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

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2

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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4

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

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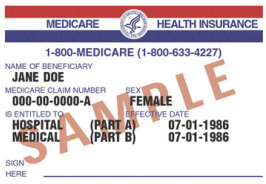
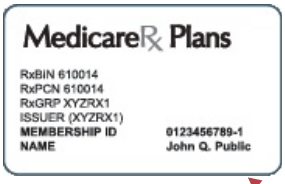
5

6

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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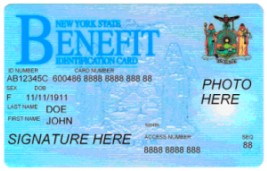
7

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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8

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**

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Who is required to enroll in MLTC?

1. Dual Eligibles (people with Medicare and Medicaid – not just MSP); and
2. Age 21 and older; and
3. Residing in a mandatory county; and
4. Requiring >120 days of Community-Based Long-Term Care Services in a calendar year

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11

Where is MLTC mandatory?

- Sep. 2012 – NYC
- Jan. 2013 - Long Island, Westchester
- Sep. 2013 - Orange, Rockland
- Dec. 2013 - Albany, Erie, Onondoga, Monroe
- Apr 2014 - Columbia, Putnam, Sullivan, Ulster
- **** SCHEDULED ****
  - May 2014 - Rensselaer, Cayuga, Herkimer, Oneida
  - Jun 2014 - Greene, Schenectady, Washington, Saratoga
  - Jul 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 for complete schedule.

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12

Does client need CBLTC > 120 days?

MLTC is mandatory for adult dual eligibles who live in mandatory county and need either:

- personal care (PCA)
- Consumer-Directed Personal Assistance (CDPAP)
- Certified home health aide services for long term (CHHA),
- adult day care (medical model only)
- private duty nursing; or
- LTHHCP waiver (Lombardi)

A Medicare recipient who doesn't need one of the above services on a long-term basis does NOT HAVE TO JOIN MLTC OR ANY OTHER TYPE OF MEDICAID MANAGED CARE 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 if in mandatory county and meet other criteria – may not join an MLTC Plan

- In TBI, NHTD or OPWDD waivers
- Have hospice care at time of enrollment
  - **Note:** MLTC members who come to need hospice are no longer required to disenroll from MLTC
- Live in Assisted Living Program
- Under age 18
- Some other limited exceptions (in Breast Cancer Treatment program, etc.)

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14

Who is **exempt** from MLTC?

- **Medicaid-only** - MAY enroll in MLTC if age 18+, need home care – but must need a nursing home level care
- **Age 18-21** - MAY enroll if need home care – but must need nursing home level care
- **Live outside mandatory counties** – Duals over 21, if they need home care, MAY enroll in MLTC

Exempt individuals have options:

- Obtain LTC the way they always did
- OR MAY enroll in MLTC, MAP or PACE

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15

Who is **eligible** to enroll in MLTC?

- Approved for Community Medicaid w/CBLTC coverage; and
- Over age 18; and
- In need of CBLTC, excluding:
  - Social Adult Day Care (SADC)
  - Housekeeping

Initially, plans were enrolling people in need of only SADC or housekeeping. DOH clarified policy, instructing plans to disenroll them and send them back to local DSS with transition rights.*

DSS has resumed accepting applications for Housekeeping (Personal Care Level I).

* 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 a county becomes mandatory?

Two different groups of clients are affected:

- Current recipients of Medicaid CBLTC services
  - They transition from fee-for-service to an MLTC through a mandatory enrollment process, described below
- New applicants for Medicaid CBLTC
  - If they don't have Medicaid, they first apply for Medicaid at local DSS.
  - Once they have Medicaid, they must choose and enroll in an MLTC plan. The "front door" is closed to apply for or obtain CBLTC services through their local DSS, adult day care program, Lombardi program, or other pathway.

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17

Group 1: Transition Process

- Client receives "announcement letter" from DOH
- Client receives 60-day "choice notice" from NY Medicaid Choice – with list of plans and brochure
- Client chooses a plan
  - Find out which plans contract with preferred providers
  - Call plans to schedule home visit for assessment
- Enroll either with MLTC plan or NY Medicaid Choice by deadline on notice
  - If choose Medicaid Advantage Plus or PACE, not MLTC, must enroll directly with plan.
- If client doesn't enroll in a plan within 60 days, he/she will be auto-assigned to an MLTC plan randomly.

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18

Group 1: Transition Rights

- MLTC plans (and MMC) 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. Client has right to appeal.
- If plan fails to give transition services, complain to State DOH Complaint Lines
  - 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

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19

Group 2: New Applicants for Home Care

- **Still apply for MEDICAID at LDSS*, but Front Door Closed** to apply for home care/CDPAP LTC at LDSS. Date front door closes varies by county.
  - In NYC – apply at
    HRA HCSP Central Medicaid Unit
    785 Atlantic Avenue, 7th Floor
    Brooklyn, NY 11238
    T: 929-221-0849
- MLTC plans can't give services Medicaid-pending. Some will help apply for Medicaid and w/pooled trust.

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

20

Group 2 - New applicants: Tips for filing Medicaid applications

- Must complete Supplement A and provide current asset documentation
- Indicate on top of Application and Cover Letter that seeking MLTC
- If client will have a spend-down – special steps:
  - Must request code 06 to obtain provisional coverage, or plan will be unable to enroll (see GIS 14 MA/010)
  - Wait to enroll in pooled trust until AFTER Medicaid approved and enrolled in MLTC.
  - MARRIED APPLICANTS may not have a spend-down – Spousal Impoverishment protections now apply!

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21

Options for dealing with spend-down

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

1. Nursing Home Transition Shelter Allowance
2. Spousal Impoverishment Budgeting
3. Negotiate the spend-down with the plan
4. Pay the full spend-down to the plan
5. Enroll in a pooled income trust
6. Pay-In Program

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22

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);
- Medicaid must have made a payment for the nursing home stay;
- 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).

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2013 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	$368
Long Island	Nassau, Suffolk	$1,045
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1,003
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$408
North Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$805
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$380
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$338

N.Y. Dep't of Health, GENERAL INFORMATION SYSTEM MESSAGE: 2013 SPECIAL INCOME STANDARDS FOR HOUSING EXPENSES, GIS 13 MA/04 (February 20, 2013).

24

Example budget with NH transition shelter allowance

Gross monthly income		$1,500
Health insurance premiums	(Medicare Part B) (Medigap)	- 105 - 161
Unearned income disregard		- 20
Shelter deduction (NYC)		- 1,003
Net countable income		***$211***
Income limit for single		- 809
Excess income	✓	**$0**

25

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!
- After lengthy advocacy, DOH released guidance in May 2014 requiring MLTC plans to assess applicants residing in nursing homes.
- Plan must also visit community residence, but applicant need not be present for that visit (what about applicants with no family?)
- 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

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26

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.
- If applicant has a **community spouse**, he/she may shelter up to $2,931/mo. of joint income (and up to $74,820 of assets).
- It works almost the same as for nursing home, but with some minor variations.

N.Y. Dep't of Health, General Information System Message: Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care, GIS 13 MA/018 (September 24, 2013).

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27

Example budget with spousal impoverishment

Gross monthly income		$1,500
Personal Needs Allowance		- 383
Community Spouse Monthly Income Allowance (CSMIA)	MMMNA ($2,931) - Otherwise Available Income of spouse ($1,500) =	- 1,431
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).

28

Spousal Impoverishment - Choices

Married applicants have a choice of budgeting:

- Spousal Impoverishment budgeting
  - Use if Applicant's income > $829. If combined income < $3312, then no spend-down and no spousal refusal. Can't use pooled trust.
  - ASSETS – may use Spousal Impoverishment limits
- OR Budget applicant as if s/he were Single, and ignore spouse's income.
  - Use if Applicant's income < $829
  - If non-applying spouse's income > MMMNA ($2,931/mo.), this choice is better, because spouse's income is ignored. S/he will not have to do a spousal refusal. Can still use pooled trust if applicant's income is high.
  - ASSETS – Must use regular community asset limits

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29

Both Transitioning Recipients and New Applicants must Choose an MLTC Plan

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
  - NYLAG compiled lists posted at http://www.wnylc.com/health/entry/114/#List%20of%20Plans

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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
- 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.
- Family member, advocate, or geriatric care manager should be present at the assessment
- Ask questions:
  - How many hours?
  - What services?
  - Keep same agency?

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

31

What if plan refuses enrollment?

- GROUP 1 – Transition population is deemed eligible so plan cannot refuse enrollment
- GROUP 2 – New applicants
  - The PLAN, not Medicaid, determines eligibility for MLTC enrollment
  - Plan has incentive to avoid enrolling costly/complicated clients. Rather than formally deny enrollment, they sometimes 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"

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

32

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 *dis*enrollment until first of the *second* month.
  - **Should be no gap in services!**
- **Disenrollment –** Plan may disenroll for not paying spend-down, among other reasons.

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33

Nursing Homes and Managed Care

Big Changes Starting in 2014 for both

- Dual Eligibles will be required to enroll in an MLTC plan to get nursing home care; and
- People with Medicaid only will be required to enroll in an MMC plan to get nursing home care

WHEN

- June 2014 – NYC, Long Island, Westchester
- Dec. 2014 – Rest of State

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

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34

Mandatory enrollment of nursing home residents in managed care plans

- Until now, MLTC was mandatory only for duals who need CBLTC
  - Once an MLTC member needed NH placement, would typically "voluntarily disenroll," even though NH is in MLTC benefit package
  - Medicaid-onlies have long been required to join MMC plans, but were disenrolled from the plans if in a nursing home for more than 60 days.
- **Now, all adult Medicaid recipients who become permanent nursing home residents will be required to enroll in a managed care plan** (MLTC for duals, MMC for Medicaid-onlies).
- WHEN –Those who first become PERMANENT NH residents –
  - After June 1st, 2014 (NYC, Long Island, Westchester)
  - After Dec. 1st , 2014 (rest of state)
- As of 5/26/14, this is still not approved by CMS! May be postponed again!

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Process for new nursing home admissions

- Consumers NOT already enrolled in MLTC/MMC
  - Select 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)

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Process for new nursing home admissions (cont'd)

- Consumers already enrolled in MMC plan
  - 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.

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MLTC: Transition from hospital to NH

- NH stays where Medicare pays primary are not limited to MLTC plan's network. MLTC plan pays Medicare 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 until 1st of the next month. May be a gap in coverage
- Upon discharge, 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 and MMC, may change in any month to a plan that has a preferred NH in its network

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Current NH Residents Grandfathered in!

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 FFS Medicaid.

- 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.

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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

40

Snapshot: Change in LTC Delivery

		April 2012	December 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***
LI, Westch.	MLTC	1,149	8,406
	MAP/PACE	267	295
Rest of State*	PCS	19,729	18,348
	MLTC	2,318	3,151
	MAP/PACE	1,631	1,770

* Includes Long Island and Westchester
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 /

41

Warning: Transition from MMC to MLTC

Medicaid recipients with no Medicare in a MMC plan are disenrolled automatically when they obtain Medicare – either by reaching 65 or because of receiving SSDI for 2 years.

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."**

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MLTC BECOMES FIDA IN 2014

FIDA – Fully Integrated Dual Advantage

43

What is FIDA?

WHAT? FIDA plans are fully capitated plans similar to **Medicaid Advantage Plus**. They will control 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 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 b**egins Oct. 1, 2014 (pushed back 6 months on Jan. 16, 2014). Demo ends Dec. 2017.

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44

Timing of FIDA implementation

- WHO – Dually eligible adults over age 21 who are:
  - Currently MLTC members or newly applying for MLTC living in the community on or after 10/1/2014; **OR**
  - Permanently residing in a nursing home as of 10/1/14, or become new residents after that date
- WHEN
  - Oct. 1, 2014 – Marketing begins to both above groups – may enroll on a voluntary basis to be effective Jan. 1, 2015
  - Nov 1, 2014 – 60-day notices sent to first batch
  - Jan. 1, 2015 – Enrollment effective for those who voluntarily enrolled since Oct. 1, 2014. Also, notices to MLTC members who must enroll or opt out by Jan. 1, 2015

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45

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

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46

Passive Enrollment

- MLTC members in metro area (and later duals in NH) 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:
  - Select and enroll in a FIDA plan
    - must enroll through NY Medicaid Choice – not directly with plan or to
  - 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.

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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.
- **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 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.
  - **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

- **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).
- 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

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49

Transition/Continuity of care

- For someone in Original Medicare, enrollment in FIDA is like switching to a Medicare Advantage plan, with attendant restriction of provider network affecting choice of doctors, specialists, hospitals, etc.
- 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.

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50

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, but this was not clearly defined.

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51

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.

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52

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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53

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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54

Info on FIDA

National resources on CMS Guidance on the Duals Demonstrations

- 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

- Service Authorizations, Concurrent Review
- Grievances and Appeals

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

56

Requesting new or additional services

- **"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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57

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]

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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."

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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/

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60

61

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.wnylc.com/health/entry/184/

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62

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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63

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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64

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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65

Aid Continuing Change in MLTC

- 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.

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42 CFR § 438.420

66

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!

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67

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/