



Managed Long Term Care and FIDA – Status in January 2015

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Acronyms -Vocabulary

Dual Eligible = Someone who has Medicare & Medicaid

TYPES OF PLANS/ Agencies

- MLTC – Managed Long Term Care
- MA – Medicare Advantage or Medicaid Advantage (beware!)
- MAP – Medicaid Advantage Plus
- PACE – Program for All-Inclusive Care for the Elderly
- LDSS – Local Dept. of Social Services/ Medicaid program
- DOH – NYS Dept. of Health

Managed Care Concepts – in Dual Eligible plans

- Full Capitation – Rate covers all Medicare & Medicaid services (PACE & Medicaid Advantage Plus)
- Partial Capitation – Rate covers only certain Medicaid services – MLTC package of long term care services



More Acronyms!

TYPES OF SERVICES

- CB-LTC - Community-Based Long-Term Care services
- LTC – Long Term Care generally also known as
 - LTSS – Long Term Services & Supports
- PCS or PCA – Personal care services – Personal Care Aide
- CDPAP or CDPAS – Consumer Directed Personal Assistance Program
- CHHA – Certified Home Health Agency
- ADHC – Adult Day Health Care (medical model)
 - SAD or SADC – Social Adult Day Care
- PDN – Private Duty Nursing

“Waiver” programs – Home & Community Based Services (HCBS)

- Lombardi – Long Term Home Health Care Program
- TBI – Traumatic Brain Injury waiver
- NHTDW – Nursing Home Transition & Diversion Waiver
- OPWDD – Office of Persons with Developmental Disabilities Waiver



4 big changes – Managed care & LTC

Change	Description	Status
DUAL ELIGIBLES adults with Medicare and Medicaid AND who need Long Term Care		
MLTC – Managed Long Term Care	Must join MLTC, PACE, or Medicaid Advantage Plus plan to get long-term Medicaid home care services	Since 9/2012 in NYC, in 33 counties as of 9/14. Rest of state by early 2015
FIDA – Fully Integrated Dual Advantage	Dual Eligible MLTC members in NYC, Long Island & Westchester will be “passively enrolled” into FULL CAPITALIZATION FIDA managed care plans that control all Medicare & Medicaid services	Moving toward 1/2015 start (delayed from 7/2014).
People with Medicaid ONLY – Not Medicare		
Mainstream managed care – carve-in PCS, CDPAP, PDN	Non-dual eligibles must get personal care, CDPAP, private duty nursing thru same managed care plans that provide most of their other Medicaid services	Plans took over PCS/CDPAP 8/2011. Nursing home will start 1/2015 if approved
EVERYONE – Duals PLUS people with Medicaid Only		
Nursing homes “carved into” managed care package	Both Duals in MLTC plans and non-duals in Mainstream Medicaid managed care plans must access nursing home care through plan, rather than fee for service.	CMS approval pending for January 2015 start (delayed from March 2014)

Managed care for Medicare and Medicaid


Client's Insurance	Managed care is...	Managed Care Model
Medicare Only	VOLUNTARY May keep Original Medicare (FFS) + Medigap + Part D	Medicare Advantage plan - usually includes Part D <ul style="list-style-type: none"> • ONE card replace 3 (Part D, Medigap, Original Medicare) • PRO: Costs less than a Medigap premium, control other out-of-pocket costs; • CON: must be in-network and get plan approvals.
Medicaid Only	MANDATORY – Exceptions: <ul style="list-style-type: none"> • Has spend-down • OPWDD, TBI waivers 	“Mainstream” Medicaid Managed care plan <ul style="list-style-type: none"> • Over 3.5 million NYS Medicaid recipients in these plans, but unfamiliar in elder law because anyone with Medicare or a spend-down is excluded. • SSI recipients with no Medicare MUST enroll. • Plan now responsible for all home care – personal care, CDPAP. In 2015, will add NURSING HOME CARE.
Medicaid + Medicare (Dual Eligible)	Voluntary for Medicare. Mandatory for Medicaid only if need Home Care (MLTC).	See next slide – Options different depending on if individual needs any type of long-term home care - personal care, CDPAP, private duty nurse, adult day health care

DUAL ELIGIBLES who need Home Care

Fee For Service	Managed Care Model
MEDICARE - Choice of FFS or Managed Care	
1. Original Medicare 2. Part D plan 3. Medigap (optional)	Medicare Advantage with Part D
MEDICAID	
MEDICAL CARE FFS Medicaid card – but only use for primary, acute care.	MLTC –MANDATORY for most dual eligibles 21+ who need long term care. Some exclusions. <ul style="list-style-type: none"> • Covers Medicaid LTC only + some other Medicaid services (Dental, eyeglasses, hearing aides, ambulette to MD) • “Partial capitation” – limited package of services
LONG TERM CARE. NO FFS OPTION	
OPTIONAL: ONE MANAGED CARE PLAN FOR BOTH MEDICARE + MEDICAID	
	Medicaid Advantage Plus (MAP) or PACE or FIDA <ul style="list-style-type: none"> • Plan REPLACES all Medicare, Medicaid & MLTC coverage – all in one plan • Full capitation. • FIDA coming in 2015 – same idea as MAP

DUAL ELIGIBLES who don't need home care.

Insurance	Fee For Service	Managed Care Model
Medicaid & Medicare (dual eligibles)	IF YOU DON'T NEED LONG TERM CARE/ HOME CARE – You do not need to join any managed care plan. Can choose FFS or Managed Care for both Medicaid and Medicare	
	MEDICARE: 1. Original Medicare 2. Part D plan 3. Medigap (optional)	Medicaid Advantage (MA) -voluntary - combines Medicare Advantage with a Medicaid managed care plan and a Part D plan. Provides all MEDICARE and MEDICAID services EXCEPT not long-term care services. <i>WARNING: Medicaid Advantage plans do not provide long-term home care, just short-term. If you are in Medicaid Advantage, and you need Medicaid home care, you may not join an MLTC plan. If you want home care you must switch to either:</i> <ul style="list-style-type: none"> Medicaid Advantage PLUS or MLTC and Original Medicare or MLTC and Medicare Advantage.
	MEDICAID: 4. Medicaid card (covers hospital deductible, 20% coinsurance, dental, etc.)	




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Different Types of Plan and What They Cover

Medicare (A, B, D)	Medicaid (medical)	Medicaid (LTC)
Medicare Advantage		
Medicaid Advantage		
	Mainstream Medicaid Managed Care (MMC)	
		Managed Long-Term Care (partial cap) (MLTC)
Medicaid Advantage Plus (MAP)		
Program of All-inclusive Care for the Elderly (PACE)		
Fully Integrated Duals Advantage (FIDA)		



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Managed Long Term Care (MLTC) Benefit Package ALL are Medicaid services – No Medicare services

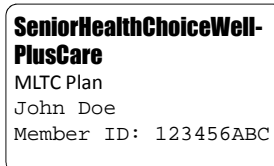
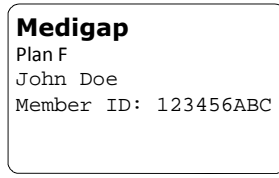
- Home care:
 - Personal Care (home attendant and housekeeping)
 - Consumer-Directed Personal Assistance Program (CDPAP)
 - Home Health Aide, PT, OT (CHHA Personal Care)
 - Private Duty Nursing
- Adult day care – medical & Social
- PERS, home-delivered meals, congregate meals
- Medical equipment, supplies, prostheses, orthotics, hearing aids, eyeglasses, respiratory therapy, Home modifications
- **4 Medical specialties-Podiatry, Audiology, Dental, Optometry**
- Non-emergency medical transportation
- **Nursing home** – big changes coming!!

Above are *partial capitation MLTC plans only*.
PACE, MAP = FULL capitation --all primary and acute medical services



Combination Example 1

Dual Eligible with Original Medicare Part D and MLTC



NOTE: Extra Help - Part D subsidy is automatic.

Medigap is optional



Combination Example 2

Dual Eligible with Medicare Advantage and MLTC

MediChoice Options Plus
 Medicare Advantage
 w/MedicareRx
 John Doe
 Member ID: 123456ABC

NOTE: Extra Help - Part D subsidy is automatic.

NO Medigap allowed.



SeniorHealthChoiceWell-PlusCare
 MLTC Plan
 John Doe
 Member ID: 123456ABC



Combination Example 3

Dual Eligible with Medicaid Advantage Plus (MAP)

MediChoice Options Plus Complete
 Medicaid Advantage Plus (Dual-SNP)
 John Doe
 Member ID: 123456ABC

Warning: Many MAP plans do not call themselves “MAP;” they say Medicare Advantage Special Needs Plan for Duals (Dual-SNP). All MAPs are Dual-SNPs, but not all Dual-SNPs are MAPs!

FIDA is essentially the same as MAP!!



UPDATE ON MLTC IN NYC

- New – Conflict Free Assessment
- Problems with Medicaid eligibility codes
- Spousal Impoverishment update



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Who is enrolled in MLTC?

1. MOST adult Dual Eligibles seeking Medicaid home care on a long-term basis in NYC must enroll in an MLTC plan – no more CASA or Lombardi. Includes CDPAP and Private Duty Nursing.
2. As of Dec 1, 2014 in NYC - # of recipients
 - 118,352 MLTC - includes over 50,000 transitioned from home attendant, Lombardi, etc.
 - 3,486 Home Attendant (down from 40,000)
 - 998 Housekeeping (down from 5600)
 - 222 Lombardi (Kids + last to send to MLTC)



Who is **EXCLUDED** from MLTC?

- **Duals who may not enroll in MLTC even in mandatory county –**
 - In **Traumatic Brain Injury, Nursing Home Transition & Diversion or Office for People with Developmental Disabilities waivers**
 - Have **hospice** care at time of enrollment (but may stay in MLTC if enroll in hospice once already in MLTC. MLTC Policy 13.18 (June 25, 2013)* or
 - Live in **Assisted Living Program**
 - Under **age 18**
 - **Needs not extensive enough to qualify -- If need only --**
 - **Housekeeping** services – apply at HRA HCSP (See MLTC Policy 13.21*) (if have housekeeping and then later need upgrade to home attendant, submit M11q to HCSP – will get thru CASA. Eventually will be required to join MLTC.
 - **Social Adult Day Care** services – not available thru Medicaid
- **Who **MAY** enroll but not required? Age 18-21 with or without Medicare, if would otherwise need Nursing Home**

* Policies posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm .



Transition Process from Fee for Service

- All NYC dual eligible adults in CASA, CHHA, Lombardi given 60-day notice to pick an MLTC plan or be auto-assigned.
- MLTC plans must continue previous LTC services for a **90-day transition period**,* or until the initial assessment, whichever is LATER. This includes providers who are out of network.
- At end of 90-day transition period, Plan may reduce or discontinue services with advance written notice. Client has right to request **internal appeal** with Aid Continuing, then, if adverse, request a fair hearing with Aid Continuing.
- If plan fails to give transition services, call State DOH Complaint Line MLTC (866) 712-7197 MMC (800) 206-8125

*http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_13_continuity_of_care.pdf; DOH Policy 13.10

New Applicants for Home Care in NYC

Still apply for MEDICAID at HRA, but Front Door Closed to apply for home care through CASA *unless* in home hospice or need only housekeeping.

- In NYC – If need MLTC apply for Medicaid
HRA HCSP Central Medicaid Unit
 785 Atlantic Avenue, 7th Floor
 Brooklyn, NY 11238
 T: 929-221-0849
- If need **HOUSEKEEPING ONLY (max 8 hours/week)** – Submit Medicaid application and M11q to:
NYC HCSP Central Intake
 109 East 16th Street, 5th Floor,
 New York, NY 10003
 T: 212-824-0706 FAX 212-896-8814.



NOTE: MLTC plans can't give services Medicaid-pending. Some will help apply for Medicaid and w/pooled trust.



Tips for filing Medicaid applications

- Must complete Supplement A and provide current asset documentation (+ last 3 months if want retro)
- Indicate on top of Application and Cover Letter that seeking MLTC (see sample Cover Sheet)
- If client will have a spend-down – special steps:
 - May be worth having MLTC plan file app, avoids “coding” problems
 - Wait to enroll in pooled trust until AFTER Medicaid approved and enrolled in MLTC. Faster.
 - Submit any medical bills client has paid in last 3 months, and any unpaid bills from before that.
 - MARRIED APPLICANTS may only have a spend-down initially. Once one spouse enrolls in MLTC, can request Spousal Impoverishment protections. More later. See form.



Options for dealing with spend-down

Start from the top of the list and rule out each option before proceeding to the next.

1. REDUCE or ELIMINATE SPEND-DOWN
 - a. Nursing Home Transition Shelter Allowance
 - b. Spousal Impoverishment Budgeting (but only AFTER Medicaid accepted)
 - c. Enroll in a pooled income trust (but wait to submit trust and other forms AFTER Medicaid approved with spenddown)
2. Negotiate the spend-down with the plan
3. Pay the full spend-down to the plan



1) Nursing Home Transition Shelter Allowance

Medicaid will subtract a regionally-standardized shelter cost deduction from income where:

- The individual **has been in a nursing home for at least 30 days** (not counting the day of discharge), **or has been residing in an adult home**;
- Medicaid must have made a payment for the nursing home stay (in the case of adult home residents, the resident must have been on Medicaid);
- Not receiving spousal impoverishment budgeting; and
- Eligible for and enrolled in an MLTC plan upon discharge.

N.Y. Dep't of Health, ADMINISTRATIVE DIRECTIVE: SPECIAL INCOME STANDARD FOR HOUSING EXPENSES FOR INDIVIDUALS DISCHARGED FROM A NURSING FACILITY WHO ENROLL INTO THE MANAGED LONG TERM CARE (MLTC) PROGRAM, 12 OHIP/ADM-5 at 2-4 (October 1, 2012); GIS 14 MA/17 (August 5, 2014).



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2014 Special Income Standards for Housing Expenses

Region	Counties	Deduction
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	\$380
Long Island	Nassau, Suffolk	\$1,066
NYC	Bronx, Kings, Manhattan, Queens, Richmond	\$972
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	\$435
North Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	\$786
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	\$372
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	\$315

N.Y. Dep't of Health, GENERAL INFORMATION SYSTEM MESSAGE: EXPANSION OF THE SPECIAL INCOME STANDARD FOR HOUSING EXPENSES TO INDIVIDUALS DISCHARGED FROM AN ADULT HOME AND THE 2014 LEVELS FOR THE SPECIAL INCOME STANDARD FOR HOUSING EXPENSES, GIS 14 MA/17 (August 5, 2014).

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Example budget with NH transition shelter allowance

Gross monthly income		\$2,067
Health insurance premiums	(Medicare Part B)	- 105
	(Medigap)	- 161
Unearned income disregard		- 20
Shelter deduction (NYC)		- 972
Net countable income		\$809
Income limit for single		- 809
Excess income		\$0



Getting home from nursing home

- Catch 22: can't get home and receive home care without MLTC, but no MLTC plan will assess in nursing home! Plus – MLTC enrollment only on 1st of month – must coordinate discharge & starting services.
- After lengthy advocacy, DOH released guidance in May 2014 requiring MLTC plans to assess applicants in NH.*
 - Plan must also visit community residence, but applicant need not be present for that visit (arrange for family to give access)
- HRA **Medicaid Alert** of Feb. 14, 2013 “*MLTC Submissions of Nursing Home Enrollments*” explains enrollment in NYC
<http://wnylc.com/health/download/439/>

* N.Y. Dep't of Health, MLTC POLICY 14.04: MLTCP POTENTIAL ENROLLEE ASSESSMENTS (May 22, 2014),
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_nursing_home_assess_v2.pdf



Nursing home discharge - Strategy

YOU must coordinate 3 parties and carefully time discharge.

Work with:

1. MLTC plan must assess client in NH and agree to enroll her effective 1st of next month;
2. HRA Home Care Services Program Medicaid unit must convert “code” from nursing home to community eligibility effective 1st of month. (929) 221-0849
3. NH must arrange discharge on 1st. If 1st of month on a weekend, or plan can't arrange discharge and start services on the 1st of the month, may be able to enroll on the 1st but discharge a day or two later. All must be coordinated.



2) 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. But only AFTER enrolled in MLTC.
- If applicant has a **community spouse**, he/she may shelter up to \$2,980/mo. (2015) of joint income (and up to \$74,820 of assets).
- It works almost the same as for nursing home, but with some minor variations.

Use **Request for Assessment Form** – at p. 9 of this update
http://www.health.ny.gov/health_care/medicaid/program/update/2014/mar14_mu.pdf. Send to HCSP Centralized Medicaid Eligibility Unit
 , 785 Atlantic Avenue, Brooklyn, NY 11238



Example budget with spousal impoverishment

Gross monthly income		\$2,130
Personal Needs Allowance (2015)		- 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

N.Y. Dep't of Health, Medicaid Update Vol. 30, No. 3 at 5-9 (March 2014); N.Y. Dep't of Health, GENERAL INFORMATION SYSTEM MESSAGE: SPOUSAL IMPOVERISHMENT BUDGETING WITH POST-ELIGIBILITY RULES FOR INDIVIDUALS PARTICIPATING IN A HOME AND COMMUNITY-BASED WAIVER PROGRAM, GIS 12 MA/013 (April 16, 2012); N.Y. Dep't of Health, MEDICAID REFERENCE GUIDE: INCOME at 278-282 (June 2010).

Hot issue – May a married MLTC enrollee use a pooled trust?

- At first in 2013, the State said that a married MLTC enrollee could choose either spousal impoverishment rules *or* use community budgeting– with a pooled trust -- as a household of one
- This allowed enrollees to choose community budgeting with pooled trust if better; i.e. if community spouse had her own income over \$2980, applicant couldn't give her part of his own income as a spousal allowance – has a spend-down.
- 8/5/14 - DOH issued a GIS making spousal impoverishment rules mandatory, and eliminating the option of a pooled trust for MLTC enrollees. Suffolk County rebudgeted all couples!
- 11/3/14 – DOH rescinded 8/5/14 GIS and issued new GIS 14 MA/025 – **but stay tuned!** Only pending CMS clarification.

N.Y. Dep't of Health, GENERAL INFORMATION SYSTEM MESSAGE: SPOUSAL IMPOVERISHMENT BUDGETING WITH POST ELIGIBILITY RULES UNDER THE AFFORDABLE CARE ACT- GIS 14 MA/25 (Nov. 3, 2014).



Dealing with Spend-down after Apply

See handout on Spend-down Tips. Since we advise NOT to submit pooled trust with application, because of delays, and you can't get Spousal Impoverishment protections initially, client will have a spenddown at first. If plan refuses to assess and/or enroll client because code says Not Eligible:

- Give the plan a copy of the **notice** approving Medicaid.
- Give the plan the **HRA HCSP FAQ** dated Nov. 13, 2013 (copy in handout and posted at <http://www.wnyc.com/health/download/449/>)
- Tell the plan it must fax a **MAP Medicaid Cover Sheet Form HCSP-3022** (known as a “**CONVERSION FORM**”) to the **HRA HCSP MLTC Provider Relations Unit**, requesting that the eligibility code be changed.

TEL: (929) 221-2427 Fax: (718) 636-7848 - copy attached and posted at <http://www.wnyc.com/health/download/450/>.

- DO NOT use “pay-in.” Causes problems.

Gets complicated if you want to access CHHA pending MLTC enrollment. You will need to get codes changed...



NEW: Conflict-Free Eligibility & Enrollment Centers (CFEEC) for new applicants

- 10-2014- State added a new step in enrollment for MLTC.
- Until now, once Medicaid is approved by local DSS, individual contacts an MLTC plan directly and enrolls effective 1st of next month. The MLTC plan assessed eligibility for MLTC and determined number of hours of care.
- Now, after Medicaid is approved by local DSS, individual must be assessed by Maximus/NY Medicaid Choice, State contractor, which will now handle not only enrollment but also determine eligibility for MLTC.
 - State aims to end “cherry picking” – plans recruiting people who don’t even need any home care and turning away high-need people.
 - Concern about delays. Supposed to take 7 days.
 - CFEEC does not determine HOURS. Plan does.



Conflict-Free Assessment *con'd.*

- Roll-out schedule:
 - Region 1 – Manhattan, Bronx – Oct. 2014 **STARTED 10/1/14**
 - Region 2 – Brooklyn, Queens, Staten Island, Nassau – **Started Nov. 1, 2014**
 - Region 3 - Westchester, Suffolk – Dec. 2014
 - Regions 4-6 – All other counties – March through May 2015
- Nurse conducts assessment using same Uniform Assessment Tool as MLTC plans. Conducted in-home, hospital or nursing home.
 - TIP: MAKE SURE FAMILY OR SOCIAL WORKER ARE AT ASSESSMENT!
 - TIP: Have MD letter/M11q with diagnoses, meds, functional impairments at assessment
- No new assessment needed if transferring from plan to plan, or from a previous Medicaid LTC service. Just new applicants.
- http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
- <http://nymedicaidchoice.com> -On home page click on [Do I Qualify for Long Term Care?](#)
Direct link <http://nymedicaidchoice.com/ask/conflict-free-evaluation-and-enrollment-center>

Choosing an MLTC Plan

- Choose MLTC, Medicaid Advantage Plus or PACE. In 2015 will also be able to choose FIDA.
- Online lists on:
 - DOH website –
http://www.health.ny.gov/health_care/managed_care/mltc/mltclplans.htm
 - NY Medicaid Choice website (see Long Term Care plans)
(<http://nymedicaidchoice.com/program-materials>)
 - NYLAG compiled lists posted at
<http://www.wnyc.com/health/download/371/> (by county)
<http://www.wnyc.com/health/download/429/> (by company)



Ask Plan to Assess Client before enrolling

- Transition folks are not required to get assessed before enrolling – they can do “blind enrollment” through NY Medicaid Choice – but it’s better to get assessed first and try to find a good match
- New applicants must be assessed before they can enroll – Plan should also come to nursing home to assess. See slide 33.
- Client doesn’t have to sign on the spot during home visit, or as a condition of the plan making the visit. Insist on seeing written plan of care before enrolling. Required by State DOH Q&A 8/21/12 # 39*.
- Family member, advocate, or geriatric care manager should be present at the assessment and ask questions:
 - How many hours AFTER 90-day transition?
 - What services?
 - Keep same home care agency, adult day care?

* http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-21_mltc_faq.pdf



What if plan refuses enrollment?

- Transition population (from CASA, etc.) is deemed eligible so plan **cannot refuse** enrollment
- New applicants
 - Conflict-Free Eligibility & Enrollment Center, not the PLAN, determined eligibility for MLTC enrollment
 - But Plan still has incentive to avoid enrolling costly/ complicated clients. Since can't formally deny enrollment, they may illegally* use pretexts to discourage enrollment.
 - You need family to cover night-time care
 - We can't give 24-hour care / our budget doesn't allow.
 - You aren't safe at home or you need family to be a "backup"

* http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf



State tackles plan behavior in turning away high need people

- On May 8, 2013, DOH released [MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care](#)* which attempts to bar plans from discouraging prospective members from enrolling.
 - "The MLTC plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party."
- **BACK-UP AGREEMENTS** --Policy 13.10 says plan cannot obligate informal caregiver to provide backup assistance.
- Recourse if plan tries to discourage enrollment OR authorizes too few hours or requires back up agreement –
 - No appeal rights if not yet an enrollee!
 - Choice – shop around for better plan or
 - Enroll and start care, and file appeal re inadequate hours authorized.
 - **COMPLAIN to STATE DOH! 1-866-712-7197**

*http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf
 posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm



MLTC Enrollment/disenrollment

- No lock-in!
 - Members can switch to a different plan at anytime
 - But, cannot go back to fee-for-service Medicaid for long-term care services
- Enrollment lag time – 1st of the month only!
 - Generally, if you switch plans by the 20th of the month, the enrollment in the new plan will take effect the first of the next month.
 - No mid-month pick-up dates
 - However, contract appears to give plans ability to drag out *disenrollment* until first of the *second* month.
 - Should be no gap in services!**
- **Disenrollment** – Plan may disenroll for not paying spend-down, among other reasons.



NURSING HOME CARE “CARVED IN” TO MLTC AND MAINSTREAM MANAGED CARE - 2015

Permanent nursing home residents will be required to enroll in an MLTC or Mainstream MMC plan

DOH Powerpoint on NH transition (March 2014)
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-03-10_trns_of_nh_services.pdf; DOH Policy on Transition of NH Population to Managed Care (March 2014),
http://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf; more at
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm



Nursing Homes and Managed Care

Big Changes Starting **STATEWIDE** in 2015 for both

- Dual Eligibles -- will be required to stay enroll in – or stay in -- an MLTC plan to get nursing home care; and
- People with Medicaid only – not Medicare- will be required to enroll in or stay in an MMC plan to get nursing home care

WHEN (projected – not yet approved...may be further delayed)

- February 2015 – NYC
- April 1, 2015 - Long Island, Westchester
- July 1, 2015 – Rest of State



Until now – nursing home was “fee for service” – not through managed care

- Until now, MLTC was mandatory only for duals who need **home care**
 - Once an MLTC member needed NH placement, would typically “voluntarily disenroll,” even though NH is in MLTC benefit package
 - Would disenroll if didn’t like choice of nursing homes in MLTC plan’s network.
 - Medicaid-onlies have long been required to join mainstream Medicaid managed care (MMC) plans, but *were disenrolled* from the plans if in a nursing home for more than 60 days.
- **Now, all adult Medicaid recipients –when they become permanent nursing home residents -- will be required to enroll in a managed care plan (MLTC for duals, MMC for Medicaid-onlies).**



When must NH residents enroll in a managed care plan?

- Will be different for people who were:
 - Already in an MLTC or mainstream MMC plan or
 - Were not in an MLTC or mainstream plan at the time of NH placement
- Merely going into NH for short-term rehab does not require enrollment in any plan. It is only after they are admitted, apply for Medicaid and institutional Medicaid is approved (with the 5-year lookback), that they will be required to enroll
- **No one is required to enroll in a plan if they were in a nursing home and approved for institutional Medicaid BEFORE:**
 - Feb. 1, 2015, and in NYC, Long Island, Westchester
 - April 1, 2015 (rest of state)

NOT YET APPROVED BY FEDS as of 1/12/15



Process for new nursing home admissions

- **Consumers NOT already enrolled in MLTC/MMC**
 - Select and enter any **nursing home of their choice**
 - Apply for **Institutional Medicaid** (Includes 5-year look-back and transfer penalties)
 - If approved, they will receive **notice giving 60 days to pick a plan** (should pick one that includes their nursing home in the network)
 - If they don't pick a plan, will be **auto-assigned** to a plan that has that NH in network (MLTC for duals, MMC for non-duals)



Process for new nursing home admissions (cont'd)

- **Consumers already enrolled in mainstream MMC plan** (do not have Medicare)
 - **Must enter a NH in that plan's NETWORK** or Medicaid will not pay for it
 - MMC plan no longer will disenroll someone because they need long term nursing home placement. Plan must pay for NH.
 - Plans should assess members who are NH residents for possible discharge home and provide home care services on discharge.



MLTC: Transition from hospital to NH

- Rehab/ NH stays where Medicare pays primary are not limited to MLTC plan's network. MLTC plan must pay Medicare coinsurance out of network too. **DOH Q&A Aug. 16, 2012*** - Question 42 on page 7.
- **Once Medicare ends, if NH is not in the plan's network, it is not clear whether the MLTC plan must pay.** Individual may change to MLTC plan that has NH in network, but not effective until 1st of the next month. We think old MLTC plan should pay for reasonable time to transfer plans, but not clear.
- Upon discharge from NH, MLTC provides home care services
 - Usually via Medicare episode of CHHA arranged by MLTC, possibly supplemented with Medicaid hours
- No LOCK-IN – In both MLTC & MMC, may change in any month to a plan that has a preferred NH in its network

*http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_faq2_final.pdf



Current NH Residents Grandfathered in!

NO ONE WILL BE FORCED TO MOVE – People already in nursing homes as **permanent residents** on 2/1/2015 (4/15 Long Island & Westchester, and 7/1/15 upstate) are grandfathered in – don't have to enroll in MLTC or mainstream MMC plan - can stay in their nursing home with FFS Medicaid.

- But – after six months, “voluntary enrollment” begins for these NH residents, when they MAY enroll in MLTC plans.
- BEWARE OF aggressive marketing by plans to enroll residents into FULLY CAPITATED Plans that control MEDICARE services.
- In NYC/L.I./Westchester, almost all companies with MLTC plans will also have a FIDA plans and want to increase market share.



Minimum Network Size = # NHs required

	# of NHs	Network minimum
Manhattan	16	5
Brooklyn	42	8
Queens	55	8
Bronx	43	8
Staten Island	10	5
Nassau	35	8
Suffolk	43	8
Westchester	38	8
Monroe, Erie		5
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

WHEN MEDICAID RECIPIENT FIRST GETS MEDICARE

Continuity of long-term care services threatened when client received home care from mainstream MMC plan but is disenrolled from plan when gets Medicare.



Warning: Transition from MMC to MLTC when someone first enrolls in Medicare

Medicaid recipients who were in a mainstream MMC plan are disenrolled automatically when they obtain Medicare – either by **reaching 65** or because of **receiving SS Disability for 2 years**.

If that person received personal care, CDPAP, or other LTC through the MMC plan, disruption of services is likely.

For 2 years NYLAG led demand for a seamless transition – whether back to DSS/CASA or, in mandatory MLTC areas, to MLTC plans.

- DOH has agreed to adopt a procedure to transition these members to an MLTC plan with no interruption in services. Client will be auto-assigned to MLTC plan with right to choose other plan. But not yet in place as of 1/2015.

How to Prevent disruption of home care when transition from Mainstream MMC

Be proactive! If your client is newly on Medicare, and they received home care through Medicaid managed care –

1. **Help them enroll in an MLTC plan.** They may want to stay with the company that sponsored their mainstream plan. But they should shop around.
2. **Call the managed care plan** to make sure care doesn't stop. Contact list at <http://www.wnylc.com/health/download/306/> (see "Medicaid Managed Care" plans – page 1)
3. Call the MLTC plan and make sure they know what care the client was receiving. Must continue that for 90 days as "transition plan."
4. For problems call DOH MLTC Complaint line 1-866-712-7197 or MMC line 1-800-206-8125

FIDA: FULLY INTEGRATED DUAL ADVANTAGE

Demonstration Program in New York City, Nassau, Suffolk, and Westchester only

Starts in December 2014

What is FIDA?

WHAT? FIDA plans are fully capitated plans similar to **Medicaid Advantage Plus**. They will control and provide all:

- **Medicaid** services including LTC now covered by MLTC plans PLUS other Medicaid services NOT covered by MLTC
- **Medicare** services – ALL primary, acute, emergency, behavioral health, long-term care

WHERE? **NYC, Nassau, Suffolk and Westchester only**

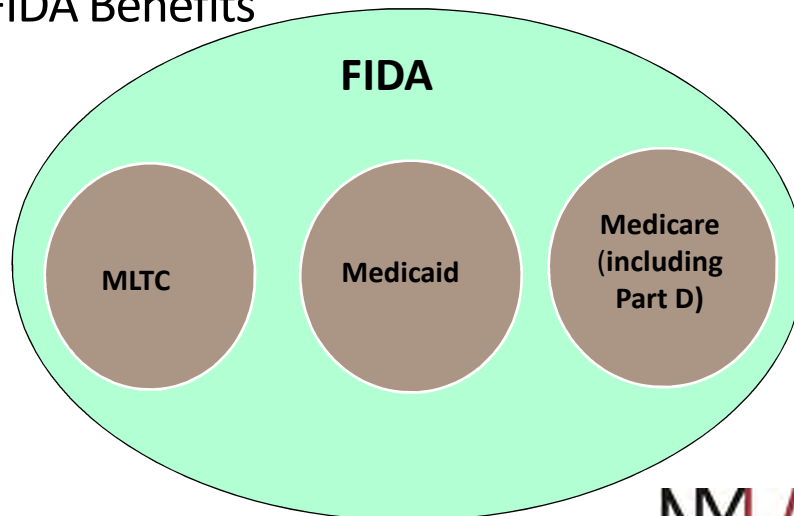
WHO? Adult dual eligibles – estimated 180,000 – living in the demonstration area who are receiving or applying for Medicaid long-term care services:

1. MLTC, MAP or PACE services (125,000 people) OR
2. Nursing home care – will affect residents who are first permanently placed in 2015
3. EXCLUDES – people in TBI, NHTDW, OPWDD waivers, hospice, Assisted Living Program.

WHEN? **Roll-out begins Dec. 1, 2014** (pushed back since July 1, 2014). Demo ends Dec. 2017.



FIDA Benefits



Why FIDA?

- Feds and State want to control costs of dual eligibles. The ACA included money for states to develop Dual Demonstration programs. Plans must reduce costs compared to FFS by 1% in Year 1, 1.5% in Year 2 and 3% in Year 3.
- Hoped that enhanced “person centered” care coordination will both improve outcomes and save money.
- Aims to control perverse financial incentives of FFS Medicaid/Medicare system
 - frequent hospital readmissions
 - revolving door between hospitals and SNFs
 - FFS incentives to bill for unnecessary care



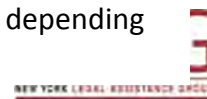
Passive Enrollment

- MLTC members will be notified that they MAY voluntarily enroll in a FIDA plan (“announcement notice” and 90-day notice)(In NYC, sent in Dec. 2014 & Jan. 2015)
- Next, they receive 60-day notice they have 60 days to:
 - Select and enroll in a FIDA plan OR
 - **OPT OUT** of FIDA, and stay in MLTC - requires an affirmative step – with NY Medicaid Choice.
- If they do not opt in or out opt of FIDA, they will be **automatically assigned** to a FIDA plan (“passive enrollment”)

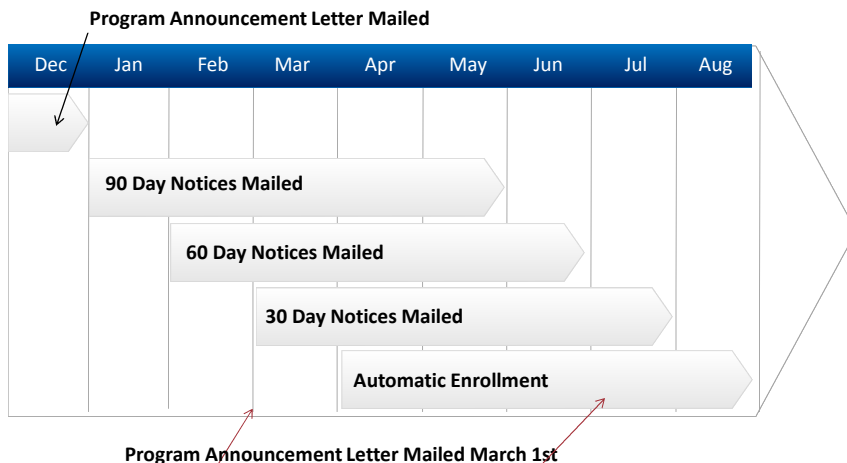


Timing of FIDA implementation

- WHO – Dually eligible adults over age 21 in MLTC:
 - Currently **MLTC members** or newly applying for MLTC living in the community on or after 2/1/2015 in **NYC & Nassau**
- WHEN – NYC & Nassau
 - Dec. 1, 2014 – “Announcement notice” sent to all MLTC members– may enroll on a voluntary basis to be effective Jan. 1, 2015
 - Jan. 1, 2015 – “Voluntary” enrollment effective for those who enrolled since Dec. 1, 2014.
 - Feb. 1, 2015 – 60-day notices to enroll or opt out sent –NYC
 - Mar. 1, 2015 – 30-Day notice to enroll or opt out
 - April, May, June, July, 2015- “Passive” enrollment effective for those who did not opt out – on rolling basis depending on renewal date for Medicaid.



2015 FIDA phased enrollment – NYC & Nassau



Long Island and Westchester Delayed Start
Automatic Enrollment eff. 7/1/15



FIDA update as of Jan 2015 as of 12/20/14

Announcement letters sent (<i>Region I only</i>)	Number of calls received	Total number of opt-ins for January 1, 2015 eff date*	Total number of opt-outs*
App. 100,000	11,246	372	3,853



FIDA and Nursing Home Residents

- Original FIDA proposal would have required 55,000 adult nursing home residents who are Dual Eligibles to enroll in FIDA, including long-time residents.
- CHANGE* - Only NEW people “new to custodial status” in 2015 will be passively enrolled, but not til August 2015. We think this means only people who are first approved for Institutional Medicaid (5-year lookback) after Jan. 1, 2015.
- How does this dovetail with mandatory enrollment of NH residents in MLTC?

*DOH Policy & Planning update dated Oct. 16, 2014, slide 7 posted at

<http://www.wnyc.com/health/download/518/>



Which plans will be FIDA plans– and how will “Intelligent Assignment” Work?

- **21 plans will be** FIDA plans – passed a “Readiness Review” to ensure systems, procedures, and networks are ready.
- **All but 4 MLTC plans will have an affiliated FIDA plan**, so that FIDA is essentially an MLTC plan with an added benefit package of all Medicare services. See list at <http://www.wnyc.com/health/download/429/>.
 - 4 MLTC plans with no FIDA plan: HHH Choices, Extended, Montefiore & UnitedHealth – only 3% NYC enrollees.
- **“Intelligent assignment”** – State will assign MLTC members to FIDA plan affiliated with MLTC plan, if any. Won’t look at whether member’s doctors are in the FIDA plan’s network.
 - **WARNING.** While assignment to the FIDA plan linked to their MLTC plan will promote continuity of their **home care providers** and other MLTC providers (dentist, adult day care program, etc), the FIDA plan may not contract with all of their **MEDICARE providers** – physicians, specialists, hospital, physical therapy clinic, etc. So continuity of care is not assured.



FIDA Plans in NYC

1. AETNA BETTER HEALTH FIDA
2. AGEWELL NEW YORK FIDA
3. ALPHACARE SIGNATURE FIDA
4. HEALTHPLUS AMERIGROUP FIDA
5. ARCHCARE COMMUNITY ADVANTAGE FIDA
6. CENTERLIGHT HEALTHCARE FIDA
7. FIDA CARE COMPLETE (CENTERS PLAN FOR HEALTHY LIVING)
8. RIVERSPRING FIDA (ElderServe)
9. EMBLEMHEALTH DUAL ASSURANCE FIDA
10. FIDELIS CARE FIDA
11. GUILDNETGOLD PLUS FIDA
12. HEALTHFIRST ABSOLUTECARE FIDA
13. ELDERPLAN FIDA TOTAL CARE
14. ICS COMMUNITY CARE PLUS FIDA MMP
15. INTEGRA FIDA
16. METROPLUS FIDA
17. ~~MONTEFIORE EMERALD CARE FIDA PLAN~~ (dropped out Jan. 2015)
17. NORTH SHORE-LIJ FIDA LIVEWELL
18. SWH WHOLE HEALTH FIDA
19. VILLAGECAREMAX FULL ADVANTAGE FIDA PLAN
20. VNSNY CHOICE FIDA COMPLETE
21. WELLCARE ADVOCATE COMPLETE FIDA



Right to OPT OUT of Demonstration

- **Clients have the right to opt-out of FIDA**
- If they opt out of FIDA, they still must stay in an MLTC plan to receive long term care services (or opt for MAP, PACE, NHTDW or TBI waiver). But will keep regular Medicare+Part D or their Medicare Advantage plan
- If they opt out once, they cannot be passively enrolled again during the length of the Demonstration, which goes through December 2017.
- If client misses opting out before FIDA enrollment, they **may still disenroll** from FIDA and return to MLTC at any time later.
 - But only effective first of next month
- Must call NY Medicaid Choice to Opt Out **1-855-600-3432**



Transition/Continuity of care

- FIDA is a type of Medicare Advantage plan, with restriction of **provider network** affecting choice of doctors, specialists, hospitals, etc.
- FIDA plans must allow you to maintain ALL current providers and service levels, including doctors and prescription drugs, at the time of enrollment for at least the later of **90 days after enrollment**, or until a care assessment has been completed by the FIDA plan.
 - But: MD must accept FIDA plan's terms – may refuse – in which case can't see MD during the 90 day transition period.
- **WARNING:** Because plan must cover out-of-network doctors for 90 days, client may not realize she's in FIDA! But if wants to keep her doctors, must disenroll or change FIDA during that 90 days!



Transition/Continuity of care (cont'd)

- FIDA plan has 60 days to complete an assessment for people who transitioned from MLTC, and 30 days for new applicants who never had MLTC.
- FIDA plans must allow **nursing home residents** who were passively enrolled to stay in the same NH for the duration of the demonstration – they cannot make them transfer to a different nursing home. So FIDA plans must contract with ALL nursing homes.
- DOH announced on January 10th, 2014 that the continuity period for **behavioral health care** will be more than 90 days – for the duration of the period of care, up to 2 years.



Whether to Enroll in FIDA:

1. Provider Networks

Are preferred providers in the plan's network? Physicians, clinics, pharmacies, hospitals, nursing homes, home care agencies

- This may be difficult to find out. All Provider directories not yet posted on their websites.
- Talk to your doctors and the plans. See website links and phone numbers in list at <http://tinyurl.com/FIDAlist> .
- If client was already in a Medicare Advantage or Medicaid Advantage Plus plan, s/he is accustomed to being limited to a provider network. If she was in Original Medicare, caution about losing access to MD's & other providers.
- NOTE: Guildnet has "Point of Service" network – any Medicare provider will be paid Medicare rate no in-network requirement IF they agree to procedures. Unclear if MDs will agree.

Whether to Enroll in FIDA

2. Prescription Drugs

Are your prescription drugs on the plan's formulary?

Unlike stand-alone Part D Prescription Drug Plans (PDP) and Medicare Advantage plans that include Part D ("MA-PD"), the formularies for FIDA plans cannot be searched via the Medicare.gov Planfinder website.

As of mid-December 2014, all FIDA plans have not yet posted either their drug formularies or their full provider network directories on their websites.



Whether to Enroll in FIDA:

3. Costs

- **NO COSTS to CONSUMER** – FIDA plans may not charge their members at all. If consumer stays in network she will have:
 - NO copayments allowed, including for Part D drugs.
 - NO Part B premium – this is paid for by State (even if not in Medicare Savings Program).
 - NO premium or deductibles
- **NOTE: Medicaid Spend-down** still applies – plan will bill member for spend-down.



Whether to enroll in FIDA:

4. Medigap

- A Medigap plan won't do much good when you have FIDA. This is because there are no out-of-pocket costs with FIDA - not even the monthly Part B premium.
- You might be tempted to drop your Medigap policy if you join FIDA.
- **CAUTION** - if you later decide to disenroll from FIDA and return to Original Medicare, you will not be able to buy a Medigap policy. Federal law bans the sale of Medigap policies to Medicaid recipients, since it is essentially duplicate coverage. However, if a Medicaid recipient already has a Medigap policy, she may renew it or replace it with a different policy. 42 USC 1395ss(3)(3).
- So - consider keeping your Medigap policy active while you "test drive" FIDA and see if it meets your needs.



Whether to enroll in FIDA:

5. Retiree Health Coverage

- If you or your spouse have retiree health coverage that supplements Medicare, or that provides Prescription Drug coverage, be sure to ask the benefits administrator before you enroll in FIDA.
- Enrolling in FIDA may result in TERMINATION of your retiree health coverage, depending on the type of coverage. This may affect not only you but your spouse or other dependents who may rely on this coverage.



NEW: FIDA Integrated Appeal Process

- A unique and positive (hopefully) component of NYS's FIDA demonstration is that it will integrate into **one system of appeals for Medicare and Medicaid services**. Part of the goal of FIDA is to simplify access to care for consumers, so that they don't have to separately navigate Medicare and Medicaid bureaucracies.
- Consumer receives ONE notice – not separate Medicare and Medicaid notices.
- In a victory for advocates, Aid Continuing will be granted in ALL appeals – even when MEDICARE services are denied, if the appeal is requested within 10 days of the notice. If timely requested, Aid Continuing will apply throughout all stages of the appeal process.



Integrated Appeal Process – Stages of Appeal

There are 4 stages of appeal for all Medicare and Medicaid appeals. Aid Continuing applies through the 3rd stage.

1. **Initial appeal** is to the Plan. MAY NOT REQUEST FAIR HEARING!!
2. If plan denies internal appeal, may appeal is to the **State's integrated hearing officer** – who will hear both Medicare and Medicaid appeals (except for Part D). This is reportedly going to be a new entity within OTDA (current hearing office)
3. If hearing is lost, may appeal to the **Medicare Appeals Council** – which will hear Medicaid issues as well as Medicare. Aid continuing applies if timely requested.
4. **Federal district court** appeal. (NO automatic aid continuing)



Ombudsman Program - ICAN - & other Consumer Protections

- **OMBUDSMAN** – Though the state declined federal funding for an Ombudsman program, NYS is funding one to assist and advocate for consumers navigating FIDA and MLTC.
 - Community Services Society won contract – will launch “ICAN” – Independent Community Advocacy Network. Not open yet.
 - TEL 1-844-614-8800 <http://icannys.org> E-mail ICAN@cssny.org
- **Medical Loss Ratio (MLR)** – 85% of all capitation rates must be spent on services and care coordination, not administration/profit. Plan must remit difference to CMS if fails test.



Info on FIDA

National resources on CMS Guidance on the Duals Demonstrations

- dualsdemoadvocacy.org (Natl. Senior Citizens Law Center)

NYS DOH FIDA website – includes Memorandum of Understanding between CMS and DOH, FAQ, other guidance –

- http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm
 - Subscribe to state listserv
http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm
 - FAQ Sept 2013
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013_09_fida_faq.pdf

NYLAG info: <http://www.wnylc.com/health/entry/166/>
<http://www.wnylc.com/health/download/518/>

NYS Coalition to Protect the Rights Of New York’s Dually Eligible – includes NYLAG, Medicare Rights Center, Legal Aid Society, Empire Justice Center check for updates at <http://www.nyduals.org/>

CMS Duals website <http://www.integratedcareresourcecenter.com/>





NAVIGATING MLTC

- Service Authorizations, Concurrent Review
- Grievances and Appeals

Model MLTC Contract – download at
http://is.gd/NY_MLTC_contract

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Requesting new or additional services

- **“Prior Authorization” – new service requested**
 - A request by the **Enrollee or provider** for a **new service** (whether for a new authorization period or within an existing authorization period) or a request **to change a service** as determined in the plan of care for a new authorization period.
- **“Concurrent Review” – increase in home care hours**
 - A request by an Enrollee or provider for
 - Additional services (i.e., more of the same) that are currently authorized in the plan of care; or
 - Medicaid covered home health care services following an inpatient admission.

[Model Contract, Appendix K, ¶ \(3\) \[p. 113 of PDF\]](#)



Service Authorizations: Timing

- **Concurrent review – plan must decide**
 - **Expedited** – within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services.
 - **Standard** – within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services.
 - In the case of a request for Medicaid covered home health care services following an inpatient admission, 1 business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, **72 hours after receipt of necessary information; but in any event, no more than 3 business days after receipt of the request for services.**

[Model Contract, Appendix K, ¶ \(3\) \[p. 114 of PDF\]](#)



Service Authorizations: Timing

- Both prior and concurrent can be **expedited**; the standard is the same as for appeals
 - Appeals of concurrent reviews are automatically expedited
- Prior authorization
 - **Expedited** - 3 business days from request for service.
 - **Standard** – within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services.

ALERT – Plans don't meet these deadlines, or fail to process these increases altogether – care manager may fail to pass the request on to the appropriate personnel, or give no notice of appeal rights. Must be assertive and file internal appeals

[Model Contract, Appendix K, ¶ \(3\) \[p. 114 of PDF\]](#)



Advocating for more Hours – with Plan or at Fair Hearing

- There has been **NO CHANGE** in the amount or type of services available under MLTC versus under PCA/CHHA.
- If an individual was medically appropriate for 24-hour care (even split-shift) under the PCA regulations, then that person should also receive 24-hour care under MLTC.
 - Note new defn. live-in and 24-hour split-shift. See [GIS 12 MA/026](#) (App. 29-30) http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma026.pdf
- All managed care plans must make services available to the same extent they are available to recipients of fee-for-service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a) (4)(i). The Model Contract also states: “Managed care organizations may not define covered services more restrictively than the Medicaid Program.”



More on standards for authorizing amount of hours

MLTC plans must follow old rules re Medicaid personal care --

- Can't use task-based-assessment when client has 24-hour needs (“Mayer-III”) 18 NYCRR 505.14(b)(5)(v)(d);
- New definition of 24-hr care - [GIS 12 MA/026](#).
- must provide adequate hours to ensure safe performance of ADLs (DOH GIS 03 MA/003)
- non-self-directing people eligible if someone can direct care, who need not live with them (92-ADM-49)
- Must reinstate services after hospitalized or in rehab, *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996)GIS 96 MA-023
- Cannot reduce services without justification.
Mayer v Wing

See <http://wnylc.com/health/entry/114/> & <http://wnylc.com/health/entry/7/>



Appeals vs. Grievances

MLTC has two types of appeals – may request orally or in writing:

- **Grievances** – Complain to plan about quality of care or treatment but not about amount or type of service that was approved. EXAMPLES:
 - chronic lateness or no-show of aide or nurse or care manager,
 - can't reach care coordinator or other personnel by phone,
 - Transportation delayed in taking to or from MD, day care
- **Appeals** – Object to AMOUNT or TYPE of service approved,
 - Denial or termination of enrollment for allegedly being “unsafe” at home
 - Denial, reduction or termination of any service.
 - Failure to process or respond to request

See <http://www.wnyc.com/health/entry/184/>



Plans must give **written notice** of initial plan of care and any changes in plan of care

- **Denials**
- **Authorizations/ Reauthorizations - Notice of Action**
 - At least 10 days before the intended change in services, the plan must send a written notice to the member, containing:
 - The **action** the plan intends to take,
 - The **reasons** for the action, including clinical rationale,
 - Description of **appeal rights**, including how to request appeal and how to seek an expedited appeal, AND
 - **If a reduction/discontinuation, the right to aid continuing**
- ***You still have the right to appeal a reduction or denial even if plan doesn't give written notice***

<http://www.wnyc.com/health/entry/184/>



NEW: Must Request **Internal Appeal** First Before Fair Hearing

- An appeal may be filed orally or in writing.
 - Oral: plan must follow up with written confirmation of oral appeal. Date of oral request is treated as date of appeal.
- Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal
- If the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.
- Plan must provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Plan must provide the opportunity to examine the case file and any other records.

42 CFR § § 438.402, 438.406;
[Model Contract, Appendix K, ¶¶ \(1\)\(B\)](#) [p. 106 of PDF]



Expedited Appeals / Grievances

- If you don't have Aid Continuing, make sure to ask for Expedited Appeal. The plan must decide an expedited appeal within **3 days** instead of **30 days**. Plan must agree that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function; or
- The plan may deny a request for an expedited review – best practice is to have doctor explain in writing jeopardy to health or ability to function without services.

42 CFR § 438.410;
[Model Contract, Appendix K, ¶¶ \(1\)\(A\) & \(B\)](#)
 [pp.103, 106 of PDF]



Aid Continuing Change in MLTC

- Plan must continue benefits unchanged whenever it proposes to reduce or terminate services if :
 - the appeal is timely requested (within 10 days of notice or before effective date of the action)
 - the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - the services were ordered by an authorized provider;
 - the enrollee has expressly requested Aid Continuing

Before April 1, 2014, Aid Continuing was required only if the original authorization period for the service has not expired. The State 2014-15 budget eliminated that requirement!!! Plan must continue services even if that period expired.

42 CFR § 438.420; NY Soc. Serv. L. § 365-a(8); N.Y. Dep't of Health, MLTC Policy 14.05: AID-CONTINUING TO BE PROVIDED WITHOUT REGARD TO THE EXPIRATION OF PRIOR SERVICE AUTHORIZATION (August 6, 2014) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_aut



Advocacy Tips:

If there is no notice or notice is unclear –

- If MLTC – request an internal appeal with the plan with AID CONTINUING.
 - If MLTC plan refuses to restore Aid Continuing, call NYS Department of Health Complaint Hotline (866) 712-7197 and cc mltcworkgroup@health.state.ny.us
- If Mainstream managed care – request a fair hearing with the State immediately and request aid continuing. <http://otda.ny.gov/oah/FHReq.asp>

Plans rarely give proper notice! Client has appeal rights even if no notice!



Taylor v. Zucker

- NYLAG filed a class action filed July 15, 2014 on behalf of Medicaid recipients in New York State who receive home care services through Managed Care Organizations (“MCOs”), against DOH and OTDA, challenging their failure to send timely and adequate notices of denial, reductions, and terminations, and to provide an opportunity for a Fair Hearing and aid-continuing, in violation of the Due Process Clause of the U.S. Constitution and the Medicaid Act and its implementing regulations.
- If you have a client who you believe may be a member of the Taylor class please contact vbogart@nylag.org or btaylor@nylag.org.



[Taylor v. Zucker, No. 14-CV-5317 \(SDNY July 15, 2014\)](#)

Contact numbers & Other Info

New York Medicaid Choice (Enrollment Broker)

- To request a Conflict-Free Assessment (after Medicaid approval) 1-855-222-8350
- For information about MLTC 1-888-401-6582
- FIDA – for information or to OPT OUT 1-855-600-3432
- Maximus Project Directors 1-917-228-5607, -5610, -5627
- Website <http://nymedicaidchoice.com/>
- <http://www.nymedicaidchoice.com/program-materials> - Scroll down to *Long Term Care plans* =
- <http://tinyurl.com/MLTCGuide> - Official guide to MLTC

NYS Dept. of Health MLTC/FIDA Complaint Hotline 1-866-712-7197
mltcworkgroup@health.state.ny.us (write “Complaint” in subject line)

NYS DOH Mainstream managed care complaint hotline 1-800-206-8125
managedcarecomplaint@health.state.ny.us

Consumer FIDA Ombudsprogram – ICAN – 1-844-614-8800 <http://icannys.org>

Related online articles on <http://nyhealthaccess.org>:

- All About MLTC - <http://www.wnylc.com/health/entry/114/>
- Tools for Choosing a Medicaid Managed Long Term Care Plan <http://wnylc.com/health/entry/169/>
- Appeals & Grievances - <http://www.wnylc.com/health/entry/184/> with advocacy contacts
- MLTC News updates: <http://www.wnylc.com/health/news/41/>