Managed Long Term Care: Status in 2014 and Preview of "FIDA" Expansion of MLTC to Cover ALL Medical Care

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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

- CBLTC - 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

DOH – NYS Dept. of Health "**GIS"** – type of DOH directive

DSS or LDSS – local Dept. of Social Services

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4 big changes – Managed care & LTC

Change	Description	Fed Approval/Status
MLTC – Managed Long Term Care	**Dual eligibles age 21+** access to most home care services is solely through an MLTC, PACE or Medicaid Advantage Plus plan in NYC & 9 other counties	CMS approved 1115 Waiver expansion 9/2012, started NYC/Metro area, rolling out Statewide 2013-14
Nursing home care "carved into" managed care package	**Both Dual eligibles 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 June 2014 start roll-out downstate, then Dec. 2014 Upstate
Mainstream managed care – carve-in PCS, CDPAP, PDN	***Non*-dual eligibles STATEWIDE** in mainstream Medicaid managed care must get personal care, CDPAP, private duty nursing thru MC plans	CMS approved for PCS/ CDPAP eff 8/2011 STATEWIDE/ nursing home will start 6/2014
FIDA – Fully Integrated Dual Advantage	**Dual Eligible MLTC** members in NYC, Long Island & Westchester will be "passively enrolled" into FULL CAPITA-TION FIDA managed care plans that control *all* Medicare & Medicaid services	11/13 CMS reached "Memorandum of Understanding" with SDOH. CMS now doing "Readiness review" of 25 FIDA plans.

BASICS:
MANAGED CARE VS. FEE FOR SERVICE (FFS) - COMPARISON

- Features of managed care
- Types of managed care plans in Medicaid and Medicare

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	Fee for Service (FFS)	Managed Care
Who does Medicare or Medicaid pay?	Pays each provider **fee for each service** rendered	Pays flat monthly fee (**capitation**) to insurance plan
Who does provider bill?	Provider bills Medicare or Medicaid directly	Bills the managed care plan, which pays from a monthly capitation rate from Medicare or Medicaid
Providers available	Any provider who accepts the insurance (e.g. Medicare)	Only providers in the insurance plan's **network**
Permission needed for services?	Sometimes. In Medicaid, need approval for personal care, CDPAP, etc. but not for all medical care.	Often. Plan may require authorization to see specialists, or for many services. May not go out of network.
Policy – incentive to give too much/ too little care?	Incentive to bill for unneces-sary care. But offset when authorization needed for services like Medicaid personal care.	Plan has incentive to DENY services, and keep part of capitation rate for profit.
What package of services is available?	Original Medicare = all Medicare services.	Package of services may be "partial" (MLTC) or full (PACE = all Medicare & Medicaid services).

Options if ONLY have either Medicare **OR** Medicaid

Insurance	Fee-For Service	Managed Care Model
Has Medicaid Only	Regular Medicaid – only for people *excluded or exempt* from managed care – if have Medicare, a spend-down, in OPWDD or waiver.	**Mainstream Medicaid Managed Care = 3.5 million people!** • ***Mandatory*** for *non*-dual eligibles (families, kids, single adults, those with SSI but no Medicare, homeless) • Covers primary, acute *& recently long term care* –personal care, home health, CDPAP, private duty nursing. Mental health still "carved out" received FFS. • Before, if needed nursing home you were disenrolled from plan. Soon in 2014, plan must cover nursing home care.
Medicare Only	**Use 2-3 cards:** 1. Original Medicare 2. Part D plan 3. Medigap (optional)	**Medicare Advantage** plan - usually includes Part D • ***Voluntary*** but 30% of all Medicare beneficiaries join. Still voluntary for Dual Eligibles as well but FIDA changes 2015 • ONE card replace 3 (Part D, Medigap, Original Medicare) • PRO: cheaper than a Medigap premium, control other out-of-pocket costs • CON: must be in-network and get plan approvals (Con's may outweigh Pro's for Dual Eligibles because Medicaid pays Medicare deductibles, coinsurance as long as see Medicaid providers)

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Managed care – DUAL ELIGIBLES

Insurance	Fee For Service	Managed Care Model
Medicaid & Medicare (dual eligibles)	IF DON'T NEED LONG TERM CARE/ HOME CARE	
	MEDICARE: 1. Original Medicare 2. Part D plan/*Extra Help* automatic 3. Medigap (optional) **MEDICAID:** 4. Medicaid card	**Medicaid Advantage** -***voluntary*** - combines Medicare Advantage with a Medicaid managed care plan in ONE. *Duals are Excluded* from joining "mainstream" Medicaid managed care. *If in Medicaid Advantage, excluded* from joining MLTC plans. If want home care must join MA Plus (below).
	IF NEED LONG TERM CARE/HOME CARE	
	MEDICARE: 1. Original Medicare 2. Part D w/Extra Help 3. Medigap (optional) **MEDICAID:** 4. Medicaid card – only for primary, acute care. Must join MLTC for LTC.	1. **MLTC –MANDATORY** for most dual eligibles 21+ who need long term care. Some exclusions (slide 17). Covers LTC only -package next slide (**partial capitation**). • Primary & acute care is thru Medicare, with CHOICE of Original Medicare/Part D or Medicare Advantage, with Regular Medicaid as secondary insurance. 2. **Medicaid Advantage Plus (MAP) or PACE** • ***VOLUNTARY*** OPTION - REPLACES all Medicare, Medicaid & MLTC coverage – all in one plan (**Full capitation**). **FIDA** coming in 2015 – same idea.

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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

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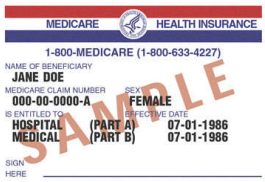
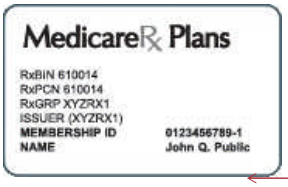
Combination Example 1

- Dual Eligible with Original Medicare Part D and MLTC





Medigap
Plan F
John Doe
Member ID: 123456ABC

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

NOTE: Extra Help - Part D subsidy is automatic.

Medigap is optional

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Combination Example 2

- Dual Eligible with Medicare Advantage and MLTC

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

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

NOTE: Extra Help - Part D subsidy is automatic.

NO Medigap allowed.

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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!

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WHO MUST ENROLL IN MLTC?

Some People still Excluded but Changes in 2013-2014 –

- **New Counties become Mandatory**
- **Lombardi program ends – must join MLTC**
- **Nursing home residents – must join MLTC (coming June 2014)**

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Which Dual Eligibles Must join MLTC plans?

TWO FACTORS control whether an adult > 21 must join MLTC.

1. **WHERE DO THEY LIVE?**
2. **Does client need Community-Based Long-Term Care > 120 days?**

1. WHERE IS MLTC MANDATORY?

Sept. 2012 - NYC Jan. 2013 - Long Island, Westchester
Sept. 2013 - Orange, Rockland
Dec. 2013 - Albany, Erie, Onondoga, Monroe.
April 2014 - Columbia, Putnam, Sullivan, Ulster
******* SCHEDULED *******
May 2014 - Rensselaer, Cayuga, Herkimer, Oneida
June 2014 - Greene, Schenectady, Washington, Saratoga
July 2014 - Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, Oswego
Will be statewide by 12/2014 see http://www.wnylc.com/health/news/41/;
NYS GIS MA 14/04 in Appendix p. 12 for complete schedule.

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2. Does client need CB-LTC > 120 days?

- **MLTC is mandatory** for adult dual eligibles who live in mandatory county and need either:
  - personal care
  - Consumer-Directed Personal Assistance (CDPAP)
  - Certified home health aide services for *long term* (CHHA),
  - adult day care or
  - private duty nursing
- **If dual eligible doesn't need long-term HOME CARE does NOT HAVE TO JOIN ANY MLTC PLAN!** They apply for Medicaid as always and get a regular Medicaid card, to supplement their original Medicare or Medicare Advantage plan, and to receive "Extra Help" to subsidize their Part D plan**.**
- Some **EXCLUSIONS and EXEMPTIONS from mandatory enrollment** – see below.

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Who is EXCLUDED from MLTC?

- **Duals *Excluded* from Mandatory MLTC even in mandatory county – may not join an MLTC Plan**
  - In **Traumatic Brain Injury, Nursing Home Transition & Diversion or Office for People with Developmental Disabilities waivers**
  - Have **hospice** care at time of enrollment or
  - Live in **Assisted Living Program**
  - Under **age 18**
  - Some other limited exceptions (in Breast Cancer Treatment program, etc.)
- If do not need Community-Based Long Term Care (CB-LTC) services for > 120 days as defined by State, excluded from MLTC. State has restricted the definition of who meets this criterion. See later slide.
- **HOSPICE NOTE** – if they first come to need hospice AFTER they enroll in MLTC, they no longer have to disenroll from plan. They may receive hospice out of plan. MLTC Policy 13.18 (June 25, 2013)*

*All DOH guidance at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

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Who *may* but does *not* have to join MLTC? (they are **exempt** from MLTC)

- **Those who don't have Medicare** (not a dual eligible)(MAY enroll in MLTC if age 18+, need home care – but must need a *nursing home level care*)
- **Under 21** (but MAY enroll if over 18 and need home care – but only if would need nursing home level care)
- **Live outside mandatory counties** – If over 21 and have Medicare, if they need home care, they *may* enroll in MLTC but have options:
  - Obtain LTC the way they always did -
    - Local DSS – for Personal care & Consumer-Directed Personal Assistance
    - State Dept. of Health – for Private duty nursing services
    - Adult day care or Certified Home Health agency-apply directly Adult Day Care program or CHHA
    - Lombardi program
  - OR *MAY* enroll in MLTC, MAP or PACE.

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Lombardi recipients must enroll in MLTC

- When MLTC started in NYC in 8/2012, Lombardi (long term home health care program or LTHHCP) recipients did not have to enroll in MLTC plans and were allowed to remain in Lombardi. In April 2013, CMS approved State closing down Lombardi program over time – but it's still open in counties where MLTC not mandatory.
  - Why? **$$** - Payment was 75% of NH rate (about $6000/mo in NYC) versus $3800 average capitation rate paid to MLTC plans.
- New enrollment of **DUAL ELIGIBLES** into Lombardi stopped 6/17/2013 in NYC, Nassau, Suffolk and Westch, later in other mandatory counties.
  - 17,600 Lombardi recipients in those areas were required to transition to MLTC, or to NHTDW, TBI, or OPWDD waivers.
- 3100 **NON-dual eligibles** were in the Lombardi program statewide, including 400 children < 18. Move to Care at Home, OPWDD, NHTDW waivers, or access personal care or other LTC services through mainstream managed care plan. If not in a plan, then through local DSS.
- Spousal impoverishment protections CONTINUE in MLTC – see below.

http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-03-18_lthhc_trans_mc_webinar_present.pdf

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Who *may not* join MLTC (cont'd)

Clients EXCLUDED who only need Housekeeping or Social Adult Day Care

- In initial roll-out of MLTC, plans were/are marketing to people who either didn't need long term care at all – they (1) were recruited from senior centers to switch to "**Social Adult Day Care**" (SADC) programs in contract with MLTC plans or (2) only need "**housekeeping**" and not other assistance with ADLs (Personal Care Level I – limited to 8 hours/week by SSL 365-a)
- State has now changed the definition of who "needs" CB-LTC so that MLTC plans don't cherry-pick low-need people to make $$.
- **People who need ONLY "Social Adult Day Care" (SADC) or Housekeeping are not eligible for MLTC** if they don't need personal care or other LTC service too. In August 2013 - plans were instructed to disenroll them and send them back to local DSS with transition rights.*
- DSS has resumed accepting applications for Housekeeping – Personal Care Level I, even in Mandatory MLTC counties.

* See MLTC Policy 13.21 posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

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What happens when county becomes mandatory?

Two different groups of clients are affected:

1. **Current recipients of Medicaid CB-LTC services** (personal care, CHHA, adult day care, Lombardi, private duty nursing) – they ***transition*** from fee-for-service to an MLTC through a mandatory enrollment process, described below.
2. **New applicants for Medicaid CB-LTC** –
   a. If they don't have Medicaid, they first apply for Medicaid at local DSS.
   b. Once they have Medicaid, they must choose and enroll in an MLTC plan. The "FRONT DOOR" is closed to apply for or obtain CB-LTC services through their local DSS, adult day care program, Lombardi program, or other pathway.

For both groups, choosing a plan is important – tips on that later

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Group 1: Transition of Current LTC recipients to MLTC in mandatory counties

1. Client receives *"announcement letter"* from DOH (App. p. 19)
2. Client receives **60-day "choice notice"** from NY Medicaid Choice (Maximus) [about 2 weeks later] – with list of plans and brochure. App. p. 21 (posted at http://nymedicaidchoice.com/program-materials)
3. Choosing a plan – Discussed further below:
    1. Find out which plans contract with preferred providers:
    2. Call plans to schedule home visit for assessment
4. Enroll either with MLTC plan or NY Medicaid Choice by deadline on notice.
    1. If choose Medicaid Advantage Plus or PACE, not MLTC, must enroll directly with plan. NY Medicaid Choice may not enroll in these plans because of Medicare enrollment.
5. If don't enroll in a plan, will be auto-assigned to an MLTC plan *randomly*.

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Group 1: Rights when Transition to MLTC From other LTC Services - 90-Day Transition Period

- **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 assess needs. Client has right to appeal a proposed reduction – see next slide.
- MUST BE Vigilant – Plans ignore Transition rights and appeal rights!!
    - If fail to give transition services, complain to State DOH Complaint Lines- **MLTC 1-866-712-7197 or MMC 1 (800) 206-8125**
- Same transition rights apply to people WITHOUT Medicare, who received FFS personal care or other services before being enrolled in a *mainstream* Medicaid managed care plan. Period was 60 days, being extended to 90 days in May 2014.

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

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What happens AFTER 90-dayTransition from personal care/ Lombardi, etc.? What are Appeal Rights?

- Plan must send client a **written notice of new care plan** to take effect no earlier than Day 91 after enrollment. That plan of care may reduce services below what the DSS/ CASA/ CHHA/Lombardi program had authorized previously.
  - **Notice** to client must explain appeal rights.
  - "**Aid Continuing**"– If appeals in time, client has right to receive services in the same amount as PREVIOUSLY authorized until internal appeal and hearing is decided-- DOH Policy 13.10
  - May challenge reduction if client's medical condition, circumstances haven't changed! *Mayer v Wing* case. Seek legal help!
- **NEW – MUST EXHAUST INTERNAL APPEAL** – In MLTC, client must first request an Internal Appeal within the Plan. Only if she loses that may she request a State Fair Hearing.

See APPEALS section and http://www.wnylc.com/health/entry/184/.
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

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Group 1: (2) Continuity of Care – Keeping Same Aide and other Providers when transition to MLTC

- MLTC plans WERE required to contract with all personal care & CDPAP under contract with the local county DSS/ CASA (DOH Policy 13.22*). The plan must pay the current county payment rate to any vendor willing to accept it
  - Same is true for people transitioning from Lombardi and CHHA – MLTC must pay them their former rate for 90 days.
- DOH has made it clear that ensuring continuity of the client-aide relationship is an important goal
- Plans can enter into single-client agreements with vendors, and can use their "out-of-network" policy in some cases.
- **This requirement was only effective for PCS ONLY until March 1, 2014.** For Lombardi, CHHA still effective for 90 days after enrollment.
- Complaints about MLTC plans unwilling to contract with a vendor in order for the client to keep her aide should file a complaint with DOH: (866) 712-7197

** http://www.health.ny.gov/health_care/medicaid/rates/mmc/docs/policy_13.22_pers_care_rates.pdf
Link posted http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm /

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Group 2: New Applicants for Home Care in Mandatory MLTC Counties

- **Still apply for MEDICAID at DSS*, but Front Door Closed** to apply for home care/CDPAP LTC at DSS. Date front door closes varies by county.
- April 21, 2014 - Front door closes in **Columbia, Putnam, Sullivan, Ulster.** All new applicants age 21+ who need home care must first apply for Medicaid at local DSS. Once approved, they are redirected to enroll in MLTC plan.
- MLTC plans can't give services Medicaid-pending. Some will help apply for Medicaid and w/pooled trust.

*In NYC –apply at
HRA--HCSP Central Medicaid Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238
T: 929-221-0849

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

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Group 2 - New applicants: Tips for filing Medicaid applications

1. **SUPPLEMENT A** - Must be submitted with application. This supplement REQUIRED for Aged, Blind & Disabled applicants. MUST include current bank statements and proof of all other assets, or won't be eligible for LTC.
2. Indicate on top of Application and Cover Letter that seeking MLTC.
3. If client will have a spend-down – special steps:
   - If client plans to enroll in **pooled trust**, paperwork will cause delays being approved by HRA/DSS. (Complex steps needed – see http://www.wnylc.com/health/entry/44/) One strategy is to delay enrolling in trust until AFTER Medicaid approved and enrolled in MLTC. Downside is you must deal with the spend-down (see next slide).
   - **MARRIED APPLICANTS** may not have a spend-down- **Spousal Impoverishment protections** now apply! Below.

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Group 2: ALERT: Applicants with a Spend-down face delays in MLTC enrollment

- DSS may CODE applications with a spend-down as "DENIED" or "INACTIVE" – leading MLTC plan to DENY enrollment. This is partly the result of antiquated "WMS" Medicaid computer systems that don't show the nuance that applicant was approved with a spend-down but has not met it yet.
- TIP: Request DSS to use "Code 06" which approves Medicaid PROVISIONALLY. Should NOT have to "Pay In" Spend-down!!
- THEN, Plan must contact DSS to confirm eligibility, regardless of what computer says. In NYC plans must submit a "conversion" package to DSS. Appendix p. 28*. Then DSS changes code to full coverage. See HRA FAQ.*

*Download HRA form at http://www.wnylc.com/health/download/450/ and FAQ at http://www.wnylc.com/health/download/449/

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Spousal Impoverishment Protections – Strategy for Eliminating Spend-down

Spouses of MLTC recipients are now entitled to a "spousal impoverishment" allowance. **GIS 13/ MA-018**. This is the same that used to be in the LOMBARDI program, but is now available to everyone in MLTC. Example -

- MARV is in MLTC. His income is $2000/month. His wife DORIS is not on Medicaid. Her income is $1273. Before, he had to use a pooled trust for his excess income over $820, and she had to do a spousal refusal.
- Now, DORIS may keep their combined income up to **$2931.**
- MARV may keep **$383/month** as his personal needs allowance. Total allowed combined is $3314. They may keep ALL INCOME without any spend-down or spousal refusal.
- ASSETS: Marv may have $14,550. Doris may have $74,820

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Spousal Impoverishment - Choices

Married applicants have a choice of budgeting:

1. Spousal Impoverishment budgeting – as in previous slide
    1. Use this where Applicant's income is above $829. If both spouses' combined income is under $3312, applicant will have no spend-down and will not need spousal refusal. MAY NOT use pooled trust with this model
    2. ASSETS – may use Spousal Impoverishment limits
2. OR Budget applicant as if s/he were Single, and ignore spouse's income.
    1. Use this where Applicant's income is under $829 – regardless of amount of spouse's income, or
    2. If non-applying spouse's income is more than CSMIA allowance ($2,931) – this choice is probably better, because spouse's income is ignored. S/he will not have to do a spousal refusal. Applicant may have a spend-down to extent own income exceeds $829. Can use pooled trust if applicant's income is high.
    3. Must use regular community asset limits – not spousal impoverishment.

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Both Transitioning Recipients and New Applicants must **Choose an MLTC Plan**:

1. **What plans are available in your county?**
    - Some counties have only 1 or 2 plans.
    - Some counties don't have options of TYPES of plans – only MLTC, not Medicaid Advantage Plus or PACE.
    - Online lists on:
        - DOH website – http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm
        - NY Medicaid Choice website - http://nymedicaidchoice.com/program-materials - Look only at Long Term Care plans, not "Health Plans" – those are mainstream managed care plans not for DUAL ELIGIBLES!
    - Appendix – NYLAG compiled lists App. pp 1-11, also posted at http://www.wnylc.com/health/entry/114/#List%20of%20Plans

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(2) Choose Model: Full or Partial Capitation

1. If client wants to keep all of her current doctors, hospitals, clinics, etc., then choose **Partial Capitation – MLTC**
   - Most primary and acute medical care is not in the MLTC service package, so client keeps her regular Medicare card (or Medicare Advantage plan) for all Medicare primary/acute care.
2. **FULL CAPITATION – PACE or Medicaid Advantage Plus (MAP)**
   - Plan controls all Medicare as well as Medicaid services. Must be in-network for all services. Plan may require approval of many Medicare services.
   - **PACE** vs. Medicaid Advantage Plus (**MAP**):
     - **PACE** provides services through a particular site – a medical clinic or hospital. Because all providers are linked, potentially more opportunity for coordinated care.
     - **MAP** is a traditional insurance model - Insurance plan contracts with various providers to provide care. CAUTION: Medicaid Advantage **Plus (**MAP) is not the same as Medicaid Advantage (MA). Both include all Medicare services PLUS
       - MAP = Medicaid with long term care.
       - MA - Medicaid without LTC. If client needs home care – must join MAP or MLTC.

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Choosing a Plan (3) Ask Plan to Assess Client before enrolling

- To make an informed choice, call several plans to visit client, do an assessment and propose a plan of care, before client agrees to enroll. Many plans refuse to do this unless client has enrolled, but see **State DOH Q&A 8/21/12** # 39*.
  - Client doesn't have to sign on the spot during that visit, or as a condition of the plan making the visit.
- **Advocacy Tip**: Family member, advocate, or geriatric care manager should be present at the assessment
- Ask plan rep – How many hours would plan give now, if there was no 90-day "transition period" requirement?
  - Same agency? Same aides? What other services?

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

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Choosing a Plan (4) – What if plan refuses enrollment or denies adequate hours?

- **GROUP 1 – People transitioning** from other Medicaid LTC services MUST be accepted by MLTC plan, since they have been found to qualify for LTC.
- **GROUP 2 – New applicants** -- The PLAN, not DSS/CHHA/Lombardi program, decides if eligible for CB-LTC (needs LTC > 120 days, capable of remaining in the home without jeopardy to health/safety, has someone to "direct" care if not self-directing)
- Plan has incentive to avoid enrolling clients who need a lot of care or who are complicated (dementia, etc.) But they don't formally deny care – they use pretexts to discourage enrollment. Common pretexts --
  - 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" i.e. supplement care
  - We're not right plan for you.
- Either shop around for another plan or accept the hours AND appeal. Either way, file a complaint with State DOH **1-866-712-7197**

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State tackles plan behavior in turning away high need people

- Advocates brought this problem to DOH attention, as reported in New York Times on May 1, 2013 – link posted at **http://tinyurl.com/MLTC-NYT. (App. p. 23)** See other advocacy at http://www.wnylc.com/health/news/39/.
- 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."
- Recourse if denied enrollment – No appeal rights if not yet an enrollee! Client has to shop around to find a plan to accept her – 25 plans in NYC alone! But – technically plan should notify Maximus (NY Medicaid Choice) if denying enrollment.
- **BACK-UP AGREEMENTS** --Policy 13.10 says plan cannot obligate informal caregiver to provide backup assistance.
- **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

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Logistics of Enrollment

- **MLTC**
  - **May enroll either through the plan or through NY Medicaid Choice** (Maximus – enrollment broker contracting with DOH)(888-401-6582)
  - Enrollment has no impact on Medicare – you keep your Medicare Advantage plan or stay in Original Medicare
- **MAP / PACE**
  - **Must enroll through the plan, not through NY Medicaid Choice**
  - Enrollment consists of two transactions: enrollment in Medicare Advantage plan and in connected Medicaid plan
  - By enrolling in a MAP or PACE, you are automatically disenrolled from any/all of the following plans:
    - Medicare Advantage (including some retiree/union plans)
    - Stand-alone Prescription Drug Plan (PDP)
    - Mainstream Medicaid Managed Care

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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 15th 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 *dis*enrollment until first of the *second* month.
  - **Should be no gap in services!**
- **Disenrollment –** Plan may disenroll for not paying spend-down! Also other reasons. Have right to fair hearing.

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Nursing Homes and Managed Care

- **Big Changes Starting in 2014 for both**
  - **Seniors and People with Disabilities who have Medicare** – will have to enroll in an MLTC plan to get nursing home care
  - AND
  - **People with Medicaid only, with no Medicare** – will have to enroll in a "mainstream" Medicaid managed care plan to get nursing home care
- **WHEN** – June 2014 – NYC, Long Island, Westchester
  Dec. 2014 – Rest of State

DOH Powerpoint on NH transition http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-03-10_trns_of_nh_services.pdf (March 2014) , and also see DOH Policy on Transition of Nursing Home Population to Managed Care, revised March 2014, posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf . All documents posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm

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NEW mandatory enrollment of Nursing Home residents in Managed care plans

- Until now, MLTC was mandatory only for dual eligibles who need Medicaid home care or other COMMUNITY-BASED LTC services.
  - Those without Medicare have long been required to join "mainstream" managed care plans, but were disenrolled from the plans if in a nursing home for more than 60 days.
- In NYS move to "managed care for all," all adult Medicaid recipients age 21+ who become **permanent nursing home** residents will be required to enroll in a managed care plan.
- **WHICH PLANS** -- MLTC (for dual eligibles age 21+) or Mainstream Medicaid managed care plan (those without Medicare)
- **WHEN** –Those who *first* become PERMANENT nursing home residents--
  - After June 1st, 2014 (NYC, Long Island, Westchester)
  - After Dec. 1st , 2014 (rest of state)
- **As of 4/22/14, this is still not approved by CMS! May be postponed!**

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Nursing homes & managed care – Process for new nursing home admissions > 6/14 (12/14 upstate)

- **Those who were NOT in an MLTC or Mainstream managed care plan before** will select any nursing home of their choice.
  - Once in nursing home, they **apply for Institutional Medicaid** (Includes 5-year look-back and transfer penalties)
    - Plan must deny NH care if Medicaid imposes a transfer penalty. Either must private pay OR advocate to be discharged home with MLTC services, since no transfer penalty in the community.
  - 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).
- **IF they were already in a MAINSTREAM MMC plan** before NH admission, they must enter a NH in that plan's **NETWORK** or Medicaid will not pay for it. *See next slide for MLTC.*
  - Mainstream Managed care 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.

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MLTC: Transition from hospital to NH

- Most Dual Eligibles leaving the hospital enter a nursing home TEMPORARILY for rehabilitation, paid for by Medicare.
  - Their **MLTC plan *MAY NOT* restrict them to nursing homes in the plans' networks**. MLTC plan must pay the Medicare coinsurance for the rehab even if NH is not in plan's network.
    - If patient has Medigap, then Medigap usually pays coinsurance.
  - 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 MLTC plans but not effective til 1st of the next month. May be a gap in coverage.
  - When client can go home, MLTC must arrange and provide home care services.
- **No LOCK-IN** –In both MLTC and MMC, may change in any month to a plan that has a preferred NH in its network.
  - This is true in MLTC generally, but in MMC there IS LOCK-IN generally, but no lock-in for nursing home residents.
  - Changing plans takes time.. Only effective the 1st of the next month or later. Unclear if current plan must pay for out of network NH while change plans.

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Current NH Residents Grandfathered in!

- **CONTINUITY GUARANTEED – NO ONE WILL BE FORCED TO MOVE -** People already in nursing homes as permanent residents on 6/1/2014 (12/14 upstate) are grandfathered in – don't have to enroll in MLTC or mainstream MMC plan - can stay in their nursing home with Medicaid paying as before.
  - But – after Oct. 1, 2014 in NYC/ West/L.I. – and later upstate - "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, the MLTC plans are all trying to become FIDA plans and want to increase market share.
- *Nursing home care was ALREADY part of the MLTC benefit package..* But MTLC plans were disenrolling members who needed NH care. This will stop because new NH residents after 6/1/14 must join an MLTC plan.
- Complicated issues re payment, division of care mgt between plan and NH (ie who decides if need to be hospitalized?)

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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

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Getting Out of a Nursing Home

- People in Nursing Homes who want to be discharged and live at home face challenges in doing so.
- If they are already in an MLTC or mainstream plan, they should request plan to assess them for return to community.
- If they were not in an MLTC or mainstream plan, if county has mandatory MLTC, the only way to obtain Medicaid home care is through an MLTC. (IF not a dual eligible – then must get it through mainstream plan).
- Must contact plans in your county and request them to assess individual in the nursing home, and enroll them.
- INCENTIVES: Special Housing Expense Allowance – see later slide.

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Getting out of a NH – Barriers to Enrollment

- In NYC and Westchester, MLTC plans often refuse to assess nursing home residents for potential discharge home. Has to do with Medicaid eligibility code as "institutional" not "community Medicaid." But plans MAY assess resident in NH in Month A, and request that local DSS "convert" Medicaid code to community Medicaid effective the 1st of Month B for discharge home that day. Plan may also require a home visit to make sure home appropriate.
- For all this to happen, must arrange all before the end of the preceding month.
- HRA **Medicaid Alert of** Feb. 14, 2013 "*MLTC Submissions of Nursing Home Enrollments*" explains enrollment in NYC - www.wnylc.com/health/download/439/
- DOH has promised to clarify that plans must assess enrollees in NHs but so far has not done so.

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Special Income Standard for Housing Expenses for Individuals Discharged from NH to an MLTC Plan

- MLTC Policy 13.02: MLTC Housing Disregard --Medicaid budget uses a Special Income Standard if recipient has a housing expense – **can reduce/ eliminate spend-down**
- NYS GIS 13 MA/04 -- 2013 -$1003 NYC, $1045 Long Isl, $805 N. Metro (Westch., Orange, Rockland), $368 Central (Onondoga), $408 NE (Albany), $380 Rochester (Monroe)
- To be eligible, must:
  - Be approved for participation in MLTC
  - Have been in a nursing home for at least 30 days
  - Medicaid has made a payment toward the cost of care in nursing home
  - Have a housing expense
  - Not be using spousal impoverishment budgeting
- Submit MAP-3057 form with enrollment

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Snapshot: Change in LTC Delivery

		April 2012	12/2013
NYC	PCS/(home attendant)	30,425	3,851
	Housekeeping	4,101	869
	Lombardi	15,589	1,678
	MLTC	43,151	101,693
	MAP/PACE	4,558	7,877
	Total	**97,824**	**115,968**
Long Island, Westch'er	MLTC	1,149	8,406
	MAP/PACE	267	295
Rest of State*	PCS (includes LI, West'r)	19,729	18,348
	MLTC	2,318	3,151
	MAP/PACE	1,631	1,770

Data from http://www.health.ny.gov/statistics/health_care/medicaid/quarterly/aid/
And http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly /

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Transition: When disenrolled from Mainstream managed care when Medicare starts - disruption of home care services

- Medicaid recipients with no Medicare in a mainstream Medicaid managed care plan are disenrolled automatically when she obtains Medicare – either by reaching 65 or because of disability.
- If that person received personal care, CDPAP, or other LTC through the MMC plan, disruption of services is likely.
- Advocates demand a seamless transition – whether back to DSS/CASA or, in mandatory MLTC areas, to MLTC plans.
  - DOH developing a policy that will notify these individuals to select an MLTC plan. But.. If they don't, care just stops. They don't get auto-assigned to an MLTC plan.
  - **Be proactive! If your client's Medicare is becoming effective, and they received home care through Medicaid managed care – help them enroll in an MLTC plan. Call the managed care plan to make sure care doesn't stop. Call the MLTC plan and make sure they know what care the client was receiving. Must continue that for 90 days as "transition plan."**
  - *Contact NYLAG if problems.*

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MLTC BECOMES FIDA IN 2014

FIDA – Fully Integrated Dual Advantage

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WHAT IS FIDA – Fully Integrated Dual Advantage FIDA Demonstration

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

- **Medicaid** services including long term care 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 either:

1. MLTC, MAP or PACE services (125,000 people) OR
2. Nursing home care (55,000 people), but
3. EXCLUDES – people in TBI, NHTDW, OPWDD waivers, hospice, Assisted Living Program.

WHEN? Roll-out begins Oct. 1, 2014 (pushed back 6 months on Jan. 16, 2014). Demo ends Dec. 2017. .

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Timing of FIDA enrollment -*updated 1/16/14*

In the demonstration area (NYC, Long Island & Westchester), On 1/16/2014 DOH announced moved back 6 months. **NEW SCHEDULE:**

1. **WHO – Dually eligible adults over age 21 who are EITHER**
   1. **Currently MLTC members** or newly applying for MLTC living in the community on or after 10/1/2014 OR
   2. **Nursing home residents** –permanently residing as of 10/1/14 or become new residents after that date
2. **WHEN**
   - **Oct. 1, 2014** – Marketing begins to both above groups – MLTC and nursing home – may enroll on a voluntary basis to be effective Jan. 1, 2015 - *BE ALERT for misinformation* – plans will tell them MUST enroll in order to keep their aide, etc. but may OPT OUT!!
   - **Jan. 1, 2015** –
     - Effective coverage begins for those who voluntarily enrolled since Oct. 1, 2014. Notices to MLTC members that must enroll or opt out by Jan. 1, 2015
     - Passive enrollment/ "intelligent" auto-assignment begins of MLTC members and nursing home residents who did not "opt-out."
     - They may still disenroll but won't be effective immediately.

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WHY FIDA? $$

- Feds and State want to **control costs** of dual eligibles. The Affordable Care Act 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.
- CMS approved NYS as one of 19 state demo's now being launched.
- 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, such as frequent hospital readmissions, revolving door between hospitals and rehabilitation centers/ nursing facilities, FFS incentives to bill for unnecessary care. Providers in plan network will NOT be paid FFS by plan – will be bundled or paid for performance

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PASSIVE ENROLLMENT

- MLTC members in NYC and the three other demonstration counties, and later, dually eligible nursing home residents, will be notified that they MAY enroll in a FIDA plan. After a certain "voluntary" enrollment period --
- They will receive **notice** they will **have 60 days** to either:
  1. **Select and enroll in a FIDA plan**
     - must enroll through NY Medicaid Choice – not directly with plan or to
  2. **OPT OUT of FIDA, and stay in MLTC** - requires an affirmative step – with NY Medicaid Choice.
- If they do not enroll in or affirmatively OPT OUT of FIDA, they will be automatically assigned to a FIDA plan. This is called "passive enrollment with opt-out." Unlike MLTC, this will not be random.

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

- **25 plans** were approved by the State to be FIDA plans. The federal government is now conducting a "Readiness Review" of these plans to make sure their systems, procedures, and networks are ready. Some plans may drop out. See list in appendix.
- **Most of the downstate MLTC plans are becoming FIDA plans**, so that FIDA can be considered an MLTC plan with an added benefit package of all Medicare services. See list showing types of plans offered by each insurance company, indicating which will be FIDA plans, posted at http://www.wnylc.com/health/download/429/.
- "**Intelligent assignment**" – State will use algorithm that will select a plan based on existing plan affiliation and historic provider utilization -- most likely will assign them to the FIDA plan sponsored by their MLTC plan.
  - **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.

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Right to OPT OUT of Demonstration

- Advocates must help clients understand their right to opt out of the demonstration.
- 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).
- If they opt out once, they cannot be passively enrolled again during the length of the Demonstration, which goes through December 2017.
- If they miss the chance to opt out before being enrolled in FIDA, they may still disenroll from FIDA and return to MLTC at any time later. But.. this is only effective the following month so may cause disruption of services.

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Transition/Continuity of care

1. New enrollees in FIDA will face the loss of access to many physicians, other medical providers, and even prescription drugs. If they were in Original Medicare, they had full access to any Medicare provider. Now they must see only i*n-network* doctors.
   - The FIDA plan will also function as a Part D plan, and may have a more limited formulary than the previous Part D plan.
2. **FIDA plans must allow participants to maintain ALL current providers and service levels**, including 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.
   - 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.
3. 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.

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More on continuity of old providers

- NY's 90-day transition requirement is less than California's, where plans must allow use of previous:
  - MEDICARE providers and services for 6 months and
  - MEDICAID providers & services for 12 months.
  - Advocates asked for longer period… not successful
- 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, but this was not clearly defined.

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Integrated Appeal Process

- A unique and positive (hopefully) component of NYS's FIDA demonstration is that it will integrate into one system 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 – see next slide.

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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.
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)

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Ombudsman Program & other Consumer Protections

- **OMBUDSMAN** -Though the state declined federal funding for an Ombudsman program, NYS has committed to including an Ombudsprogram to assist and advocate for consumers navigating FIDA.
  - An RFP was issued in late February 2014.
- **COSTS to CONSUMER** – NO copayments allowed, including Part D drugs. Spend-down (NAMI in NH) will be billed for though.
- **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.

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Info on FIDA

- **National resources on CMS Guidance on the Duals Demonstrations**, the demo's in other States, best practices (enrollment, quality metrics, rate setting etc.)
  www.dualsdemoadvocacy.org (Natl. Senior Citizens Law Center)
- **NYS 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
- **NYS Coalition** to Protect the Rights Of New York's Dually Eligble – includes NYLAG, Medicare Rights Center, Legal Aid Society, Empire Justice Center – check for updates at http://www.wnylc.com/health/news/33/

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NAVIGATING MLTC

- Requesting more hours or new services
  - New Terminology: "Service Authorizations, Concurrent Review"
- Grievances and Appeals

Model MLTC Contract – download at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf

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Requesting new or additional services – new vocabulary

- **"Prior Authorization" – new service requested**
  - A request by the Enrollee or provider on Enrollee's behalf 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 on Enrollee's behalf 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]

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Service Authorizations: Timing

- **Concurrent review**
  - **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]

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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 NYS DOH Model Contract for MLTC Plans also states: "Managed care organizations may not define covered services more restrictively than the Medicaid Program."

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_model.pdf

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More on Standards for authorizing amount of hours – import to MLTC from personal care/CHHA law

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 def'n 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/

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Appeals vs. Grievances

MLTC has t**wo 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,
  - delay in approving services, e.g. can't get dental appointment
  - Transportation delayed in taking to or from MD, day care
  - no response to request for increase in hours
- **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

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See http://www.wnylc.com/health/entry/184/

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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.wnylc.com/health/entry/184/.

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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]

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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]

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Aid Continuing for Clients Transitioning from CASA/DSS/Lombardi/CHHA FFS

- When a plan decides to reduce or discontinue your services, you have the right to continue receiving the prior level of services while awaiting a decision on your appeal
- Transition Period
  - For changes immediately after the 90-day transition period, plan must provide aid continuing until a decision on the internal appeal, or Fair Hearing if it goes to that stage
  - Feb. 6, 2013 and May 8, 2013 directives require Aid Continuing. http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.04_personal_care_contract.pdf and http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf
- Post-Transition
  - For all subsequent changes, State says aid continuing only goes through the end of the current authorization period. Advocates disagree – you should request aid continuing and refer cases.

See APPEALS section and http://www.wnylc.com/health/entry/184/.

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Aid Continuing for Non-Transitioning MLTC Recipients

- Plan must continue benefits unchanged whenever it proposes to reduces 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.**
- If enrollee loses internal appeal, should receive Notice denying internal appeal, with right to request fair hearing within 10 days of mailing that notice and receive Aid Continuing pending fair hearing.

42 CFR § 438.420

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Reinstating Personal Care at NH Discharge

- Contact the MLTC or MMC plan and ask that the prior plan of care be reinstated
- If plan delays or denies request contact the plan in writing to request:
  - Expedited Concurrent Review/Prior Authorization for reinstatement of personal care services.
  - Advocacy tip: Include a letter from the doctor indicating the need for services.
  - Plan should provide a written notice denying or granting services.
- There is federal case law holding that Medicaid recipients are entitled to immediate reinstatement of their previously authorized services upon discharge from a hospital stay. *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996).
- Call EFLRP at 212-613-7310 for technical assistance!

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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 1-866-712-7197 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!

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Contact numbers & Other Info

- **New York Medicaid Choice** (Enrollment Broker) **1-888-401-6582** General
  - **ADVOCATES HOTLINE** **1-855-886-0570**
  - Maximus Project Directors Marjorie Nesifort 1-917-228-5607
  - Awilda L. Martinez-Rodriguez 1-917.228.5610
  - Raquel Pena, Deputy Project Mgr. 1-917.228.5627
  - Website http://nymedicaidchoice.com/
  - http://www.nymedicaidchoice.com/program-materials - Scroll down to *Long Term Care plans* - separate lists for regions of state
  - **http://tinyurl.com/MLTCGuide** - Official Guide to MLTC
- **NYS Dept. of Health MLTC Complaint Hotline** **1-866-712-7197**
  mltcworkgroup@health.state.ny.us
- **Mainstream Managed Care Complaint Line** 1-800-206-8125
  managedcarecomplaint@health.state.ny.us
- **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/