "NAMI"** as explained *infra* for non-MAGI Medicaid recipients. *Id*.

3. MAGI Medicaid A/Rs also have no resource test. *Id*.

4. MAGI Medicaid A/Rs **cannot use spousal impoverishment** protections unless they can qualify for Medicaid under the non-MAGI category for the aged (over 65), blind, and disabled. *Id*. Such persons may choose the more favorable budgeting methodology.

5. A MAGI Medicaid A/R who is in a nursing home for more than 29 days is still subject to a **60 month look-back for asset transfers** (and the imposition of a penalty for assets that are transferred without compensation) and a **home equity limit**, both discussed *infra*. But, their home in the community is **not subject to a lien** while they are in the nursing home. *Id*.

6. Effective April 1, 2014, Section 369 of the Social Services Law was amended to limit the Medicaid costs that can be recovered from the estate of a deceased individual who received Medicaid under a MAGI eligibility group. Recovery from assets in a MAGI individual's estate is limited to the amount of Medicaid paid for the cost of nursing facility services, home and community-based services, and related hospital and prescription drug services received on or after the MAGI individual's 55th birthday. Other than that, the same limitations and exceptions to **estate recovery**

that are described in Section 369 of the Social Services Law apply to recoveries from the estates of both MAGI and non-MAGI individuals. *Id*.

VI. Non-MAGI Coverage of a Long-Term Nursing Home Stay:

An individual eligible for Medicaid under the "non-MAGI" Federal and State laws and regulations existing prior to the Affordable Care Act, for people who are **disabled, over age 65, or blind** is often-called "**DAB**" or "**SSI-related**." DAB Medicaid A/Rs are subject to the following rules to receive "**Institutional Medicaid**" coverage of their nursing home stay beyond the 29 day short-term rehabilitation benefit.

A. **Resources/Assets:** A DAB Medicaid A/R in a nursing home may have the same amount of assets as a single person living in the community (**$14,850** in 2016) and is subject to the same resource exemptions as a DAB Medicaid A/R in the community, except for their home which will be discussed *infra*. N.Y. S.S.L. § 366-c; 18 N.Y.C.R.R. § 360-4.10; N.Y. State DOH, Deficit Reduction Act of 2005- Long-Term Care Medicaid Eligibility Changes, 06 OMM/ADM-5 (July 20, 2006).

1. **Asset Protections for a Community Spouse:** An institutionalized DAB Medicaid A/R may keep resources up to $14,850 and their community spouse may keep a "**Community Spouse Resource Allowance**" up to the greater of $74,820 or one-half of the couple's total combined assets up to $119,220 (2016), or an amount established by court order or fair hearing. *Id*.; N.Y. State DOH, *2016 Federal*

Poverty Levels, GIS 16 MA/07 (January 1, 2016). The balance is deemed available to the institutionalized spouse for the cost of their care.

2. **The Home as a Countable Resource:** 20 C.F.R. § 416.1212(c) provides:

   If an individual (and spouse, if any) moves out of his or her home without the **intent to return**, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there.

   Anna W. v. Bane, 863 F. Supp. 125 (W.D.N.Y. 1993), held that a person's "subjective intent to return home" is sufficient to exclude the homestead as an available resource, as opposed to requiring proof of the actual possibility of their return home. This intent may be indicated by filing a statement of intent to return home. In NYC, use form NYC HRA MAP-259H *Intent to Return Home* (6/20/2008) (available at http://www.wnylc.com/health/download/555/).

3. **Medicaid Lien on Home:** Even if the institutionalized DAB Medicaid A/R does intend to return home, the Medicaid program may impose a lien on the home in some cases. Even where the individual "intends to return home," ensuring that the home is not counted as an available resource disqualifying the individual from eligibility, the controlling factor for the imposition of a lien is whether the DAB Medicaid A/R is **permanently absent** and not "reasonably expected to be discharged" back home. 42 U.S.C. §§ 1396a(a)(18) and 1396p(a)(2); N.Y. S.S.L. § 369(2)(a)(ii); 18 N.Y.C.R.R. § 360-7.11(a)(3)(ii); N.Y. State DOH, Medical

Assistance Liens and Recoveries, 92 ADM-53 (December 15, 1992); N.Y. State DOH, Medicaid Liens and Recoveries, 02 OMM/ADM-3 (April 17, 2002). The LDSS must provide adequate **notice of intent to place a lien** on the home and, if challenged, bear the burden at a hearing to prove that the person cannot reasonably be expected to be discharged back home. *Id*.

a. **If the person returns home, the lien dissolves.** *Id*.

b. **No lien may be placed on the home** of an institutionalized DAB Medicaid A/R if one of the following lawfully resides in the home: a spouse; a child under 21 or an adult child who is blind or permanently and totally disabled; or a sibling who has an equity interest in the home and who resided in the home for at least one year before the date of the DAB Medicaid A/R's admission to the medical institution. *Id*.

c. **A lien validly placed cannot later be liquidated** if any of these relatives live in the home: a sibling who lived there for a year (regardless of any equity interest), immediately before the individual's admission to the medical institution, and has lawfully resided in the individual's home on a continuous basis from the date of the individual's admission to the medical institution through the present day; or a child who provided care to the individual has resided there for two years immediately before the individual's admission to the institution, and who has continued to lawfully reside there to the present day. *Id*.

4. **Home Equity Limit:** Individuals with more than **$828,000** in home equity are not eligible for Medicaid coverage of a nursing home services, home care, or other long-term care services. N.Y. State DOH, Deficit Reduction Act of 2005- Long-Term Care Medicaid Eligibility Changes, 06 OMM/ADM-5 (July 20, 2006) (also providing examples of undue hardship).

    a. A **mortgage** or other liens and encumbrances can lower the individual's equity value. *Id*.

    b. **No equity limit applies if:** A spouse or minor or disabled child lives in the home or if an undue hardship would be caused by the equity limit. *Id*.

5. **Five Year Look-back and Transfer Penalty:** The LDSS will examine the Medicaid A/R's and spouse's financial records within a five-year **look-back** period for any **uncompensated transfers**, meaning transfers for less than fair market value. Uncompensated transfers will result in a **transfer penalty** during which time the nursing home resident will have to private pay for their nursing home stay, rather than having Medicaid coverage of those services. *See* 18 N.Y.C.R.R. § 360-4.4.; N.Y. State DOH, OBRA '93 Provisions on Transfers and Trusts, 96 ADM-8 (March 29, 1996); N.Y. State DOH, Deficit Reduction Act of 2005- Long-Term Care Medicaid Eligibility Changes, 06 OMM/ADM-5 (July 20, 2006).

    a. **Start Date of Look-back Period:** N.Y. State DOH General Information System "*Policy Change for the Begin Date of the Transfer of Assets*

Lookback Period," GIS 15 MA/07 (revised April 2015), states that for Medicaid applicants "[t]he look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid (the application date). In cases where an applicant is requesting coverage of nursing home care in the three-month retroactive eligibility period, the look-back period is 60 months immediately preceding the month of application." For Community Medicaid recipients seeking an upgrade to cover their nursing home stay:

> … the look-back period is 60 months preceding the month of institutionalization. Although requests for an increase in coverage for Medicaid payment of nursing home care can be applied up to three months prior to the date the request is received by the local district, the transfer of assets look-back period is 60 months from the date of institutionalization, not the date the increase in coverage is made. For Medicaid recipients who exceed 29 days of short-term rehabilitation services, the look-back period is 60 months prior to the month in which the individual started to receive the short-term rehabilitation services." *Id*.

b. What Must be Documented in Look-back Period: N.Y. State has adopted a policy of only requiring an applicant to list and explain transfers over $2,000 at application. N.Y. State DOH, Revised DOH-4220: Access NY Health Care Application and Release of DOH-4495A: Access NY Supplement A, 10 OHIP/ADM-5 (April 20, 2010). The Medicaid program still reserves the right to inquire about and include smaller transfers in the computation of the total amount transferred during the lookback period. *Id*.

c. Penalty Rate:

> An institutionalized individual who has made an uncompensated transfer of assets during the look-back period is subject to a period of ineligibility for Medicaid coverage of nursing home care. The period of ineligibility, or penalty period, is the number of months equal to the uncompensated value of the transferred assets divided by the Medicaid regional rate established for the region in which the nursing facility is located. The rates are based on average private pay nursing home costs in each of the seven regions in the state and are subject to change annually. For purposes of calculating a transfer penalty period, districts must use the regional rate in effect on the date the institutionalized individual applies for Medicaid (application date), or requests an increase in coverage for Medicaid payment of nursing home care.

N.Y. State DOH, Policy Change for Determining the Appropriate Medicaid Regional Rate for Calculating a Transfer Penalty Period and the Regional Rates for 2016, GIS 15 MA/023 (January 1, 2016). The penalty rate is increased every year, announced in a GIS message by NYS DOH. The same GIS cited above gives the penalty rates for 2016.

d. Start Date of Penalty Period: The penalty period begins to run when three conditions are met: the applicant is in the nursing home; is otherwise eligible for Medicaid (i.e., is below the asset limit); and has submitted an application for Institutional Medicaid (which will inevitably be denied, because of the transfers). N.Y. State DOH, Deficit Reduction Act of 2005- Long-Term Care Medicaid Eligibility Changes, 06 OMM/ADM-5 (July 20, 2006).

e. <u>Exceptions to the Transfer Penalty – Assets Other than the Home:</u>

For transfers of assets other than the home transfers that will not result in a penalty include these exceptions:

i. Transfers to a **spouse** (However, Medicaid deems the spouse's resources as available to the Medicaid applicant, subject to the spousal impoverishment rules, discussed *supra*. Also, a transfer by the non-applicant spouse within the look-back period *and while the application is pending* will still incur a transfer penalty for the applicant spouse.);

ii. Transfers to a certified **disabled child of any age** (The child must be determined disabled by the Social Security Administration or the N.Y. State Medicaid program and must have been disabled at the time of the transfer.) The child may be over age 65. *See* N.Y. State DOH, Disability Reviews for Adult Children Over 65, GIS 08 MA/036 (December 29, 2008);

iii. Transfers to a **trust established solely for the benefit of an individual who is disabled and under 65** (this can include a supplemental needs trust for the applicant, if under age 65 and disabled);

iv. Transfers of an **exempt asset** (for example, Holocaust restitution);

v. The individual or spouse **intended to dispose of the resources at fair market value** or for other valuable consideration;

vi. Transfers for a purpose **other than to qualify for Medicaid** [*see* N.Y. State DOH, OBRA '93 Provisions on Transfers and Trusts, 96 ADM-8 (March 29, 1996) (State guidance provides examples of transfers considered for a purpose other than to qualify for Medicaid and examples of undue hardship)];

vii. Imposition of a penalty would work an **undue hardship** (see 96-ADM-8, *supra*);

viii. All or part of the **resources were returned** to the applicant. 42 U.S.C. § 1396p(c)(2)(B); 18 N.Y.C.R.R. § 360-4.4; N.Y. State DOH, 96 ADM-8, *supra*; *see also* Weiss v Suffolk County DSS, 121 A.D.3d 703, 993 N.Y.S.2d 368 (2d Dept. 2014) (family paying for Assisted Living not "return" of assets so did not cancel transfer penalty).

f. **Transfers of the Home:** A home can be transferred without penalty to a **spouse**; a **child under 21** or an **adult child who is blind or permanently and totally disabled**; a **sibling who has an equity interest in the home** and who resided in the home for at least one year before the date of the Medicaid A/R's admission to the institution; or an **adult child who resided in the home for at least two years immediately prior to the institutionalization and who provided care** to the applicant which

permitted them to reside at home rather than in a medical facility. 42 U.S.C. § 1396p(c)(2)(A); N.Y. S.S.L. § 366(5)(d)(3)(i)(B); 18 N.Y.C.R.R. § 360-4.4(c)(1)(ii)(B). Notice of placement of a lien on the home gives 90 days to make an exempt transfer.

B. <u>Income: Maintaining Community Medicaid Budgeting for an Individual Without a Community Spouse:</u>

1. **What is Community Budgeting?** Many DAB Medicaid A/Rs are admitted to nursing homes but plan to return to their homes in their community. For DAB Medicaid A/Rs living in the community, Medicaid has an $825 income limit for a single person and a $1,209 income limit for a married person in 2016. DAB Medicaid A/Rs living in the community can have excess income over those amounts but in order to receive Medicaid coverage need to either pay the excess income to Medicaid, spend the excess income down by incurring medical expenses, or deposit it in a supplemental needs trust where the trust funds will be limited to paying for their living expenses. *See* N.Y. S.S.L. § 366; 18 N.Y.C.R.R. § 360-4.8. Upon admission to a nursing home, it is important for DAB Medicaid A/Rs, who do not have a spouse living outside of the nursing home, to maintain this Community Medicaid budgeting so that they can continue to pay rent, mortgage, utilities, and other living expenses to preserve their apartment or home for their return.

2. **Chronic Care Budgeting:** Any patient who enters a nursing home, or stays in a hospital for 6 months and has no community spouse, is **presumed** to be in "permanent absence status," meaning they are not expected to return home. 18 N.Y.C.R.R. § 360-1.4(k). For patients in "permanent absence status," Medicaid uses "chronic care" budgeting to calculate how much of their income must be used to pay toward the cost of their nursing home care. *See* 18 N.Y.C.R.R. § 360-4.9. Beginning with the first full calendar month of the patient's admission to the nursing home, they are allowed to keep only a personal needs allowance of $50. *See* 18 N.Y.C.R.R. §§ 360-1.4(c), 360-4.9; N.Y. DOH Medicaid Reference Guide, pages 232-235 (Chronic care budgeting is discussed in more detail, *infra*.).
3. **The presumption of permanent placement can be *rebutted* to allow the DAB Medicaid A/R to retain the same income they are allowed in the community, $825/month or $1,209/ month**, and the same procedures they were using to deal with any excess income, such as utilizing a supplemental needs trust to pay living expenses. This presumption of permanent absence may be overcome by "adequate medical evidence" that the patient expects to return home. 18 N.Y.C.R.R. § 360-1.4(k). The medical evidence need not guarantee that the patient will return home - it is only a reasonable expectation. Since the nursing home generally prepares and submits the Medicaid application, it is the nursing home's role to inform Medicaid that the patient expects to return home and to submit "adequate medical evidence" to rebut the presumption that the resident

will not return home. However, since the nursing home has no incentive to do this extra work, the patient, family, or advocate must ask the nursing home to do this. In New York City, the nursing home should file a form called a Discharge Alert: Non-Chronic Budget (MAP-259d), on which the treating physician certifies that the patient is planning to return to community living, specifying an anticipated discharge date, available at http://www.wnylc.com/health/download/132/.

4. **No State law or regulation says that community budgeting is just for six months**. In June 2015, DOH confirmed that there is no time limit for community budgeting. *See* N.Y. State DOH webpage "Transition of Nursing Home Populations and Benefits to Medicaid Managed Care: Frequently Asked Questions," Eligibility Section, Question #2 (revised January 2016), available at http://www.health.ny.gov/health_care/medicaid/redesign/2016-jan_rev_nh_transition_faqs.htm#eligibility. DOH explained that "…[t]here is no set durational limit, for example 6 months, for temporary status in a nursing home; however, for Medicaid eligibility purposes, the consumer´s status should be re-evaluated periodically based on medical evidence." At the end of a 6 month period, it may be necessary for the nursing home to file a new "Discharge Alert" stating the new anticipated discharge date.

C. <u>Income: Chronic Care Budgeting:</u>

1. **<u>The "NAMI" = Net Available Monthly Income</u>**: The NAMI is the amount that a DAB Medicaid A/R, residing in a nursing home permanently, is expected to contribute toward the cost of their care. The outcome of **"chronic care" budgeting** for a DAB Medicaid A/R, who does not have a spouse living in the community, is that nearly all income must be paid over to the nursing home as the NAMI. Income is counted for this "chronic care" **"post-eligibility" budgeting** that would be excluded if received while the individual was on Medicaid with community budgeting. 42 CFR § 435.832(c) provides that "income that was disregarded in determining eligibility must be considered in this process [the post-eligibility determination of the amount to be paid from the individual's income and the amount to be paid by Medicaid]." "Post-eligibility" is the budget calculation of the NAMI, as opposed to "eligibility," which is whether the individual is eligible for Medicaid at all (they might not be because of a transfer of assets or because income is so high that it exceeds the cost of nursing home care).

    a. The only deductions from the NAMI calculation are a **$50 Personal Needs Allowance**, an amount to cover **health insurance premiums**, an amount to meet the maintenance needs of dependent family members, and an amount to cover medical expenses not covered by Medicaid or other health insurance. 18 N.Y.C.R.R. § 360-4.9.

b. Some sources of income are excluded from consideration in the NAMI and are listed at 18 N.Y.C.R.R. § 360-4.9(a)(5).

c. If an individual is not admitted to a nursing home on the first of a month, for the partial month of admission, they will receive "non-chronic" community budgeting. 18 N.Y.C.R.R. § 360-1.4(c).

2. **Spousal Impoverishment Budgeting:** A DAB Medicaid A/R, who is in a nursing home and likely to be there for 30 days and has a spouse living outside of the nursing home, may use all or part of their income to support their community spouse, depending on the spouse's own income. If the spouse at home has income that is less than the "**Minimum Monthly Maintenance Needs Allowance**" ("**MMMNA**") which is $2,980 per month in 2016, then the community spouse may keep their own otherwise available income plus enough of the institutionalized spouse's income to bring the total up to the MMMNA level. This is called the "**Community Spouse Monthly Income Allowance**" ("**CSMIA**"). *See* N.Y. S.S.L. § 366-c; 18 N.Y.C.R.R. § 360-4.10; *see also* N.Y. State DOH, 2016 Federal Poverty Levels, GIS 16 MA/07 (January 1, 2016). The community spouse's otherwise available income consists of income solely in their name plus half of any income that is in the joint name of both spouses. *Id*. If the institutionalized spouse has income that is above the amount needed to bring the community spouse's income up to the MMMNA and a $50 personal

needs allowance, the balance must be paid to the nursing home as the NAMI (minus the cost of any medical expenses not covered by a third party). *Id*.

3. If the community spouse needs more of the institutionalized spouse's income than is allowed with the CSMIA, they can sue in family court for an order of support, or request a fair hearing, but must prove "exceptional circumstances which result in significant financial distress." *Id*. If the community spouse's own income exceeds the MMMNA, Medicaid will ask for a contribution of 25% over that amount toward the institutionalized spouse's care. *Id*. This contribution is "voluntary," though the community spouse risks being sued for support if they refuse.

4. Minor children and dependent children/ parents/ siblings (defined as having over 50% of their needs met by the community or institutionalized spouse and who lives with the community spouse) also get a **Family Member Allowance** from the institutionalized spouse of up to $668 per month (up to a maximum of $2,003 per family) in 2016. *Id*.

D. **Spousal Refusal:** Under N.Y. Social Services Law 366.3(a), the community spouse's **refusal to contribute income and/or resources** to the cost of nursing home care does not make the institutionalized Medicaid A/R ineligible for Medicaid. But, the LDSS has the right to sue a spouse who refuses to contribute. The community spouse must still disclose their income and resources, since any transfer of resources by the community spouse can cause a transfer penalty even if they do a spousal refusal to contribute

resources. *See* N.Y. State DOH, Spousal Impoverishment: Family Member Allowance Increase and Community Spouse Entitlement to Monthly Income Allowance, 91 ADM-33 (August 22, 1991).

E. **Estate Recovery:** Medicaid can recover the costs of a DAB Medicaid A/R's care from their estate after the individual's death if the deceased recipient was 55 years of age or older when they received Medicaid; or if the deceased recipient was any age and was permanently institutionalized. *See* 42 U.S.C. § 1396p; N.Y. S.S.L § 369; N.Y. State DOH, Medicaid Liens and Recoveries, 02 OMM/ADM-3 (April 17, 2002).

VII. What Happens to Other Public Benefits in a Nursing Home?

A. **Social Security Retirement ("SSRI") or Disability ("SSDI"):** Admission to a nursing home does not affect the amount of SSRI or SSDI benefits an individual receives, though Medicaid requires contribution of most of these benefits as the NAMI. But, sometimes a nursing home will try to become the individual's "Representative Payee" so that the facility is guaranteed the patient's NAMI. (Representative Payee is explained in more detail in the Social Security Administration, Program Operations Manual, Section GN 00502.000)

B. **Supplemental Security Income ("SSI"):** Admission to a nursing home does affect the amount of SSI an individual receives. SSI will reduce to $55 per month for recipients permanently in a nursing home, after one full month in the nursing home. Social Security Administration, Program Operations Manual, Section SI 00520.140; N.Y. State

Office of Temporary and Disability Assistance, Social Security Administration (SSA) and Cost-of-Living (COLA) for January 2016 and updated SSI and SSP Benefit Levels Chart, 15-INF-10 (December 14, 2015). If the SSI recipient's nursing home stay is expected to last less than three months, they can keep their full SSI award for three months. *Id*. To do so, a physician (or other appropriate source) must certify in writing to the Social Security Administration, before the 90th day of the institutionalization or the discharge home, whichever is earlier, that they expect the medical confinement will not last longer than 90 days. The SSI recipient must also demonstrate that they need to pay expenses to return home. If they are still in the nursing home after 3 months, SSI will reduce to $55. *Id*. A Fact Sheet and sample forms that can be used to make this request are available at http://www.wnylc.com/health/download/594/.

C. **Public Assistance ("PA"):** PA recipients in a medical facility, such as a nursing home, are entitled to personal needs allowance ("PNA") for clothing and incidentals. 18 NYCRR § 352.8. In 2016 the PNA is $40 per month. N.Y. State Office of Temporary and Disability Assistance, Personal Needs Allowance (PNA) in Non-Medical and Medical Facilities, 15-INF-03 (February 17, 2015).

D. **Supplemental Nutrition Assistance Program ("SNAP") (commonly called "Food Stamps"):** SNAP recipients are not entitled to benefits while residents of a nursing home. The SNAP Sourcebook, section 5, page 106, available at http://otda.ny.gov/programs/snap/snapsb.pdf, states, "Residents of institutions are those individuals who are provided the majority of their meals (over 50% of three meals

daily) as part of the institution's normal service. Residents of institutions cannot participate in the FS program."

VIII. Carve-in of the Nursing Home Benefit to Medicaid Managed Care:

The N.Y. State Medicaid Redesign Team Initiative 1458 "Care Management Population and Benefit Expansion, Access to Services and Consumer Rights" carved nursing home services into the benefit package of Medicaid managed care plans. As a result, beginning February 2015 in N.Y.C., April 2015 in Long Island/Westchester, and July 2015 in the rest of N.Y. State, most adult Medicaid A/Rs are required to enroll in or stay enrolled in a Medicaid managed care plan for coverage of their nursing home stay. N.Y. State DOH, Transition of Long Term Nursing Home Benefit into Medicaid Managed Care, 15 OHIP/ADM-01 (April 1, 2015). The N.Y. State DOH webpage for Initiative 1458 contains Webinars, a Policy Paper, Frequently Asked Questions, and a Timeline providing more details of this carve-in under the subsection "February 1, 2015 Population Transition – Nursing Homes ("New" Duals and Non-Duals) (FIDA Region Adults) (NYC, Nassau, Suffolk & Westchester)" "Transition of Nursing Home Populations and Benefits to Medicaid Managed Care" at https://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm. This managed care enrollment requirement applies only to people who are approved for permanent nursing home placement and Institutional Medicaid (after the 60-month lookback review is completed) after the above-listed dates. N.Y. State DOH, Transition of Long Term Nursing Home Benefit into Medicaid Managed Care, 15 OHIP/ADM-01 (April 1, 2015). Anyone permanently placed with

Institutional Medicaid before those dates will not have to enroll in a managed care plan, and will continue to have Medicaid pay for their nursing home services on a "fee for service" basis unless they lose their bed if hospitalized and not entitled to "bed hold." *Id*.

A. The type of managed care plan in which the Medicaid A/R must enroll depends on whether or not they receive Medicare.

1. Individuals with Medicare ("**dual eligibles**") will have to enroll in a **Managed Long Term Care** ("**MLTC**") plan, unless otherwise excluded or exempt. *See* CMS Special Terms and Conditions, Partnership Plan Medicaid Section 1115 Demonstation, at 27, available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/partnership_amendment_stc.pdf (for a list of exclusions/exemptions).

2. Individuals without Medicare will have to enroll in a "**mainstream**" Medicaid managed care plan, unless otherwise excluded or exempt. *See* N.Y. S.S.L. § 364-j(3) (for a list of exclusions/exemptions).

B. Individuals already enrolled in an MLTC or mainstream Medicaid managed care plan in the community, who come to need permanent nursing home placement after the above-listed dates will no longer be disenrolled from their plan when they need nursing home services. They will need to choose a nursing home within their plan's network (or may sometimes change plans) and the plan will still manage their care in the nursing home, which includes discharge planning as needed. N.Y. State DOH, Transition of Long

Term Nursing Home Benefit into Medicaid Managed Care, 15 OHIP/ADM-01 (April 1, 2015).

C. **Individuals not already enrolled in an MLTC or mainstream Medicaid managed care plan in the community**, who come to need permanent nursing home placement after the above-listed dates and are then approved for Institutional Medicaid, will receive a notice from N.Y. Medicaid Choice giving them 60 days to choose a managed care plan or they will be auto-assigned to a plan that has their nursing home in network. *Id*. They do not need to enroll in a managed care plan until they get the notice. Their nursing home services will be paid for by Medicaid fee for service meantime.

D. **MLTC enrollees who only need short-term rehabilitation care**, however, may go to any skilled nursing facility of their choice, and are not restricted to facilities in their MLTC plan's network. The MLTC plan must pay the Medicare coinsurance for the skilled nursing facility stay. *See* N.Y. State DOH Frequently Asked Questions, Question 42 on page 7, available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2016-jan_rev_nh_transition_faqs.pdf. However, once the Medicare-covered stay is over and they are determined to be permanently placed with Institutional Medicaid, they will need to switch to a MLTC plan that includes their preferred facility in its network to receive coverage for the nursing home services. MLTC enrollments are always effective on the 1st of a month so timing and payment between the end of the Medicare-covered days and the 1st of the month must be considered.

IX. Getting Home Care for a Nursing Home Discharge:

A nursing home should not discharge a patient unless they can be safe in their residence in the community. This usually means home care.

A. Medicare pays for short term care from a Certified Home Health Agency ("**CHHA**") at a maximum of 28 or 35 hours per week. 42 C.F.R. § 409.61. Typically, CHHA's provide only about 6 to 10 hours per week. For some individuals, Medicare CHHA is sufficient for a safe discharge: If they are healthy enough; If they have caregivers to provide the rest of their care; If they can private pay for the rest of their care.

B. If an individual is already enrolled in a Medicaid managed care plan: All levels of home care are included in most Medicaid managed care benefit service packages (Medicaid Advantage does not include long-term care services: http://www.health.ny.gov/health_care/managed_care/docs/medicaid_advantage_model_contract.pdf). Ask the plan to assess the individual in the nursing home, authorize home care hours, and arrange transportation from the nursing home to the community residence per the procedures and timeframes outlined in the plan type's Model Contract with DOH. *See e.g.*, N.Y. State DOH, Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (March 1, 2014) available at http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf; N.Y. State DOH, Managed Long Term Care Partial Capitation Model Contract (September 1, 2012 - December 31, 2014) available at

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

C. **If an individual is already a member of an MLTC plan**, then the MLTC plan should assess for and arrange home care and other long-term care services for the individual to return home.

D. **If an individual is a dual-eligible (has Medicaid and Medicare) and not yet enrolled in MLTC, there are 2 possible routes to obtain home care services if Medicare home care is not enough – (1) Enroll in an MLTC Plan or (2) Apply for Immediate Need personal care services from LDSS**.

1. Enrolling in MLTC Plan from Nursing Home

a. The individual will likely need a **Conflict Free Assessment** before they can enroll in a MLTC. Under N.Y. State DOH "MLTC Policy 14.06: Implementation of the Conflict-Free Evaluation and Enrollment Center (CFEEC)" (Sept. 30, 2014), available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_auth_14.06.pdf) anyone approved for Medicaid who is seeking MLTC will need to first request a conflict-free assessment, meaning an assessment conducted by a nurse who is not employed by a MLTC plan. If that assessment finds the person eligible for MLTC, then the person can enroll in an MLTC plan. The Conflict-Free Evaluation and Enrollment Center (CFEEC) at Maximus/NY Medicaid Choice (www.nymedicaidchoice.com) schedules and conducts initial assessment visits in the home or nursing home by a nurse (employed by or under contract with the CFEEC). Using the Uniform Assessment Tool, the CFEEC makes the determination of eligibility for Medicaid long-term care. If the CFEEC determines that the applicant is ineligible for Medicaid long-term care, it will send a written notice with appeal rights.

b. If the CFEEC approves the applicant, then any MLTC plan must accept the applicant's enrollment. If the plan disagrees with the CFEEC's determination of eligibility, it may pursue a dispute adjudication

procedure via Maximus and DOH. *See* N.Y. State DOH, Conflict-Free Evaluation and Enrollment Center (CFEEC) Fact Sheet, available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-09-29_cfeec_factsheet.pdf; N.Y. State DOH, Conflict-Free Evaluation and Enrollment Center (CFEEC) Frequently Asked Questions, (September 29, 2014), available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-09-29_cfeec_faqs.pdf; N.Y. State DOH, Conflict-Free Evaluation and Enrollment Center (CFEEC) Frequently Asked Questions, (March 27, 2015), available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-03-27_cfeec_faq.pdf.

c. Then the individual will need to be assessed by the MLTC plan itself. DOH released guidance in May 2014 requiring MLTC plans to assess consumers in nursing home, within 30 days of receiving the assessment request. The plan must also visit the individual's community residence as part of the assessment process, but the individual does not need to be present for that visit. N.Y. State DOH, MLTC Policy 14.04: MLTCP Potential Enrollee Assessments (May 22, 2014), available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_nursing_home_assess_v2.pdf.

d. Since MLTC enrollment only starts on the 1st of a month, discharge and start of home care services must be coordinated for the beginning of the month. An individual must enroll in a MLTC plan by the 18th of a month for enrollment to start on the 1st of the following month. N.Y. Health Access article "Tools for Choosing a Medicaid Managed Long Term Care Plan" provides information about how and when to enroll in a MLTC plan at http://www.wnylc.com/health/entry/169/ and the NYLAG Fact Sheet "Avoiding and Troubleshooting Enrollment Delays in Managed Long Term Care for People Being Discharged from Nursing Homes" available at http://www.wnylc.com/health/download/534/ highlights issues that can be caused from converting Medicaid coverage from Institutional to MLTC-eligible.

e. The N.Y.C. Human Resources Administration, with the permission of DOH, has created a procedure to help nursing home residents who already have Medicaid, seeking discharge with MLTC home care, to enroll in a MLTC between the 21st and last day of the month prior to MLTC enrollment. The procedure is described in the February 14, 2013 Medicaid Alert "MLTC Submissions of Nursing Home Enrollments" and consists of a number of forms that must be submitted by both the nursing home and MLTC plan to two different units within HRA in order for a HRA staffer to manually complete the change in Medicaid coverage

from Institutional to MLTC-eligible and enroll the individual in the MLTC plan. The Medicaid Alert is available at http://www.wnylc.com/health/download/439/. It is a crucial procedure to utilize so that an individual's discharge from a nursing home is not delayed by up to a month and a half as it could be if pursuing the normal course of MLTC enrollment through NY Medicaid Choice.

2. **Apply for Immediate Need Personal Care or CDPAS Services from NH:** Medicaid must provide **personal care services ("PCS")** and **Consumer Directed Personal Assistance Services ("CDPAS")** to those Medicaid applicants/recipients who have an immediate need. See N.Y. S.S.L. § 366-a(12); 18 N.Y.C.R.R. § 505.14(b)(7)-(8); 18 N.Y.C.R.R. § 505.28(k)-(l); N.Y. State DOH, Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services, 16 ADM-02 (July 1, 2016). Immediate need may be used where arranging a nursing home discharge for an individual whose MLTC enrollment is delayed.

    a. In July 2016, DOH published an **Attestation Form** (OHIP-0103) and instructions for accessing immediate needs PCS and CDPAS on their webpage at http://www.health.ny.gov/health_care/medicaid/#need; http://www.health.ny.gov/health_care/medicaid/docs/ohip_form-0103.pdf (direct link to form). The form states:

    > If you think you have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), you may have your eligibility for these services processed more quickly if you:

1. have no voluntary informal caregivers able and willing to provide or continue to provide care;
2. are not receiving needed assistance from a home care services agency;
3. have no third party insurance or Medicare benefits available to pay for needed assistance;
4. and have no adaptive or specialized equipment or supplies in use to meet, or that cannot meet, your need for assistance.

b. If Institutional Medicaid is already approved, a request to convert Medicaid to Community coverage must be submitted, along with a physician´s order for home care on local LDSS form and a signed "Attestation of Immediate Need" (OHIP-0103) to LDSS. If Institutional Medicaid application is still pending, contact LDSS to find out procedure to request that the application be processed on an expedited basis for community eligibility with long-term care. In NYC, this request must be made to the Nursing Home Eligibility Department (NHED) within the Human Resources Administration ("HRA") Medicaid program.

E. If the individual does not already have Medicaid coverage or has Medicaid coverage that does not include coverage for community-based long term care services: An individual in a nursing home without Medicaid and with no application pending must submit a complete Medicaid application with "Supplement A" to apply for Medicaid. If there is an Immediate Need for PCS or CDPAS, the application should also include an Attestation form (OHIP-0103), a

physician's order for home care on local LDSS form, and all supporting documents, and should be submitted to LDSS. Note: Individuals with an immediate need for Personal Care Services or Consumer Directed Personal Assistance Services may attest to the current value of any real property and to the current dollar amount of any bank accounts.

1. If more information is needed, LDSS must send a letter, by no later than four days after receiving these required forms, to request the missing information. This letter will state what documents or information needs to be sent in and the date by which to send it.
2. By no later than 7 days after LDSS receives the necessary information, they must let the individual know if they are eligible for Medicaid.
3. By no later than 12 days after receiving all the necessary information, LDSS will also determine whether the individual could get PCS or CDPAS if they are found eligible for Medicaid. An individual cannot get this home care from Medicaid unless they are found eligible for Medicaid. If they are found eligible for Medicaid and PCS or CDPAS, LDSS will let them know and they will get the home care as quickly as possible.

F. How much personal care is authorized by local districts or by MLTC or managed care plans? PCS and CDPAS must be authorized under the process and standards described in 18 N.Y.C.R.R. §§ 505.14 and 505.28; N.Y. § S.S.L. 365-a. *See* N.Y. Health Access article on Personal Care Services, available at http://www.wnylc.com/health/entry/7/. New

regulations have re-defined standards for 24-hour live-in and split shift continuous care. *See* N.Y. State DOH, Changes to the Regulations for the Personal Care Services Program (PCS) and the Consumer Directed Personal Assistance Program (CDPAP), GIS 15 MA/024 (Dec. 31, 2015). These standards are binding both on local districts authorizing services for people excluded from managed long term care or for those with immediate need, and also binding on MLTC plans. *See* N.Y. State DOH MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), available at http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

G. If an individual is not required to enroll in (is exempt or excluded from) a Medicaid managed care or managed long term care plan and needs services other than personal care or consumer directed assistance, they may apply for other long-term care services, including:

1. **Private Duty Nursing** services, for which prior approval must be requested from DOH. *See* 18 N.Y.C.R.R. § 505.8; N.Y. State Medicaid Program, Private Duty Nursing Manual: Policy Guidelines (updated June 1, 2016); N.Y. State Medicaid Program, Private Duty Nursing Manual: Prior Approval Guidelines (updated October 1, 2015) (listing documents required for a nursing prior approval).
2. **CHHA** services, which would be requested directly from a Certified Home Health Agency, which develops a plan of care after a nurse's assessment. The plan of care must be signed by a physician. The CHHA bills Medicaid directly for

services. *See* 18 N.Y.C.R.R. § 505.23; N.Y. Health Access website article "Medicaid Certified Home Health Agency (CHHA) Services available at http://www.wnylc.com/health/entry/76/.

X. Special Budgeting for MLTC Enrollees Post-Nursing Home:

A. Medicaid Nursing Home/ Adult Home Transition Shelter Allowance: If Medicaid made a payment for a nursing home or adult home stay, Medicaid will deduct a regionally-standardized shelter cost from income upon discharge where the A/R has a housing expense and: Has been in a nursing home/adult home for at least 30 days (not counting the day of discharge); is eligible for/enrolled in an MLTC plan upon discharge; and is not receiving spousal impoverishment budgeting. N.Y. State DOH, Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program, 12 ADM-05 (October 1, 2012).

a. The 2016 allowances, which vary by region are posted in N.Y. State DOH, 2016 Medicaid Only Income and Resource Levels and Spousal Impoverishment Standards, GIS 15 MA/021 (January 1, 2016).

b. In effect, these allowances increase the amount of income the individual may keep, and decrease or eliminate the spend-down.

B. Spousal Impoverishment Budgeting: Spousal impoverishment budgeting, previously only for nursing home and waiver programs, is now available to married couples where one spouse is in MLTC. The calculation is the same as in Chronic Care Budgeting,

however the Personal Needs Allowance for the spouse enrolled in MLTC is not $50 per month but is the difference between a non-MAGI household of one and two income limits ($1209 - $825 = $384 in 2016). N.Y. State DOH, Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act, GIS 14 MA/025 (2014). For more information see http://www.wnylc.com/health/entry/165/.

a. Under DOH policy, spousal impoverishment budgeting is only available once the spouse is already enrolled in MLTC, not during the initial eligibility determination for a new applicant. GIS 14 MA/025, *supra*. However, in the new procedures for expediting Medicaid applications in seven days where there is an immediate need for personal care services, DOH policy says that spousal impoverishment can be requested in this initial budgeting. *See* N.Y. State DOH, Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services, 16 ADM-02 (July 1, 2016).

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Nursing Homes: From Admission to Discharge

Marie T. Vaz, Staff Attorney, Evelyn Frank Legal Resources Program
NYSBA Partnership Conference, September 2016

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What is a Nursing Home?

- We use the term "**nursing home**" to refer to a facility that might be operating/providing services under a number of different terms, for example:
- **Skilled Nursing Facility**
- **Residential Health Care Facility**
- **"Rehab"** (used colloquially, not to be confused with hospital's Inpatient Rehabilitation Facility services "acute" or "sub-acute")
- All of these terms are defined in accompanying outline. Citations for any proposition made in these slides found in accompanying outline.

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WHO PAYS FOR NURSING HOME CARE?

Medicare
Medigap
Long-term Care, Retiree, Private Insurance
Medicaid
Self-pay

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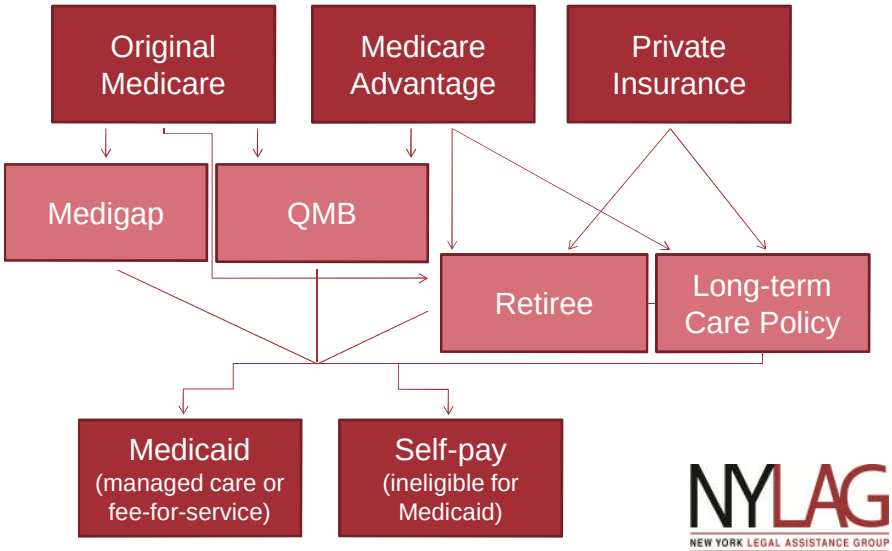
Payment Options for Nursing Home Care



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What is Medicare?

Who gives it?	U.S. Centers for Medicare and Medicaid Services (CMS)
Who gets it?	People who are over 65; people with disabilities after receiving Social Security Disability (SSD) for 24 months (or immediately for those with ALS); people with end-stage renal disease (ESRD)
Eligibility	• US citizen, or legal alien residing continuously in the US for at least 5 years • Applicant or spouse must be fully insured for Social Security purposes (40 quarters of coverage) to get free Part A
What do you get?	• **Part A** – Hospital Insurance • **Part B** – Supplemental Medical Insurance (doctor's visits, etc.) • A + B = "**Original Medicare**" • **Part C** – Parts A, B & D through Managed Care plan (optional) • **Part D** – Prescription Drug Benefit (optional)

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Medicare Payment of Nursing Home

- **Original Medicare** and **Medicare Advantage** plans can pay for up to 100 days in a skilled nursing facility per "benefit period" *if* strict criteria are met (next slide).
- Original Medicare: days 1-20 are fully covered and days 21-100 have a $161 copay
- Medicare Advantage: most if not all days have a copay, amount varies by plan
- A **benefit period** begins the day inpatient care starts and ends after being out of the hospital or skilled nursing facility for 60 days in a row.

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Medicare Payment of Nursing Home

- Must meet certain criteria for Medicare coverage:
  - Need **daily skilled care** – either nursing seven days a week or skilled therapy services at least five days a week;
  - Formally **admitted as an inpatient to a hospital for at least three consecutive days** and entered a Medicare-certified skilled nursing facility within 30 days of leaving the hospital (*warning* re: "observation status");
  - Enrolled **in Medicare Part A** before being discharged from the hospital;
  - Need care that can only be provided in a skilled nursing facility.
- There is **NO "improvement standard"**!!! Medicare should cover skilled care that helps maintain ability to function or helps prevent or slow getting worse.
  - This was clarified by the *Jimmo vs. Sebelius* settlement

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Observation Status: Barrier to Medicare Coverage

- Hospitals often keep patients in "**observation status**" in the E.R. without admitting them. Unless admitted for 3 days before discharge, Medicare won't pay for SNF care.
  - Lawsuits have not yet been successful, but some chipping away led to…
- **Notice Laws:** N.Y. is one of 5 states requiring hospitals to inform patients when they are in observation status within 24 hours and of the consequences of not being admitted as inpatients.
- The Federal *Notice of Observation, Treatment and Implication for Care Eligibility Act* requires hospitals to tell Medicare beneficiaries of their outpatient status within 36 hours, or, if sooner, upon discharge.

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More on Medicare Observation Status

- **3 day rule loosened:** Effective January 1, 2016, CMS will allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if medical record supports the admitting physician's determination that "…the admitting physician expects the patient to require hospital care that crosses **two midnights**."

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Payment Options: Filling Medicare Gaps

- Some Medicare supplemental plans (**Medigaps**) will pay for the copay of Original Medicare.
- **Medicare Savings Program – QMB** will pay the copay for Original Medicare and Medicare Advantage.
- Client might have purchased a **Long-Term Care policy** or might be enrolled in a private insurance plan or **retiree** plan that has a nursing home benefit – payment varies by policy.
  - Many plans have deductibles - might not meet to cover short-term rehab
- Client might be Medicaid ineligible or have a **penalty** for transferring assets before qualifying for Medicaid and will have to **self-pay** in the meantime.

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MEDICAID COVERAGE OF A NURSING HOME STAY

- SHORT-TERM 29 DAY REHAB BENEFIT
- LONG-TERM "INSTITUTIONAL" MEDICAID:
- MAGI
- NON-MAGI

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What is Medicaid?

Who gives it?	New York City Human Resources Administration (HRA) and the New York State of Health (NYSOH), with participation from the New York State Department of Health (DOH) and the Federal Centers for Medicare and Medicaid Services (CMS)
Who gets it?	New Yorkers of limited means
Eligibility	• Category (MAGI, Disabled/Aged/Blind, etc.) • Income • Resources (only for DAB) • Immigration Status • Residency
What do you get?	Comprehensive health insurance coverage, including long-term care services (home care and nursing home care)

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Medicaid Coverage of Nursing Home Care

- Community Medicaid will pay for up to the first **29 days** of a nursing home stay, with no five-year "look-back."
  - Some categories of Community Medicaid do not have a resource test at all. Community Medicaid for the disabled, aged 65+, blind (DAB) only considers resources at the point of application onwards i.e., no look-back.
- In order for Medicaid to pay for any portion of days 30 onwards, the client would need their coverage converted/upgraded to "**Institutional Medicaid**."
- If the client did not have Community Medicaid before entering the nursing home, they would be filing an application for Institutional Medicaid.

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Medicaid Coverage of Nursing Home Care

- Institutional Medicaid will pay for a nursing home indefinitely as long as it is medically necessary.
- Medicaid remains the "**payor of last resort**" after the insurance listed on the previous slides.
- Remember, that some Community Medicaid recipients may be in nursing homes beyond 30 days without Institutional Medicaid. For example, people with a Medigap to cover the Medicare copays of days 21 to 100 do not need to apply for Institutional Medicaid until Medicare coverage ends.

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Unique to Institutional Medicaid

- Institutional Medicaid approval includes a five-year "**look-back**" in which Medicaid examines whether the client transferred assets. With a few exceptions, if the client did make transfers, Medicaid will penalize them for an amount of time during which the client will have to self-pay.
- Medicaid could place a **lien on the client's home** (with exceptions – later slide), while no lien on home may be placed for a Medicaid recipient living in the community.
- Client must usually contribute more income toward their care (a **NAMI**) than they did in the community

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Not Unique to Institutional Medicaid

- Medicaid may pursue an **estate recovery**, which may include the home if in the client's name at death. For non-MAGI recipients, Medicaid will recover the cost of all Medicaid services (in community or nursing home) received after age 55 (with exceptions – later slide).
  - MAGI Medicaid recipients also are subject to estate recovery: for cost of long term care, hospital, and prescription drugs after age 55, but not primary/specialist care.
- Client's home in the community is subject to a **home equity limit** ($828,000) (with exceptions – later slide). This limit applies to both nursing home and community-based long term care.

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What is a Transfer Penalty?

- **Transfer Penalty** is a delay in Medicaid paying for nursing home care: Medicaid will not pay for nursing home care if assets were transferred within the look-back period.
- The **look-back period** is 60 months before application filed if new Medicaid applicant, or 60 months before institutionalization, if already on Community Medicaid and seeking "upgrade" to Institutional.
- The **penalty period begins** when:
  1. The client is in a nursing home, and
  2. Is otherwise eligible for Medicaid, and
  3. A Medicaid application is actually filed

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How Long is the Transfer Penalty?

- The **length of the penalty** depends on the amount transferred: Total amount transferred during look-back period is divided by the regional nursing home rate to reach the number of months (and/or partial month) the penalty will run. **Use regional rate in effect on date of application:**

Region	Monthly Rate
NYC	$12,029
Long Island	$12,633
No. Metro (Westchester, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster)	$11,768
Northeastern (Albany + 16 other counties)	$9,806
Western (Erie + 7 other counties)	$9,630
Central (Tompkins + 13 other counties)	$9,252
Rochester (Monroe + 8 other counties)	$11,145

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Example of Look-back + Transfer Penalty:

- Mr. G is **admitted to a NH June 5, 2016**. Medicare covers the first 20 days of his stay in full. However, he has no Medigap, and needs Medicaid to start June 25th. Five years of resource documentation shows:
  1. Mr. G added his daughter's name to the deed of his house in 2013. Now the two own it jointly. She did not pay him anything in return. His house was worth $400,000 in 2013 with no mortgage.
  2. Mr. G also gives $5,000 each year to his favorite charity.
  3. He gave another $50,000 to his daughter in 2015 so he could become eligible for Community Medicaid.
- **He must apply for Institutional Medicaid by Sept. 30, 2016** if he wants coverage back to June.
- He must submit resource documentation going back to **Sept. 2011**.

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Here's how Medicaid will calculate the total transfers:

Date	Amount	Reason
2013	$200,000	Gift of 50% of value of house to daughter
2010 - 2015	$25,000	Gift of $5000/year to favorite charity
2015	$50,000	Gift of $50,000 to charity
Total Transferred	$275,000	

$275,000 ÷ $12,029 = 22.86 months

Total transfers

Regional NH rate NYC 2016

Mr. G will have to private pay for the NH for almost 23 months, nearly 2 years!

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Exceptions to Transfer Penalty: Home

- Transfers of a home by applicant or spouse in look-back period triggers a transfer penalty unless home transferred to:

1. **Spouse**
2. **Child** under 21 or **disabled child of *any age (even over age 65)***
3. **Sibling with an equity interest** in the home who has resided in the home for at least one year immediately before placement;
4. **Caretaker adult child** who resided in the home for at least 2 years, immediately prior to the most recent institutionalization and who provided care to the applicant which permitted them to reside at home rather than in a medical facility
   - It is presumed that the child "provided care" unless there is evidence to the contrary.

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Transfers Other than the Home: Exceptions to the Transfer Penalty

- Transfer of asset penalties are not imposed when an asset other than the client's home is transferred by the applicant or spouse to:

1. **Spouse**, or to another for the sole benefit of the individual's spouse (may not be to a trust or annuity with a remainderman/ beneficiary other than the spouse)
2. **Applicant's disabled child of *any age (even over age 65)*** (may transfer cash, does not require in trust);
3. **Trust established solely for the benefit of an individual under 65 years of age who is disabled** (does not have to be applicant's child or even related)(can be for oneself if <65);
4. **Transfer of an exempt asset** has no penalty – i.e. Holocaust restitution, assets under $14,850.

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More Exceptions to Transfer Penalty

5. Applicant/spouse intended to dispose of the asset for its fair market value or exchange it for other consideration of similar value;
6. Transfer was made exclusively for a purpose other than to qualify for Medicaid nursing home coverage
   - E.g. Consistent pattern of gifts or donations
7. All of the assets transferred for less than the fair market value have been returned to the individual
   - Gift can be returned by private-paying for nursing home care, but not home care, assisted living, rent, or other expenses
   - Partial return reduces penalty proportionally

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Institutional Medicaid and the Home

- Medicaid presumes that any resident of a nursing home lives there permanently so the home is **not exempt** as an asset. But if your client expresses an **intent to return home**, even if not realistically possible, it remains **exempt**.
- Medicaid will give **notice of intent to place a lien on the home** when the Medicaid application is filed, with exceptions.
- **No lien if MAGI-eligible**, since there is no asset limit.
- **No lien may be placed** if these relatives reside in the home:
  - spouse
  - child under 21
  - child of any age who is certified blind or disabled, or
  - sibling with equity interest in the home who was residing in the home for >1 year immediately before the admission and still legally resides there

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More about the Lien on a Home

- Client has 90 days from eligibility determination to make an allowed transfer of the home (*see* exceptions to transfer penalty – later slide).
- Even if lien is validly placed on home, Medicaid **cannot force a sale** if the following relatives still reside in the home:
  - a **sibling** who lived there for a year (regardless of any equity interest), immediately before admission, and has continued to lawfully reside in there to the present day; or
  - a **child** who provided care to the individual has resided there for two years immediately before the admission and who has continued to lawfully reside there to the present day.
- **Lien is removed if your client returns home**

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More about the Home Equity Limit

- Individuals with more than **$828,000 in home equity** are not eligible for Medicaid coverage of nursing facility services, home care, or other long-term care services.
  - Home equity limit applies to MAGI Medicaid, even though no resource test.
- Intent to return home doesn't help – not eligible
- Mortgage or other liens reduce equity amount
- **No equity limit applies if**:
  - **Spouse**, **minor** (< 21) or **disabled child** (any age) lives in the home,
  - Or an **undue hardship** is caused by equity limit
    - Denial of care would endanger life or health, or deprive individual of food, clothing, shelter, or other necessities of life, or
    - Legal impediment prevents accessing equity in home

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MAGI Medicaid Coverage of Nursing Home

- MAGI Medicaid includes coverage for nursing home services if your client is "**medically frail**." Needing nursing home services meets the definition of medically frail.
  - **WHO** - MAGI eligible individuals include people < 65 without Medicare (children, parents, caretaker relatives, people who are disabled but do not receive Medicare) plus Medicare beneficiaries under or over 65 who are caretakers for a minor child/relative <18 / <19 in school
  - **HOW** - If client has Medicaid through the Marketplace, their Medicaid must be transferred to the LDSS for input of needed eligibility codes for nursing home care.
- MAGI eligible individuals who need Institutional Medicaid are still subject to the **lookback** and penalty for asset transfers, the **home equity limit**, and **estate recovery**. But their home is **not subject to a lien** while they are in the nursing home

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MAGI Medicaid Nursing Home Eligibility: Income and Resources

- If your client is eligible for Institutional Medicaid under "**MAGI**" (modified adjusted gross income) budgeting, they can keep all of their income, regardless of the permanence of their stay.
- Must qualify as a household of one with an **income limit of $1,367** (in 2016). Limit for ONE used even if they have a spouse or child living in the community – spouse's income won't count. If income exceeds that limit, then must use budgeting as for Disabled, Aged 65+, Blind (non-MAGI).
- May not use spousal impoverishment protections.
- MAGI Medicaid **does not have a resource test**.

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Non-MAGI Medicaid Nursing Home Eligibility: Resources

- To be eligible for Institutional Medicaid as **Disabled, Aged 65+, Blind** your client first faces a **$14,850 resource limit**.
  - Same resource exemptions as for Community Medicaid
- If your client is married, their spouse may keep a **Community Spouse Resource Allowance**, the higher of:
  1. $74,820 *or*
  2. One-half of the couple's total combined assets up to $119,220 *or*
  3. An amount established by court order or fair hearing
- Client has 90 days to transfer ownership to spouse
- If the community spouse has more than the allowed amount, they can execute a **spousal refusal** but are subject to a potential claim/suit by LDSS

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Non-MAGI Medicaid – Effect on Income – "Chronic Care Budgeting" and "Spousal Impoverishment" Budgeting

- If your **Disabled, Aged 65+, Blind** client will be in the nursing home **permanently**:
  - They are entitled to a **$50 personal needs allowance** per month.
  - They are entitled to keep enough income to pay health insurance premiums, child support, and the actual cost of child care/incapacitated adult child care.
  - Their spouse is entitled to a **community spouse income allowance**, to bring the income the couple keeps up to $2,980 per month ("**spousal impoverishment budgeting**").
  - Their child or adult dependent child is entitled to a **family member allowance** to bring the child's income up to $668 per month.
  - The rest of the client's, or couple's, income must be paid to the nursing home for the cost of care. This amount is called a **NAMI** (net available monthly income).

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Non-MAGI Medicaid – Effect on Income – "Community Budgeting"

- If your **Disabled, Aged 65+, Blind** client will be in the nursing home **temporarily** and has no community spouse:
- They are entitled to the same Medicaid budgeting as Disabled, Aged 65+, and Blind Medicaid recipients living in the community.
- This means they can **keep $825 of their income** plus any applicable income exclusions and disregards.
- They would pay the amount they are over the $825 limit, after subtracting any applicable income exclusions and disregards, to the nursing home. This amount is called a **spend-down** or surplus.

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Non-MAGI Medicaid – Effect on Income – More on "Community Budgeting"

- If your **Disabled, Aged 65+, Blind** client will be in the nursing home **temporarily** and has no community spouse:
- To maintain "community" budgeting at the $825 income level a doctor, usually the doctor at the nursing home, must sign a form certifying that there is a "**reasonable expectation**" that the client can return home. The doctor does not have to guarantee that the client will return home.
  - The certification must be submitted to Medicaid. It can be submitted with or after the Institutional Medicaid application is filed. NYC forms posted at http://www.wnylc.com/health/entry/117/
- Community budgeting must be renewed with a physician's certification form every **6 months**. However, there is no limit to just one 6 month period.

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Example of Chronic Care Budget (single person)

$ 1,324.90	Gross monthly income
- $ 104.90	Medicare Part B premium ($121.80 if new to Medicare)
- $ 200.00	Medigap premium
= $1,000.00	Net countable income
- $ 50.00	Personal Needs Allowance (PNA)
= $ 950.00	**Net Available Monthly Income (NAMI)**

- NAMI must go to nursing home to contribute to cost of care. Medicaid pays the rest.
- Applies to first FULL MONTH and afterward, UNLESS community budgeting requested.
- No deduction allowed for pooled trust/individual SNT.

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Example of Community Budget (single person)

$ 1,324.90	Gross monthly income
- $ 104.90	Medicare Part B premium ($121.80 if new to Medicare)
- $ 200.00	Medigap premium
= $1,000.00	Net countable income
- $ 825.00	DAB Medicaid Income Limit
= $ 175.00	**Net Available Monthly Income (NAMI)**

- This budgeting also applies to the first month of admission in a chronic care budget- if first admitted for a PARTIAL MONTH
- Community Budgeting has many more deductions and exclusions from income than Chronic Care Budgeting

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Example of Spousal Impoverishment Budget

Institutionalized Spouse- $1,835/mo. income Community Spouse- $1,500/mo. income

Gross monthly income – Institutionalized Spouse		$1,835
Personal Needs Allowance (PNA)		- $50
Community Spouse Monthly Income Allowance (CSMIA)	MMMNA ($2,980) – Otherwise Available Income of spouse ($1,500) =	- $1,480
Health insurance premiums	(Medicare Part B)	- 105
	(Medigap)	- 200
Net Available Monthly Income (NAMI)		**$0**

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WHAT HAPPENS TO PUBLIC BENEFITS IN A NURSING HOME?

- Social Security Retirement & Disability
- SSI
- PA
- SNAP

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Social Security & Supplemental Security Income (SSI)

- Admission to a nursing home does not affect client's right Social Security Retirement (SSRI) or Disability (SSDI) benefits.
  - But Medicaid rules require turning over most of benefit as NAMI. Sometimes a nursing home will try to become Representative Payee so that they are guaranteed client's $.
- Admission to a nursing home does affect the amount of SSI:
  - SSI will reduce to **$55 per month** for clients permanently in a nursing home, after one full month in the nursing home.
  - If the client's nursing home stay is expected to last **less than 3 months**, they can keep their full SSI award for 3 months.
    - Must submit medical certification of < 90 day stay and proof of housing expense. Sample Form and Fact sheet at http://www.wnylc.com/health/download/594/
    - After 3 months in NH, SSI reduced to $55.

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Public Assistance (PA) and "Food Stamps" (SNAP)

- SNAP recipients are not entitled to benefits while residents of a nursing home.
  - From SNAP Sourcebook: *Residents of institutions are those individuals who are provided the majority of their meals (over 50% of three meals daily) as part of the institution's normal service.*
- PA recipients in a medical facility, such as a nursing home, are entitled to personal needs allowance (PNA) for clothing and incidentals. In 2016 the PNA is **$40 per month**.

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MEDICAID MANAGED CARE IN A NURSING HOME

- MMCO – Mainstream Managed Care
- MLTC – Managed Long Term Care

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Transition of Nursing Home Residents to Managed Care

- Transition began February 1, 2015 in New York City, July 1, 2015 in Long Island/Westchester, and October 1, 2015 for the rest of the State
- All eligible recipients over age 21 in need of nursing home care on a permanent basis will be required to enroll in or stay enrolled in a "mainstream" managed care ("**MMCO**") or Managed Long Term Care ("**MLTC**") plan. (MLTC for duals – Medicare + Medicaid, MMCO for Medicaid-onlies)
- Current residents who were permanently placed in a skilled nursing facility prior to above dates will remain fee-for-service and will not be required to enroll in an plan.

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Current Nursing Home Residents Grandfathered In!

- **No on forced to move – No one is required to enroll in a plan if they were permanently placed in a nursing home BEFORE**:
  - February 1, 2015 in NYC
  - April 1, 2015 in Long Island, Westchester
  - July 1, 2015 Rest of State
- But – in Oct. 2015 "voluntary enrollment" began for NYC NH residents, when they *may* enroll in MLTC plans.
- Definition of "permanently placed" is unclear!
- Even if permanently placed before those dates, if later are hospitalized and not on **bed hold**, can be required to enroll in plan once return to NH.

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When Must New NH Residents Enroll in Managed Care?

- **Merely going into NH for short-term rehab does not require enrollment in any plan.** Must enroll when it's a permanent placement, definition of which is unclear.
- We thought it was only after Institutional Medicaid is approved (with the 5-year lookback), but
- Now it seems that NH is required to file a "DOH-3559" with local DSS for change of status to long-term care – within 48 hours of decision to make it "permanent placement." That could be within days of admission.
- Either way, resident would first receive notice from NY Medicaid Choice or LDSS giving **60 days to select and enroll in a plan**. If doesn't enroll, would be assigned to a plan that contracts with that NH.

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Process for New NH Admissions #1

- Consumers **not already enrolled in MMCO/MLTC**:
  - Select and enter any **nursing home of their choice**
  - When Medicare coverage ends, **apply for Institutional Medicaid** (includes 5-year look-back and transfer penalties)(can be retroactive 3 months)
  - After NH Medicaid approved, will receive **notice from NY Medicaid Choice giving 60 days to pick a plan** (pick one that includes this nursing home in the network)
  - If don't pick a plan, will be **auto-assigned** to a plan that has that NH in network (MLTC for duals, MMCO for non-duals)
  - Do not have to enroll in plan until receive 60 day notice from NY Medicaid Choice

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Process for New NH Admissions #2

- Consumers **already enrolled in a Mainstream Medicaid Managed Care Plan (MMCO)** (Medicaid-onlies):
  - **Must enter a NH in that plan's network** or Medicaid will not pay for it
  - MMCO plan can no longer disenroll consumer because they need long term NH placement. **Plan must pay for NH.**
  - If NH stay > 30 days, must do **5-year lookback**, even though no asset test for MAGI Medicaid. Consumer will not be disenrolled from MMCO if there is a transfer penalty – **During penalty period** MMCO provides coverage for community-based services and consumer pays NH for NH services
  - Plan contract with NH will determine **who bills consumer for NAMI**

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Process for New NH Admissions #3

- Where consumer is **already enrolled in MLTC plan** (dual eligibles) – and entering NH from hospital:
  - Where Medicare pays primary – choice of NH is *not* limited to MLTC plan's network. MLTC plan must pay Medicare coinsurance out-of-network too.
  - **Once Medicare ends, if NH is not in the plan's network**, consumer may change to MLTC plan that has NH in network, but not effective until 1st of the next month.
    - Old MLTC plan should pay for reasonable time to transfer plans, but DOH has not defined this clearly.
  - Must submit **5-year lookback – since NH is getting paid by MLTC plan, they may wrongly think it is not needed**!
    - If transfer penalty found, will be disenrolled from MLTC plan and client could be liable to repay cost.

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Minimum Network Size = # NHs required

	# of NHs	Network minimum
Manhattan	16	5
Brooklyn	42	8
Queens	55	8
Bronx, Suffolk	43	8
Staten Island	10	5
Nassau	35	8
Monroe, Erie	43	8
Westchester	38	8
Oneida, Dutchess, Onondaga, Albany		4
Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster		3
All other counties		2 unless only 1 exists
Specialty NHs (AIDS/ vent/ behavior)		2 unless fewer exist
Veteran's - must contract with 1 in area, if any. If none, plan must pay for member to go out of network while changes plans to one with VA NH.		

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HOW TO GET HOME CARE TO LEAVE A NURSING HOME

- Medicare CHHA
- Medicaid Managed Care Plan
- Local Department of Social Services

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Getting Home from a Nursing Home

- Nursing home should not discharge client unless they can be safe in their residence in the community. This usually means home care.
- Medicare pays for short term care from a Certified Home Health Agency (CHHA) at a maximum of 28 or 35 hours per week. Typically, CHHA's provide only 6-10 hours per week.
  - For some clients, Medicare CHHA is sufficient: If they are healthy enough; If they have caregivers to provide the rest of their care; If they can private pay for the rest of their care
- Medicaid provides up to 24 hours, 7 days per week of home care, up to a nursing level of care, indefinitely, as long as it is medically necessary.
- Where your client applies for Medicaid home care depends…

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Getting Home Care from Medicaid:

If client already in MMCO/MLTC

- If your client is already enrolled in a MMCO or MLTC plan: Ask the plan to:
- Assess the client in the nursing home;
- Authorize home care hours;
- Arrange transportation from the nursing home to the client's residence.
- If your client is not enrolled in Medicaid managed care or MLTC, then procedure depends on whether client already has Medicaid, and if they do, whether client is required to enroll in a MLTC plan.

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Getting Home Care from Medicaid:

If client newly enrolling in MLTC

- If your client is a dual-eligible and not yet enrolled in Managed Long Term Care, it can be difficult to coordinate a nursing home discharge and a MLTC enrollment at the same time
- Before enrolling in MLTC client must complete a Conflict-Free (CFEEC) Assessment by NY Medicaid Choice - whether in short-term rehab or if permanently placed
- Catch 22: Dual-eligible client can't get home and receive home care without MLTC, but MLTC plan doesn't want to assess in nursing home!
  - After lengthy advocacy, DOH released guidance in May 2014 requiring MLTC plans to assess consumers in nursing home.
  - Plan must also visit community residence, but client need not be present for that visit (arrange for family to give access)

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Getting Home Care from Medicaid:

More on client newly enrolling in MLTC

- MLTC enrollment only starts on 1st of month – must enroll by 20th of month prior to enrollment and coordinate discharge and start of services to start 1st of enrollment month or have to wait until following month!
- If institutional Medicaid was already approved, NH needs to submit request to LDSS to "convert" Medicaid to Community Medicaid. This can cause delays in discharge. See this fact sheet for tips: http://www.wnylc.com/health/download/534/
- Special procedure developed by HRA for NYC nursing home residents seeking discharge to MLTC was published via Medicaid Alert dated February 14, 2013. If followed should help expedite discharge…

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Nursing Home Discharge Strategy: NYC

HRA Medicaid Alert entitled "MLTC Submissions of Nursing Home Enrollments": (**You** must coordinate 3 parties.)

1. MLTC plan must assess client in NH and agree to enroll them effective 1st of next month. Up until the **last day of the month prior to enrollment**:
   - Plan must fax NYC **HCSP-3022** MLTC MEDICAID COVER SHEET with expected enrollment date **and** signed enrollment agreement to HRA Home Care Services Program
   - NH must fax NYC **MAP-259D** DISCHARGE ALERT to HRA Nursing Home Eligibility Division **and** to MLTC plan to forward with HCSP-3022 and enrollment agreement to HRA Home Care Services Program
2. HRA Home Care Services Program must manually convert Medicaid coverage "code" to MLTC eligible effective 1st of next month.

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Nursing Home Discharge Strategy: NYC

3. Nursing home **and** MLTC plan must arrange discharge on 1st of the month with MLTC plan starting services. If 1st of the month is on a weekend, or plan can't start services on the 1st, consumer may be able to enroll on the 1st but be discharged a day or two later. MLTC plan would pay for nursing home care for those days.

- Post Medicaid Alert HRA said: The MLTC plan's submissions to HRA Home Care Services Program may fall between the 20th of the prior month and the 5th of the enrollment month. Enrollment will be for the 1st of the enrollment month. The plan must assume responsibility for paying the nursing home if the consumer is discharged between the 2nd and 5th.

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Getting Home Care from Medicaid:
If client not required to join MMCO/MLTC

- Medicaid-only recipients who are exempt/excluded from managed care: http://www.wnylc.com/health/entry/160/
- Medicaid recipients with Medicare ("dual eligibles") who are exempt/excluded from managed care: http://www.wnylc.com/health/entry/114/#exclusions
- Medicaid recipients needing **personal care services** or **Consumer Directed Personal Care Program** ("**CDPAP")** fee-for-service submit request form signed by their doctor to their LDSS. LDSS assesses client and authorizes # of hours.
  - In NYC form is called a M11Q. "Q-tips" can help doctor report important info even if LDSS uses another form: http://www.wnylc.com/health/afile/176/32/
- If the client does not yet have Community Medicaid, they can apply at the same time as submitting the medical request form.

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Immediate Need Home Care

- **Expedited procedure for clients who need personal care services or consumer-directed personal care services URGENTLY** – even clients who are mandatory managed care but can't go without home care until plan enrollment.
- Client must attest to:
  - have no voluntary informal caregivers able and willing to provide or continue to provide care;
  - are not receiving needed assistance from a home care services agency;
  - have no third party insurance or Medicare benefits available to pay for needed assistance; and
  - have no adaptive or specialized equipment or supplies in use to meet, or that cannot meet, your need for assistance.

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Immediate Need Home Care: Documents

- A **Medicaid applicant** with an immediate need for PCS/CDPAP must submit to LDSS:
  1. A **completed Medicaid application**: Access NY Health Insurance Application (DOH-4220) + Access NY Supplement A (DOH-4495A)/(DOH-5178A) and all supporting documents, including spousal impoverishment request
  2. A **physician's order for services** on the LDSS-prescribed form (M11Q in NYC)
  3. A signed **attestation form**: "Attestation of Immediate Need" (OHIP-0103)
  4. If married and needs spousal impoverishment budgeting, include **"Request for Assessment" form** to request spousal budgeting (page 9 of this link) and/or **Spousal Refusal form** MAP-2161

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Immediate Need Home Care: Documents

- A **Medicaid recipient with no long-term care coverage** and with an immediate need for PCS/CDPAP must submit to LDSS:
  1. A **completed Supplement A** (DOH-4495A)/(DOH-5178A) and all supporting documents, including spousal impoverishment request
  2. A **physician's order for services** on the LDSS-prescribed form (M11Q in NYC)
  3. A signed **attestation form**: "Attestation of Immediate Need" (OHIP-0103)
- A **Medicaid recipient with long-term care coverage** and with an immediate need for PCS/CDPAP must submit to LDSS:
  1. A **physician's order for services** on the LDSS-prescribed form (M11Q in NYC)
  2. A signed **attestation form**: "Attestation of Immediate Need" (OHIP-0103)
- If either of above is married, submit **Spousal Impoverishment request** if applicable (prior slide).

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Immediate Need Home Care: Timeline

- LDSS has **4 calendar days** from receipt of Medicaid application to notify client if application is incomplete/what missing information is needed
- LDSS has **7 calendar days** from receipt of complete Medicaid application to notify client if financially eligible for Medicaid
  - Client can attest to resources and document later, but better to document from the get-go to avoid complications
  - Client can receive spousal impoverishment budgeting pending MLTC enrollment
- LDSS **has 12 calendar days** from receipt of complete Medicaid application to assess and notify client if eligible for PCS/CDPAP and the amount and duration of services authorized

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Immediate Need Home Care: NYSOH

- Immediate need home care is not available to clients whose Medicaid case is through the **New York State of Health**
- Case must be transferred to LDSS
- Notify NYSOH of immediate need by sending:
  1. A **physician's order for services** on the LDSS-prescribed form (M11Q in NYC)
  2. A **signed attestation form**: "Attestation of Immediate Need" (OHIP-0103)
- The M11Q and signed attestation form must reach this designated mailbox at DOH for a staffer to initiate the transfer to LDSS: hxfacility@health.ny.gov

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WHAT MEDICAID BUDGETING IS AVAILABLE UPON DISCHARGE?

- Community Medicaid budgeting
- Shelter Allowance for MLTC consumers
- Spousal Impoverishment for MLTC consumers

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Nursing Home/ Adult Home Transition Shelter Allowance

- If Medicaid made a payment for a nursing home or adult home stay, Medicaid will deduct a regionally-standardized shelter cost from income upon discharge where the consumer has a housing expense **and**:
  1. Has been in a nursing home/adult home for at least 30 days (not counting the day of discharge);
  2. Is eligible for/enrolled in an MLTC plan upon discharge; **and**
  3. Is not receiving spousal impoverishment budgeting

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MLTC Housing Allowance 2016

Region	Counties	Deduction
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$384
Long Island	Nassau, Suffolk	$1,060
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1,094
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$440
Northern Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$837
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$400
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$341

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Example Budget with NH Transition Shelter Allowance

Gross monthly income		$2,305
Health insurance premiums	(Medicare Part B) (Medigap)	- 105 - 261
Unearned income disregard		- 20
Shelter deduction (NYC 2016)		- 1,094
Net countable income		***$825***
Income limit for single (2015)		- 825
Excess income	✓	**$0**

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Spousal Impoverishment Budgeting

- Spousal impoverishment budgeting, previously only for nursing home and waiver programs, is now available to married couples where one spouse is in MLTC.
- It works almost the same as for nursing home Medicaid budgeting, but with some minor variations.
- The personal needs allowance is the difference between a non-MAGI household of one and two's income limit. In 2016, the PNA is $384 ($1209 - $825 = $394). The family member allowance is the same as in NH budgeting.

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Example of MLTC Spousal Impoverishment Budget

MLTC Spouse - $2,130/mo. Income non-MLTC Spouse - $1,500/mo. income

Gross monthly income – Applicant		$2,130
Personal Needs Allowance (2016)		- 384
Community Spouse Monthly Income Allowance (CSMIA)	MMMNA ($2,980) - Otherwise Available Income of spouse ($1,500) =	- 1,480
Health insurance premiums	(Medicare Part B)	- 105
	(Medigap)	- 161
Excess income		**$0**

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THANK YOU!

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Nursing Homes: From Admission to Discharge

Quality of Care and Resident Rights

Presented at the 2016 Partnership Conference
Albany Marriott
189 Wolf Road
Albany, NY 12205

September 15, 2016

1. Quality of Care

a. Care Planning

i. Step 1: Assessment

1. Within 14 days of resident's admission, every 12 months, and after significant change in resident's condition. 10 NYCRR § 415.11(a)(3).

2. Conducted or coordinated by RN.

3. Covers 13 categories, including:

(a) medically defined conditions and prior medical history;

(b) medical status measurement;

(c) physical and mental functional status;

(d) sensory and physical impairments;

(e) nutritional status and requirements;

(f) special treatments or procedures;

(g) discharge potential;

(h) mental and psychosocial status;

(i) dental condition;

(j) activities potential;

(k) rehabilitation potential;

(l) cognitive status; and

(m) drug therapy

10 NYCRR § 415.11(a)(2)..

ii. Step 2: Develop the Care Plan

1. Within 7 days of comprehensive assessment 10 NYCRR § 415.11(c)(2)(i).

2. By an interdisciplinary team of providers with the participation of the resident and the resident's family or legal representative to the extent practicable. 10 NYCRR § 415.11(c)(2)(ii).

3. Plan must include:

   (a) Measurable objectives and timetable to meet each medical, nursing, mental and psychosocial need identified in assessment.

   (b) Consideration of resident's ability to self-administer medication.

   (c) Documentation of each time recommended care is vetoed by resident or legal representative.

   10 NYCRR § 415.11(c)(1).

b. Follow the Care Plan

   i. Services shall "meet generally accepted standards of care and service." 10 NYCRR § 415.11(c)(3)(i).

   ii. Services shall "be provided by qualified persons in accordance with each resident's plan of care." 10 NYCRR § 415.11(c)(3)(ii).

   iii. Residents with "known or suspected mental impairment or mental retardation" must be screened at least annually and referred for evaluation for active treatment. 10 NYCRR § 415.11(e).

c. Minimum level of care: "Receive the necessary care and services to attain or maintain the highest practicable . . . well-being." 10 NYCRR § 415.12.

   i. Independence in ADLs should not diminish.

   ii. Resident must be given services to improve ADLs.

   iii. Resident must be given services to ensure good nutrition, grooming, & personal and oral hygiene.

   iv. Resident must not develop pressure sores unless they're clinically unavoidable.

d. Resident without mental/psychosocial adjustment issues at admission must not display decreased social interaction or increased withdrawal/anger/depression during course of their NH stay.

e. When things go wrong

i. Private right of action under Public Health Law 2801-d to redress a violation of "any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority."

ii. Arbitration agreements in admission contracts

1. *Friedman v. Hebrew Home for the Aged*, 131 A.D.3d 421 (1st Dep't 2015) (rehearing denied May 12, 2016): Federal Arbitration Act preempts PHL § 2801-d's prohibition of arbitration agreements.

2. CMS current interpretation: current resident cannot be discharged for failure to sign binding arbitration agreement. CMS, S&C-03-10 (Jan. 9, 2003).

3. CMS proposed rule:

(a) admission cannot be conditioned on consenting to arbitration.

(b) Facility must fully explain arbitration agreement in form, manner, and language understood by resident.

(c) Resident must acknowledge understanding rights being waived.

(d) Arbitrator must be neutral and convenient to both parties.

(e) Resident's communication with government & ombudsman officials cannot be prohibited or discouraged.

80 Fed. Reg. 42264-65, proposed to be codified at 42 C.F.R. § 483.70(n).

iii. AG's Medicaid Fraud Control Unit: 800-771-7755.

1. Handles criminal violations that also violate resident rights.

2. More likely to find violations than DOH.

3. Interested in bigger cases, but often can only meet burden for "Nurse Jackie" cases.

iv. Medicaid Inspector General: 877-873-7283

1. Levies fines

2. Withholds Medicaid payments

3. Excludes providers

4. Prosecutes civil recovery cases.

2. Residents' Rights

a. Medical decisions

i. Choice in treatment

1. Right to be told total health status (diagnosis, prognosis, treatment plan) by a doctor, in his/her own language. 10 NYCRR § 415.3(e)(1)(i).

2. Right to participate in planning care and treatment 10 NYCRR § 415.3(e)(1)(v).

3. Right to be informed, in advance, of changes to care and treatment. 10 NYCRR § 415.3(e)(1)(iv).

4. Right to choose a personal attending physician (can be community doctor). 10 NYCRR § 415.3(e)(1)(iii).

ii. Access to records

1. Medical records

a. Resident has right to review medical records within 24 hours after written or verbal request.

b. Resident has right to copy of medical records two business days after she inspects them.

c. Resident can be charged for copies, up to 75 cents per page, but not if she can't afford to pay.

d. Representative who makes health care decisions also has these rights.

10 NYCRR § 415.3(c)(1)(iv).

2. Resident has right to know the patient classification category to which the nursing home has assigned her. 10 NYCRR § 415.3(c)(1)(ix).

3. Resident has right to examine most recent DOH facility survey, including statement of deficiencies and plans of correction. Must be available where it's accessible without staff assistance. 10 NYCRR § 415.3(c)(1)(v).

b. Privacy in communications with persons outside the facility.

i. Right to send and promptly receive unopened mail. 10 NYCRR § 415.3(d)(2)(i).

- Nursing home (NH) must provide stationary, pens, and postage, but can charge the resident. 10 NYCRR § 415.3(d)(2)(ii).

ii. Right to "regular access" to a private telephone (must be accessible to wheelchair users and residents with visual or hearing impairments). 10 NYCRR § 415.3(d)(3).

iii. Right to visit is the resident's, not the visitor's.

iv. Visiting Hours:

1. 10 hours per day, minimum.

2. Must overlap with at least two meal periods.

3. Must be posted publicly (e.g., lobby or dining room).

10 NYCRR § 415.26(a)(4)(vi).

v. Facility must provide a private area for residents to meet with visitors. 10 NYCRR § 415.3(d)(1)(i).

vi. If spouse/partner/relative doesn't live in facility, NH must assure privacy during visits. 10 NYCRR § 415.3(f)(3).

vii. Resident can see anyone they want:

1. Family

2. Friends

3. Community members

4. Lawyers

viii. Certain people cannot be denied immediate access to a resident:

1. New York State Department of Health (DOH) or U.S. Department of Health and Human Services (HHS) representative

2. Resident's physician

3. Long-Term Care (LTC) Ombudsman

10 NYCRR § 415.3(c)(2)(iv).

c. Room/Roommate changes

i. Except in a medical or other emergency, a nursing home must notify a resident of a proposed room change and consult with the resident regarding the change, and reasonably accommodate the resident's needs and preferences. 10 NYCRR § 415.3(c)(2)(ii)(a).

ii. A nursing home must notify a resident regarding any proposed change in roommate assignment, and the change "shall be acceptable, where possible, to all affected residents." 10 NYCRR § 415.3(c)(2)(ii)(b).

iii. If both parties consent, relatives, partners, and spouses have a right to share a room. 10 NYCRR § 415.3(f)(3).

d. Leaving a nursing home temporarily

i. Day passes

1. Right to participate in "social, religious, and community activities." 10 NYCRR § 415.5(d)(1).

2. Right to "interact with members of the community both inside and outside the facility." 10 NYCRR § 415.5(b)(2).

3. Right to "choose activities and schedules" and "make choices about aspects of his or her life in the facility." 10 NYCRR § 415.5(b)(1), 10 NYCRR § 415.5(b)(3).

4. Right to "meet with, and participate in activities of social, religious, and community groups." 10 NYCRR § 415.3(f)(5).

5. Trend: NHs have blanket policy requiring escorts.

ii. Bed holds

1. Only applies for overnight absences, determined by evening census.

2. Medicaid will pay facility to hold a resident's bed during hospitalizations or "therapeutic leave" if

(a) Resident has been in NH for more than 30 days.

(b) NH has vacancy rate of under 5 percent.

3. NH must reserve the same bed, not any bed.

4. Bed hold lasts if Resident is expected to return within 15 days.

   18 NYCRR § 505.9(d).

5. Guidelines for Managed Care (MMC & MLTC): Three types of reserved bed days are eligible for payment

   (a) Temporary hospitalization reimbursed at 50% of Medicaid FFS rate.

   (b) Professional therapeutic leave reimbursed at 95% of Medicaid FFS rate

   - 14 days in a 12 month period, combined aggregate of temporary hospitalizations and professional therapeutic leave days

   (c) Reserved bed hold for an absence not related to a professional therapeutic leave or temporary hospitalization at 95% of Medicaid FFS rate.

   - 10 days in a 12 month period.

e. Financial rights

   i. Right to manage own money

   ii. A nursing home may not, through an admission agreement or otherwise:

      1. require third-party payments as a condition of admission to or continued stay at the facility;

      2. require a residents to waive rights to Medicare or Medicaid benefits;

      3. require assurance of a resident's ineligibility for Medicare or Medicaid; or

      4. discriminate based on an individual's entitlement to Medicaid.

      10 NYCRR § 415.3(b).

f. Organizing & grievances

   i. Resident can recommend changes to facility staff or outsiders free of interference, coercion, discrimination, or reprisal. 10 NYCRR § 415.3(c)(1)(ii).

ii. Resident Councils

1. Right to organize or participate in Resident Council.

2. Right to meetings in a private space.

3. Staff or visitors may attend only at group's invitation.

4. NH must designate a staff person to assist Council and respond to requests.

5. NH must listen to and act upon council's grievances and recommendations.

10 NYCRR § 415.5(c).

3. Involuntary Discharge from a nursing home

a. Allowable when:

i. resident's needs cannot be met after reasonable attempts at accommodation in the facility;

- Facility cannot claim its menu of services is less than what other nursing homes offer.

ii. resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

iii. the health or safety of individuals in the facility would otherwise be endangered.

1. the risk to others is more than theoretical

2. all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem;

iv. resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third-party insurance) a stay at the facility;

1. NH must first give notice of failure to pay.

2. Charge cannot be in dispute.

3. No appeal of a denial of medical benefits may be pending.

4. Resident must actually have the funds to pay.

5. If attorney-in-fact, that person has the responsibility to pay *from the resident's funds.*

v. the facility permanently closes.

10 NYCRR § 415.3(h)(1)(i).

b. Notice of discharge: Timing

i. 30 days before the specified discharge date.

ii. Except, big loophole for facilities: "as soon as practicable," no later than discharge day, if discharge is based on:

1. Health/safety of others

2. Resident's improved health

3. Urgent medical need or change in level of medical care prescribed by Dr.

4. Resident has been absent from facility for 30 days

10 NYCRR 415.3(h)(1)(iv).

c. Notice of discharge: Recipients

i. Resident

ii. Resident's representative (guardian, HCP, attorney-in-fact, etc.)

iii. Any known family member

- DOH presentation ignores "family member" requirement!

iv. Must be in a language resident and/or family member understands

v. Must be in writing

10 NYCRR § 415.3(h)(1)(iii).

d. Notice of discharge: Substance:

i. Reason for discharge.

ii. Specific regulation supporting the discharge.

iii. Date of discharge.

iv. Place to which resident will be discharged.

v. Right to appeal to DOH within 60 days of receiving notice, and that if appeal is requested within 15 days of notice, resident can stay until appeal decision.

- Not applicable if health/safety/immediate medical need is reason for discharge.

vi. Contact information for LTC Ombudsman and, if resident has MI or DD, Disability Rights New York.

42 C.F.R. § 483.12(a)(6); 10 NYCRR § 415.3(h)(1)(v).

e. Other requirements

i. Facility must "provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge."

ii. Develop discharge plan addressing residents' medical needs and how they will be met after discharge.

iii. Permit resident or legal rep/HCP to participate in decision about where to live after discharge.

iv. Provide a discharge summary at discharge.

10 NYCRR § 415.3(h)(1)(vi)-(vii).

f. Appeal process

i. Request an appeal by calling DOH.

1. Must request hearing within 60 days of receiving notice.

2. Hearing will be scheduled within 90 days of request for hearing.

ii. If request made within 15 days of the notice, resident is generally entitled to:

1. a pre-transfer, onsite appeal determination, and

2. to "remain in the facility pending an appeal determination." 10 NYCRR § 415.3(h)(2)(i).

- N/A if health/safety/immediate medical need is reason for discharge.

iii. If request is made 16-60 days after notice, the resident is entitled to:

1. a post-transfer appeal hearing

2. return to the facility to the first available bed if the resident wins the appeal.

g. Appeal hearing

i. Held at the facility

ii. Before an administrative law judge from DOH

iii. Audio recorded

iv. Facility presents case first & has burden of proof that:

1. Discharge is necessary, AND

2. Discharge plan is appropriate.

v. Resident can question facility's witnesses, present her own evidence, including her own witnesses.

vi. Resident can present an argument to the judge.

10 NYCRR § 415.3(h)(2).

QUALITY OF CARE IN NURSING HOMES

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Care Planning

Comprehensive Assessment of Resident

- Within 14 days of admission
- Annually
- After a change in condition.

13 categories, including:

- Medical conditions
- Functional levels
- Discharge potential

Care Planning

Every Resident has a written Care Plan

Developed after "Comprehensive Care Plan Meeting" between:

- Interdisciplinary team from nursing home
- Resident
- Resident's representative, family member, legal representative (resident chooses who can attend)

Care Planning

Care Plan must:

- Be developed within 7 days of assessment
- Include measurable objectives and timetable to meet each medical, nursing, mental and psychosocial need identified in assessment.
- Consider resident's ability to self-administer medication.
- Document each time recommended care is vetoed by resident or legal representative.

Quality of Care = Quality of Life

Resident must "Receive the necessary care and services to attain or maintain the highest practicable . . . well-being."

- Independence in ADLs should not diminish.
- Good nutrition, grooming, & personal and oral hygiene must be provided.
- No pressure sores unless they're clinically unavoidable.
- Level of social interaction / mood should not diminish.

MFY LEGAL SERVICES

Redressing Deficient Care

- Public Health Law § 2801-d: private right of action.
- Beware of arbitration clauses in admission agreements!
  - *Friedman v. Hebrew Home for the Aged*: Federal Arbitration Act preempts PHL § 2801-d's prohibition of arbitration agreements.
  - CMS current interpretation: current resident cannot be discharged for failure to sign binding arbitration agreement.

MFY LEGAL SERVICES

Redressing Deficient Care

AG's Medicaid Fraud Control Unit: 800-771-7755

- *Abuse and neglect*

Medicaid Inspector General: 877-873-7283

- *Billing irregularities*

Department of Health: 888-201-4563

- *Regulatory violations that aren't criminal*

MFY LEGAL SERVICES

RESIDENT RIGHTS IN NURSING HOMES

MFY LEGAL SERVICES

Choice in Treatment

- Right to be told total health status (diagnosis, prognosis, treatment plan) by a doctor, in resident's own language.
- Right to participate in planning care and treatment.
- Right to be informed, in advance, of changes to care and treatment.
- Right to choose a personal attending physician (can be community doctor).

MEY LEGAL SERVICES

Medical Records

Resident (or health care decision-maker) has right to:

- Review medical records within 24 hours after written or verbal request.
- Obtain copy of medical records two business days after she inspects them.

Resident can be charged for copies, up to 75 cents per page, but not if she can't afford to pay.

MEY LEGAL SERVICES

Privacy in Communication

- Right to send and promptly receive unopened mail.
  - Nursing home must provide stationary, pens, and postage, but can charge the resident.
- Right to "regular access" to a private telephone (must be accessible to wheelchair users and residents with visual or hearing impairments).

MFY LEGAL SERVICES

Visitors

- Right is the resident's, not the visitor's.
- Relatives can visit at any time, subject to resident's consent.
- Access cannot be denied to DOH/HHS inspector, Ombudsman, resident's physician.
- Other visitors (e.g., lawyers) subject to reasonable restrictions.
  - Visiting hours must be at least 10 hours per day, overlapping with two meal times.

MFY LEGAL SERVICES

Roommates

- Nursing home must notify a resident regarding any proposed change in roommate assignment, and the change "shall be acceptable, where possible, to all affected residents."
- If both parties consent, relatives, partners, and spouses have a right to share a room.

Excursions from the Facility

- Resident has "right to participate in "social, religious, and community activities" and to "interact with members of the community both inside and outside the facility."
- Leaving the facility temporarily (even overnight) is not alone proof that a resident does not require nursing home care.

Excursions from the Facility

Bed Holds: Medicaid will pay facility to hold a resident's bed during hospitalizations or "therapeutic leave" if

- Resident has been in NH for more than 30 days.
- NH has vacancy rate of under 5 percent.
- NH must reserve the same bed, not any bed.
- Bed hold lasts up to 15 days.

If vacancy rate is over 5 percent, facility can charge resident for bed hold.

MFY LEGAL SERVICES

Financial Rights

A nursing home may not, through an admission agreement or otherwise:

- require third-party payments as a condition of admission to or continued stay at the facility;
- require a residents to waive rights to Medicare or Medicaid benefits;
- require assurance of a resident's ineligibility for Medicare or Medicaid; or
- discriminate based on an individual's entitlement to Medicaid.

Resident, or legal representative, has right to manage finances.

MFY LEGAL SERVICES

Resident Councils

- Right to organize or participate in Resident Council.
- Right to meetings in a private space.
- Staff or visitors may attend only at group's invitation.
- NH must designate a staff person to assist Council and respond to requests.
- NH must listen to and act upon council's grievances and recommendations.

MEY LEGAL SERVICES

INVOLUNTARY DISCHARGES

MEY LEGAL SERVICES

When is involuntary discharge permitted?

- Necessary for the resident's welfare
- Resident's health has improved sufficiently
- Safety of other individuals is endangered
- Health of other individuals is endangered
- Failure to pay the facility
- Facility is closing

What does "necessary for resident's welfare" mean?

"Resident's needs cannot be met after reasonable attempts at accommodation in the facility."

- Facility cannot claim its menu of services are fewer than what other nursing homes offer.
- Facility must TRY to accommodate.

Failure to Pay

- NH must first give notice of failure to pay.
- Charge cannot be in dispute
- No appeal of a denial of medical benefits may be pending
- Resident must actually have the funds to pay.
- Attorney-in-fact has the responsibility to pay *only from the resident's funds.*

Who gets notice of discharge?

- Resident
- Resident's representative (guardian, HCP, attorney-in-fact, etc.)
- Any known family member

Notice must be in writing and in a language and manner resident/family member understands.

What's in the notice?

- The reason for transfer or discharge;
- The specific regulations that support the discharge;
- The effective date of transfer or discharge;
- The location to which the resident will be transferred or discharged; and
- A statement that the resident has the right to appeal the action to the State Department of Health.

What's in the notice? (cont'd)

- The name, address and telephone number of the long-term care ombudsman; and
- For residents with developmental disabilities or mental illnesses, the mailing address and telephone number of Disability Rights New York, the designated protection & advocacy agency.

Timing of the notice

30 days before the specified discharge date.

Except, big loopholes for facilities: "as soon as practicable," no later than discharge day, if discharge is based on:

- Health/safety of others
- Resident's improved health
- Urgent medical need or change in level of medical care prescribed by Dr.
- Resident has been absent from facility for 30 days

MEY LEGAL SERVICES

Timing & effect of requesting appeal

- Appeal can be requested any time within 60 days of notice. But don't wait!
- If appeal is requested within 15 days of the notice, the resident can stay in the facility until after the hearing decision is issued.
- If not, resident can be discharged, but if she wins appeal, must be readmitted to next available bed.

MEY LEGAL SERVICES

Involuntary Discharge Planning

- Facility must "provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge."
- Develop discharge plan addressing residents' medical needs and how they will be met after discharge.
- Permit resident or legal rep/HCP to participate in decision about where to live after discharge.
- Provide a discharge summary at discharge.

MFY LEGAL SERVICES

The Appeal Hearing

- Held at the facility
- Before an administrative law judge from DOH
- Audio recorded
- Facility presents case first & has burden of proof that:
  1. Discharge is necessary, AND
  2. Discharge plan is appropriate.
- Resident can question facility's witnesses, present her own evidence, including her own witnesses.
- Resident can make an argument to the judge.

MFY LEGAL SERVICES


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