MassNAELA
National Academy of Elder Law Attorneys
Massachusetts Chapter
Leading the Way in Special Needs and Elder Law in Massachusetts

November 24, 2015

Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: MassHealth Regulations Review

Dear Secretary Sudders:

We are excited about your undertaking of the MassHealth regulations review as part of Executive Order 562. We are particularly glad about your invitation to the public and stakeholder groups to help shape the future of MassHealth. This letter conveys some of the thoughts of the Massachusetts Chapter of the National Academy of Elder Law Attorneys (MassNAELA) on the current regulations and recommendations to make the agency procedures more efficient for both MassHealth and its consumers.

As you may be aware, MassNAELA consists of about 500 lawyers who represent older clients, disabled clients of all ages, and their families. Our interactions with MassHealth (MH) primarily concern the following populations: (1) frail elders, both those staying in the community and those needing nursing home care, and (2) disabled adults, most of whom are living in the community, both under and over 65. As such, we are intimately involved with the guidelines and regulations within MassHealth and hope that our perspective will be useful to you as you review these procedures. As you will see below, our comments focus on MH services to these groups.

This letter provides MassNAELA's comments in the areas of Customer Service, Payment and Care Delivery Reform, and Long Term Services and Supports.

Customer Service

A. Notices

1. Eligibility Review notices should have the name of the caseworker or unit with the phone number. At present a name and phone number is

provided only for initial LTC applications, not Eligibility Reviews and not community applications. Not having a name makes it difficult to resolve verification or inaccurate data match issues and causes unnecessary hearing requests.

2. All MH notices should be sent to all those listed on Permission to Share Information forms (PSI). Often we do not receive copies of notices sent to a client's Authorized Representative (usually a child of a cognitively impaired senior). This delays our ability to assist our clients to satisfy MH requirements on a timely basis and often results in appeals that would not otherwise be required.

3. Do not send notices to the nursing home unless a PSI form has been completed; the privacy rights of the applicant should be respected. Often eligibility review notices for long term care residents are sent to the nursing home and by the time the nursing home forwards them to the authorized representative or the attorney who is listed as a PSI, there is little time left to gather the requested information.

4. Notices of Eligibility Reviews and Terminations should be sent to Authorized Representatives to prevent a loss of service and increased health risk to the member, as well as a waste of MH staff time with re-enrollment.

5. A denial notice should include more detailed reasons for the denial of LTC coverage. For example, the Notice now will state that the applicant is "denied due to excess assets of $xxxx." It would help applicants and their advocates to know the nature of the excess assets (i.e. - a bank account, the value of life insurance, or funds in a trust deemed countable.) Often advocates must waste time and money to file an appeal just to find out this basic information.

6. Notices are very difficult to read and are often contradictory. We suggest that you place at the top of page one of every notice precisely which MH program that notice refers to. For example, an applicant can receive a notice indicating denial for MH and a day later another notice indicating approval. Upon very close inspection, the advocate can decipher that the client was, for example, denied for Safety Net, but approved for long-term care. Our clients cannot unravel the many and contradictory notices and call us in a panic. Placing at the top of page one the name of the program that the notice refers to could reduce confusion.

B. <u>Communication with the MECs</u>

1. Keep the Virtual Gateway up and running and make it easier to use. Having the Gateway is in itself an enormous improvement and aligns MH with 21st century consumer expectations. Unfortunately when we

try to log on to check on client cases, it is often down. It would be very helpful if the applicant could be assigned a MH log-in ID# to log into the Gateway to check the status of applications. For example, when we submit requested verifications, it would be helpful to be able to log in to see if they have been processed.

2. Better communication between MH caseworkers and applicants/advocates on issues prior to denial will result in saved resources. Allowing emails would facilitate such communication. Often, MassNAELA members work closely with MH caseworkers on aspects of a case. It is particularly difficult when a caseworker simply denies an application for a minor issue without attempting to contact the advocate first. Many advocates report denials by workers who claim they did not receive certain verifications that the advocate has provided. We feel that better communication regarding questions about the case can often resolve a perceived problem without the issuance of a denial notice. This leads to far fewer fair hearings and a quicker turn-around on processing cases.

3. Better communication prior to fair hearing. Encourage caseworkers to communicate the issues for the denial to advocates when they are contacted, to see if resolution can be reached prior to the hearing. This would save MH resources and avoid a wasted time slot for a hearing that was unnecessary in the first place.

C. <u>Application Process</u>

1. Frail Elder Waiver applications filed with a clinical screening were supposed to be subject to "streamlined processing." To achieve the goal of enabling elders to receive care at home rather than in a nursing home, it was deemed necessary to expedite the application so caregivers can be placed in the home promptly. MH implemented a process whereby we would write across the top of the application "Frail Elder Waiver – Streamline Processing" and the MH staff would do so. Now we find that Frail Elder applications are not expedited – even though we still write "Streamlined Processing" across the top – unless we call in to follow up (and sometimes we find we need to call in multiple times). We would like to see the process reinstated whereby staff knows to expedite Frail Elder applications.

2. Changes in policy should be described in an Eligibility Operations Memo so applicants and case intake workers are aware of the changes and there is consistency in the application process. For example, we have heard informally that LTC applicants in nursing homes no longer need to complete an Adult Disability Supplement and send it to the Disability Unit for a determination of disability, when the applicant has funded a pooled trust account. We have also heard that some intake workers are still requesting the Supplement. It would, of course, save

time both for caseworkers and the DU to eliminate the need for the Supplement, since any frail elder approved by an ASAP nurse as needing a nursing home level of care would satisfy the DU requirements.

3. Timeframes are inconsistently applied and usually to the applicant's detriment. Applications can sit for months with the worker claiming to have received all of the requested information but needing more time for review. On the other hand, if an applicant is not able to provide the requested verification by the deadline on the Information Request, many caseworkers will not allow an extension, and will claim they must deny the case due to regulatory timelines. Sometimes it appears that a caseworker generates a denial notice because the caseworker hasn't had a chance to review the case, but is required to approve or deny by a date certain. If timelines can be stretched due to extenuating circumstances at MH, the same should be allowed for applicants.

Payment and Care Delivery Reform

A. We support the idea to initiate a structured, fact-based review of rates paid to LTSS providers, and working on a payment-for-quality program for nursing facilities.

B. We seek EOHSS support to ensure that Medicare coverage of skilled nursing facility care is provided consistently with the holdings in the *Jimmo* case. Under *Jimmo* a nursing facility resident who needs skilled services to maintain her health should continue to qualify for Medicare coverage; showing improvement is not a prerequisite to maintaining Medicare coverage. If Medicare SNF coverage is properly provided, MassHealth dollars can be saved.

C. We urge EOHHS to advocate with CMS for the approval of its federal waiver request to waive the 3-day hospitalization requirement so that Medicare SNF coverage is available to more individuals, thereby saving MassHealth dollars for SNF coverage.

Behavioral Health and Long-Term Services and Supports

A. Reform is needed to enable elders to receive MH coverage of care at home whenever possible. Current eligibility rules encourage nursing home placement especially for an applicant with income over 300% of the Federal Benefit Rate. To encourage more elders to receive care in community-based programs such as FEW, PACE, or PCA, MH should develop a way for applicants who are over-income for waiver programs to establish eligibility. If the individual's monthly income exceeds $2,199 by even one dollar, the individual is denied coverage until a large deductible is met. Because elders lack the funds to pay privately for sufficient care, they often cannot meet the

deductible. As a result the frail elder or disabled adult is often forced to move to a nursing home and apply for MassHealth long-term care benefits, which costs the Commonwealth far more than if the individual were allowed to remain home. We propose that (1) the applicant's excess monthly income above $2,199 be paid to MassHealth as a premium, much like other MassHealth programs; or (2) the applicant be permitted to fund a pooled special needs trust each month with the excess income above $2,199, so the applicant can qualify without a deductible. (The Commonwealth of MA is entitled to the remaining funds in the pooled special needs trust upon the applicant's death.)

B. We think that MH is misinterpreting a regulation concerning adult foster care, whereby MH will not make AFC payments to a parent who is also a guardian. In households where two parents care for a disabled adult child, it is easy enough to have one appointed guardian and the other as the AFC provider. But it is heartbreaking and fundamentally unfair to give single parents of disabled children the choice between receiving the AFC payment that will enable them to keep their children at home or to continue their lifelong role as their child's advocate. Parents should be allowed to receive AFC payments and also serve as guardian. Pursuant to Massachusetts guardianship law under the MUPC, a guardian is not in charge of the protected person's money any longer; a *court-appointed conservator* is charged with protecting the estate of the minor or incapacitated individual. So if MH is looking for an independent person to oversee the MH AFC payments on behalf of the child, it should allow the parent/caregiver to be guardian, but require another person to serve as *conservator* of the child.

C. We support your intention to continue to focus on improving the financial stability of the One Care program.

Thank you for opening the doors to MassHealth and holding the listening sessions and seeking input. We are excited to see the improvements that will come from this process. If you have any questions, please contact me as co-chair of MassNAELA's Public Policy committee.

Very Truly Yours,

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