MLTC Members in Nursing Homes for 3+ Months Being Disenrolled from MLTC Plans - Since August 2020

In this article:

1. Intro - What is the Carve-Out of Nursing Home Care from MLTC?

SUMMARY --Starting in August 2020, MLTC members are involuntarily disenrolled from their MLTC plans if they have been in a nursing home for more than 3 months AND have been approved for Nursing Home or "Institutional" Medicaid by their local Medicaid agency. They have the right to remain in the plan if they are actively working on returning home. ADVOCACY is often needed to prevent the disenrollment so that the consumer can remain in the plan and fight for enough services needed to return home. If they are disenrolled, it will be much more challenging for them to return home.

BACKGROUND -- In December 2019, CMS approved the request by NYS Dept. of Health to "carve out" long-term Nursing Home Care from the Managed Long Term Care (MLTC) benefit package. In this change, the State reversed its former policy that has required, since 2015, all adult nursing home residents receiving Medicaid and Medicare to enroll in or stay enrolled in an MLTC plan. The CMS approval letter, dated December 19, 2019, with the revised "Special Terms & Conditions" of the 1115 Waiver is posted here, which states at page 28:

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

The change was approved by the State legislature in the 2018 state budget. NYS Public Health Law section 4403-f, subd. 7(b)(v)(13). DOH submitted its request to CMS - see New York Medicaid Redesign Team - MLTCP Amendment Request. Many consumer advocacy organizations oppsed this change in comments to the State and to CMS which are available on the CMS website here. Click on these links for comments by NYLAG,

the Legal Aid Society and other organizations here. Advocacy concerns are summarized here.

In April, 2020, DOH implemented the first stage of "carving out" nursing home care from the MLTC benefit. DOH stopped auto-enrolling nursing home residents into MLTC plans when they were approved for Institutional Medicaid. Since 2015, they had been assigned to MLTC plans, even if these individuals never planned to return to the community. THE MLTC plans in turn paid the nursing homes for their care, and should have reviewed whether they were able to return to the community. This procedure ended in April 2020. Since then, anyone who entered a nursing home and was not already a member of an MLTC plan had "fee for service" Medicaid, and the nursing homes bill Medicaid directly.

DOH has notified all nearly 250,000 MLTC members of the change in this informational notice.

Read about the former rules here that from 2015-2020 "carved in" the long-term nursing home benefit into the MLTC program.

2. Dashboard of Number of MLTC members disenrolled from MLTC plans since August 2020

Since the disenrollments started in Oct. 2021, they have been done in batches three times a year. Each time, DOH gives the MLTC plans, nursing homes, and Open Doors the names of MLTC members who have been in nursing homes for more than 3 months and who have been approved for Nursing Home Medicaid. The MLTC Plans, nursing homes, and Open Doors review this list and identify who has an "active discharge plan" to return home. Those individuals are not disenrolled, but the rest are using the procedures explained here.

- Feb., June and October 2024 - batches 11-13 to be scheduled
- Oct. 2023 - 10th batch scheduled
- **June 2023 - 9th batch - 813 to be disenrolled,** after plans sent a notice of Intent to Disenoll by May 3rd and NY Medicaid Choice should send a 2nd notice by May 20th
- Feb. 2023 - 8th batch
- **Oct. 2022 - 7th batch -704 disenrolled**
- **June 2022 - 6th batch**
- **Feb. 2022 - 5th batch - 1,079 disenrolled**
- **Oct. 2021 - 4th batch - 1,285 disenrolled.**
- **August 1, 2020 -- The First Batch Disenrollment was done over the objections of NYLAG, Legal Aid Society, CIDNY, Empire Justice Center & other organizations, which sent letters to Gov. Cuomo and to DOH on July 2nd and June 29, 2020,** demanding the state halt disenrollment of almost 20,000 MLTC members from their MLTC plans because they have been in nursing homes for more than 3 months. With visitors banned from nursing homes, they'll have no help to

appeal - and many will be forced to stay in the nursing homes, at risk of exposure to COVID. And COVID-19 has harmed people of color disproprotionately - in nursing homes in particular, not only in the overall population. See NYT article May 21, 2020 and NPR story April 2020.

3. PROCEDURES FOR DISENROLLMENT

1. **Every 3-4 months, NYS DOH sends Nursing Homes and MLTC Plans a list of members** who were approved for Institutional Medicaid and w**ho have been in a nursing home for more than 3 months**. The Nursing Homes, MLTC plans, and Open Doors are asked to identify those members who have an "**Active Discharge Plan"** -- **who should NOT receive notices that they will be disenrolled.** See Dear Administrator Letter of June 11, 2020, which replaces the one issued in January.

    1. The three-month period begins on the first of the month following the date the member has been designated as long-term nursing home stay on the Form LDSS-3559 or state equivalent. The LDSS-3559 is a form filed by Nursing Homes with local county/NYC Medicaid programs. NYC HRA uses different forms.
    2. The DAL letter to nursing homes limits those defined as having an "active discharge plan" as those:
        - ◊ being assessed by the Open Doors program run by the NYS Association on Independent Living, which is the contract agency implementing the Money Follows the Person program (which helps people in nursing homes to be discharged to the community), OR
        - ◊ those with an active Transition Plan in place with all the required elements (not defined), that has been incorporated into their Discharge Plan, OR
        - ◊ the resident has an expected discharge date of 3 months or less, a discharge plan in place with all the required elements, and the discharge plan could not be improved
    3. DOH said that no MLTC member who is actively engaged in planning for their discharge back to the community will be disenrolled. However, the nursing homes are being asked to identify only those with an approved discharge plan, not members with requests for home care or appeals pending. THIS IS WHY MEMBERS WHO RECEIVE THE NOTICES and WANT TO RETURN HOME MUST CALL NY MEDICAID CHOICE to request an ASSESSMENT and/or REQUEST A FAIR HEARING
    4. If a disenrollment notice is sent to someone working with Open Doors, contact mfp@health.ny.gov. See info on referrals to the Open Doors Transition Center.
2. **30-DAY NOTICE from their MLTC plan**, --Since Oct. 1, 2021, plans are required to send this notice giving members in nursing homes for 3 months a heads-up that they will be disenrolled from the MLTC plan in 30 days because their stay extends

beyond 3 months. The notice explains that Medicaid will continue to pay for the nursing home care if they remain in the nursing home. Most importantly, the notice explains how to request an assessment by the MLTC plan to approve services so that they can return home. There are no fair hearing or other appeal rights for this notice, but the 10-day notice has appeal rights.

- **DOH issued this notice in response to advocacy by Medicaid Matters NY,** a coalition in which NYLAG is a member. Though the content of the notice does not reflect all of the suggestions by the coalition, we commend DOH for adding this protection for MLTC members who need to remain in the MLTC plan in order to arrange for home care services to return home.
- **Who receives the notice** - there is no written guidance, but DOH told Medicaid Matters NY that the plan would send the **notice to the member AND the person on file as designated representative** with the plan, such as a family member or social worker. This extra notice was requested by NYLAG and other advocates. We do not know if this is being done - let us know!

3. **10-day notice from NY Medicaid Choice** (Attachment I to GIS 20 MA/06 - MLTC Enrollees Receiving Long Term Nursing Home Care - "Batch" Disenrollment Process) -- states they **may request a fair hearing with Aid Continuing** or call NY Medicaid Choice before the disenrollment. If they do, they will **remain enrolled in the plan. If they call NY Medicaid Choice, they may** request an assessment by their MLTC plan to see if they can safely return home. This postpones the disenrollment.

    - **Who receives the notice** - Only the person listed as "Authorized Representative" on the Medicaid application receives a copy of this 10-day notice. To be listed, submit Form DOH-5247 - Medicaid Authorized Representative Designation/ Change Request** to Local Dept. Social Services (DSS). In NYC-

        - if the nursing home Medicaid app was approved, fax form to 917-639-0736.
        - If the Medicaid application is still pending, ask nursing home to submit it or fax to 917-639-0735. Note the name and address of nursing home. Read more here

- The State revised an earlier draft of the 10-day notice based on a critique by NYLAG and other advocates. The revised notice gives members an opportunity to request an assessment now, which will put the disenrollment on hold. If a member requests a Fair Hearing before the disenrollment date, the disenrollment will be put on hold as "Aid Continuing."
- **NY Medicaid Choice may only send the notice to resident at the** nursing home - mail may get lost there or just filed away in their case record. NYLAG and other advocates have advocated that Notices should be given to the family member or other person designated as their representative for the nursing home care and

MLTC. And should be sent to their homes as well.

4. **What can a consumer, representative or family member do** to make sure consumer can stay in their MLTC plan in order to obtain home care services needed to return home? **BEFORE the disenrollment do one or both of the following:**

    1. Request a Fair Hearing you will not be disenrolled if you make this request before the scheduled disenrollment. Because the disenrollment notices are sent by NY Medicaid Choice and are not a direct action by the MLTC plan, the member is not required to "exhaust" the plan appeal process first before requesting a fair hearing.
    2. Call NY Medicaid Choice to report that you have a pending request for home care services, or a pending appeal or fair hearing, so need to stay in the plan, OR to request an assessment by the MLTC plan to return home. 1 -888-401-6582 (TTY: 1-888-329-1541). Either way, you will not be disenrolled as scheduled
    3. If they have any problems requesting an assessment, or reporting a pending request, or other questions about this -- contact ICAN. 844-614-8800 ican@cssny.org

5. **MEMBER HAS RIGHT TO RETURN TO PLAN within SIX MONTHS after Being Disenrolled**
    - ♦ You can re-enroll in the MLTC plan within 6 months of being dis-enrolled, without being required to do a new Independent Assessment. This is stated in the Notice to consumers of disenrollment, and is in the CMS STC Letter (12.19.19) by which CMS approved this change. The CMS letter and form consumer notice confirm that no conflict-free assessment is required (now this would be NYIA) and that NY Medicaid Choice can simply re-enroll the consumer. However, the State has not issued policies yet on issues such as --

        - ◊ will the same MLTC plan you were enrolled in before be required to accept your enrollment and provide you with home care services to return home? **We think the answer must be YES otherwise the right have enrollment reinstated is meaningless.**
        - ◊ will the MLTC plan be required to authorize the same amount of hours that you received before? We think they should be required to under MLTC Policy 16.06 and precedent including Mayer v. Wing. . **We think the answer must be YES otherwise the right have enrollment reinstated is meaningless.**
        - ◊ MLTC enrollment is always on the 1st of the month, so if you are ready to return home on the 10th, you will probably not be re-enrolled until the 1st of the following month.

4. WHAT HAPPENS TO the "NAMI" and MEDICAID PAYMENT FOR NURSING HOME CARE AFTER DISENROLLMENT?

If the resident has already been approved by the local DSS/HRA for Institutional Medicaid, the nursing home will simply switch billing to bill Medicaid fee for service instead of the MLTC plan, and the resident continues paying the NAMI (Net Available Monthly Income).

But what about those who have not yet applied for Institutional Medicaid, or whose 5-year lookback applications are pending at the time of disenrollment? According to the 6/12/20 guidance and 1/21/2021 Dear Administrator Letter, the nursing home will not be paid for its services until the LDSS/HRA has approved the lookback application, which should be retroactive allowing the nursing home to bill back to the date of disenrollment, provided the application is timely and complete to prove retroactive eligibility. For these individuals, the situation is like the old days before MLTC covered nursing home care, when the nursing home would not get paid by Medicaid until Institutional Medicaid is approved.

The Dear Administrator Letter indicates that the individual may be asked to pay their estimated "NAMI" or Net Available Monthly Income to the nursing home while the Institutional Medicaid application is pending. **For those who have an expectation to return home,** the application should include the physician's certification of this expectation so that Community Budgeting will be used, allowing the individual to keep the full Medicaid allowance in the community ($895 2020 + health insurance premiums) plus any deductions used in the community (Pooled trust deposit, earned income disregards). See more about Community Budgeting in this article. This Fact Sheet has the NYC forms. The form used outside of NYC is the LDSS-3559. This reduces the NAMI to the same as the spenddown would be in the community.

5. ADVOCATE CONCERNS

Concerns about Members Who Are Not Identified as Actively Seeking to Return Home -- who should not be disenrolled

- While DOH states that no one working with the Open Doors/MFP program will receive the disenrollment notice, many more people are working toward being discharged from nursing homes than the number working with Open Doors. Many people may be working with their families or other advocates toward discharge. The definition of who has an active discharge plan is very narrow.
- How about those with an appeal or Fair Hearing pending against an MLTC plan for denying increased home care services? Or who have a request for an increase pending with the MLTC plan? The revised notice allows them to call NY Medicaid Choice to report that these requests or appeals are pending. But.. with family and other visitors banned from nursing homes, and nursing home staff stretched by the demands of COVID, many residents will not have the wherewithal or support needed to make these calls or request a fair hearing.
- Anyone who has requested "Community Budgeting" sometimes known as Rent Retention budgeting, in order to be able to keep enough income to pay rent while they are in a nursing home -- should not receive Disenrollment notices.

- Anyone whose nursing home services are still covered by Medicare should not receive disenrollment notices, given that Medicare is generally a short-term rehabilitation benefit. But - the DOH policy allows disenrollment even if Medicare rehab is ongoing.
- There are no explicit requirements that the MLTC plan indicate when it proposed disenrollment to NY Medicaid Choice that the consumer cannot be safely discharged to the community, whether with the prior discharge plan or any combination of MLTC services, and the reason why. Where the individual had been enrolled in the MLTC plan prior to the nursing home admission, the plan is essentially terminating previously authorized home care services, and has the burden of proof as to why the individual is no longer eligible. MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services*

Concerns about Difficulty for Nursing Home Residents to Obtain Home Care Services to Return to the Community

- People who are "Long Term Nursing Home Stay" (LTNHS)(3" months in a nursing home) will now be excluded from enrolling in an MLTC plan. If they want to return home, will they be able to enroll in an MLTC plan? If they are now excluded, how can they enroll? Their other option is to apply for Immediate Need personal care or CDPAP services, through their local Medicaid program. However, those individuals will not be eligible for the important Special Income Standard for Housing Expenses, which reduces or even eliminates the Medicaid spend-down for people enrolling in or staying enrolled in MLTC plans from a nursing home or adult home.
- The CMS Cover Letter enclosing the Special Terms and Conditions states that "NH residents will be allowed to re-enroll in an MLTC and return to the community without requiring a CFEEC, if such movement is within 6 months of the ... disenrollment." This letter implies that NY Medicaid Choice must do Conflict free assessments in Nursing homes for people even though they are "excluded" from MLTC because they are LTNHS. but no Conflict free assessment should be required if less than 6 months has passed since the disenrollment.

No Written Policy or Procedures to Ensure that a Consumer who Was Disenrolled for a Long Tern Nursing Home Stay May re-Enroll in the Plan within SIX Months.

- **The right to re-enroll in 6 months is clear federal requirement - but the State has never issued procedures or policies to make this right known. See more here.**

Concerns About MLTC Plans Denying High-Need Members Sufficient Home Care, Forcing Nursing Home Placement and Eventually Disenrollment

Now that the cost of Nursing Home care is no longer borne by the MLTC plan, the plans have more incentive to deny home care to people whose needs re extensive because of severe disabilities. If these individuals end up in a nursing home - because the hours are

insufficient to maintain their safety at home, the plan can avoid high-cost care altogether if they run out the clock until the placement lasts 3 months.

Concerns About MLTC Plans Delaying Discharge to "Ride out the Clock" until 3 months have passed

If a member previously received high-hour home care services, or now needs such services, an MLTC plan may well delay discharge so that the member is disenrolled after 3 months of nursing home placement. Procedures are needed to prevent and hold plans accountable for this behavior.

The Dear Nursing Home Administrator letter issued Jan. 21, 2020, gives the procedure for MLTC members who are reaching the 3-month limit in the future. It states that in the second month of admission, the MLTC plans will identify members expected to be admitted for 3 months and send a disenrollment package to NY Medicaid Choice, for NY Medicaid choice to review and send the disenrollment notice. The first such notices will disenroll members effective May 1, 2020. This fast timeline gives essentially no opportunity for an MLTC member who expects the nursing home admission to be temporary to take the steps needed to arrange a dischage plan - before the quick disenrollment notice is issued.

The DOH policy in the Dear Administrator Letter only at the very end mentions that the nursing home should work with the member to explore options for discharge, referencing past DAL letters, such as

- DAL 19-16 Residents' Rights (PDF) - October 11, 2019
    - Open Doors (MFP) Transition Center Regional Lead and Auxiliary Independent Living Centers (PDF)
- DAL NH 18-05 Nursing Home Discharge Requirements - September 4, 2018
- NH DAL 16-10: MDS Version 3.0 Section Q - February 16, 2017

Confusion about applying for Institutional Medicaid and Help Needed to Request Community Budgeting for people expecting to return home

Stay Tuned for more news and concerns as the State releases more procedures implementing this major change. See advocacy tips for threatened disenrollments.

6. Background on Former Policy - Beginning 2015 that "carved in" Nursing Home Care into the MLTC Benefit.

Since February 1, 2015, there has been a new requirement for nursing home residents in New York City who became "permanent" residents after that date to enroll in Managed Long Term care (MLTC) and "mainstream" Medicaid Managed Care plans, which will now pay for and manage the nursing home care. CMS approved this expansion of MLTC and mainstream Medicaid managed care by letter of Dec. 31, 2014. "Permanent" status does not begin until after Institutional Medicaid eligibility has been approved, following the 5-year

lookback. Thus enrolling in a managed care or MLTC plan is not required for initial admission to a nursing home.

The requirement started in NYC in February 2015, and the rest of the state was phased in by October 2015.

Since Jan. 22, 2015 and continuing through September 2015, NYS DOH has conducted a series of webinars on this transition and has issued a series of policy papers and FAQs: All are posted on the MRT 1458 website - scroll to the bottom to:

NYS Dept. of Health Policies --Transition of Nursing Home Populations and Benefits to Medicaid Managed Care

- January 2015 Webinar (Revised)
- March 20, 2014 Presentation
- Medicaid Managed Care Nursing Home Transition - Claims and Billing Submission
- Long Term Care Nursing Home Billing Overview - March 2014
- Policy Paper
    - ♦ Frequently Asked Questions Revised January 2016
- Webinar Slides
    - ♦ January 2015
    - ♦ Recorded Webinar - January 2015 (WMV)
    - ♦ July 29, 2015
    - ♦ August 18, 2015
    - ♦ September 22, 2015
- MCO SNF Special Network Requirement

Miscellaneous

- MRT 1458 Timeline 9.30.15

State DOH Administrative Directive 15ADM-01 - Transition of Long Term Nursing Home Benefit into Medicaid Managed Care (April 1, 2015) - to local county Medicaid programs to explain the new procedures for Medicaid for nursing home care: PDF Attachment 1

NEW YORK CITY PROCEDURES and FORMS -

- **Oct. 2015 Protocol for Submission of Medicaid applications**
- Oct. 2015 MICSA Alert announcing new forms - Discharge Alert for Non-Chronic Care (Community Budgeting) - ALL FORMS ATTACHED TO THE PDF

WHAT CHANGED FOR NURSiNG HOME RESIDENTS IN NYS in 2015?

Adults age 21+ becoming permanent nursing home residents in NYC after February 1, 2015 (estimated) will be required to enroll in managed care plans starting in Feb. 2015 in NYC, in Long Island and Westchester in April 2015. Upstate mandatory enrollment will begin in July 2015 on a rolling basis. The State's presentations above reviewed timelines, network requirements, reimbursement policies and other key areas of concern.

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

- Those with Medicare (dual eligibles) will have to enroll in a Managed Long Term Care (MLTC) plan, unless otherwise exempt.
- Those without Medicare will have to enroll in a "mainstream" Medicaid managed care plan.

Current nursing home residents are "grandfathered in" - do not have to enroll in managed care plans. Anyone already in a nursing home before Feb. 1, 2015 (and before Oct. 2015 outside of the NYC metro area) will not have to enroll in a managed care plan, and will continue to have Medicaid pay for their nursing home care on a "fee for service" basis. The State says that no one already in a nursing home should have to change nursing homes because the nursing home is not in the plan's network.

If they are required to enroll in an MLTC plan or, if they are not on Medicare, in a "mainstream" managed care plan, they will enroll in a plan that affiliates and pays for their current nursing home.

This requirement will apply only people who, after Feb. 1, 2015, are approved for permanent nursing home placement and institutional Medicaid (after the 60-month lookback review is completed). It will not require enrollment into an MLTC or mainstream plan upon admission to a nursing home.. it will not be required until later, after they apply for and are accepted for institutional Medicaid.

Those who are already enrolled in an MLTC or mainstream Medicaid managed care plan in the community, who come to need long-term nursing home placement after Feb. 1, 2015 (if in NYC, or April 1, 2015 in Long Island and Westchester) or in other areas when they become mandatory, will no longer be disenrolled from the plan when they need nursing home care. They will need to choose a nursing home within the plan's network (or may sometimes change plans) and the plan will still manage their care in the nursing home.

- **MLTC members who only need short-term rehabilitation care**, however, may go to any rehab 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 (rehab) stay. SEE DOH Q&A updated 2016 - Question 11-12 under BILLING. However, once the Medicare-covered stay is over, they must switch to an MLTC plan that includes their preferred nursing home in its network. If the Medicare stay is less than 29 days, they may get additional days up to a total of 29 days,

including Medicare-covered days, under the community Medicaid short-term rehabilitation benefit. For that care no 5-year lookback application is needed.
- **Mainstream members who need 29 days or less of nursing home coverage** are entitled to Medicaid short-term rehab benefits, which covers up to 29 consecutive days under community Medicaid, without needing to do the 5-year lookback Medicaid application.

People who were NOT enrolled in an MLTC plan or mainstream plan who come to need nursing home care after Feb. 1st, 2015 (in NYC - rest of state timeline is here) may enter any nursing home of their choice. They do not have to join an MLTC or managed care plan until after they are admitted to the home, apply for and are accepted for institutional Medicaid (which includes the lookback period that screens for transfers of assets).

Phase-In Schedule - The original date was March 1, 2014, which was delayed several times. New schedule here. Concerns raised by NYLAG and other consumer advocates by letter of March 14, 2014, were part of the reason for the delay, with CMS requesting further protections in the state implementation plan. Now, with the ICAN Ombudsprogram and the **Conflict-Free Evaluation and Enrollment Center** up and running, CMS has approved this expansion of managed care. See more about this in this article in September 2014 news. People who first become permanent Nursing Home residents after the dates below, meaning their eligibility has been determined after a 60-month Lookback application, must enroll in either a Medicaid Managed Care or d Managed Long Term care plan, which one depends on whether they have Medicare.

Consumer Advocacy

Advocacy organizations including Medicaid Matters NY, the Coalition to Protect the Rights of New York's Dual Eligibles (CPRNYDE) and other organizations have participated in workgroups, voicing consumer concerns about many aspects of this expansion of managed care.

- 11/2018 - NYLAG filed comments with CMS opposing the State's request to exclude permanent nursing home residents from MLTC enrollment after 3 months. The State's proposal and accompanying documents are posted on the State's MRT webpage here. This is a reversal of the policy in effect since 2015, described in this article.

    - ♦ See the State's proposed notice to MLTC members describing the change here.
    - ♦ See the State's proposed notice to be sent by NY Medicaid Choice before it disenrolls one of the 23,000 MLTC members who have been in nursing homes for 3 or more months.. and members in the future.
    - ♦ NYLAG's comments on the rule state that the "clock" should not start ticking toward three months until disenrollment if the member intends to return

home. Disenrollment will make it much harder to return home. Also, NYLAG and other consumer advocates urged that plans must give notice of a decision to consider them "permanently placed," which the consumer should have the right to appeal. These decisions must be made with involvement of the consumer, not unilaterally by a managed care plan or nursing home. See other comments on CMS website here. Click on these links for comments by NYLAG, the Legal Aid Society and other organizations here.

- 10/22/2015 - Coalition to Protect the Rights of NY Dual Eligibles - Issues and Concerns on Carve-in of Nursing Home Benefit into Managed Care and MLTC
- On March 14, 2014, NYLAG and six other consumer advocacy organizations in NYS sent a letter to the federal Medicaid agency, CMS and to the State Dept. of Health asking them to slow down the expansion of Medicaid managed care to include all new nursing home residents who become permanently placed in nursing homes after April 1, 2014. The advocates pointed out numerous systems and procedures that are not ready for such a massive change, and the lack of education about these changes for hospital social workers, medical professionals and myriad other professionals who work with seniors and people with disabilities. Advocates are concerned that without adequate preparation, the rights of vulnerable New Yorkers will be violated -- including the right under the Americans with Disabilities Act to Medicaid services that enable them to live in the "most integrated setting" -- which is at home in the community rather than in an institution. Download the letter here.
- May 2013, consumer advocates raised concerns about nursing home enrollment in managed care in the "FIDA" proposal to manage care for dual eligibles,

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http://health.wnylc.com/health/entry/199/