Public Health Insurance in New York State

The Legal Aid Society
Health Law Unit
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New York State Public Health Insurance Program Options

- Medicaid
- Family Health Plus
- Child Health Plus
- Options for the Uninsured

Medicaid

- Comprehensive health insurance program for low-income people.
- Pays for all medically necessary care, including: hospitalization, out-patient care, mental health care, physical therapy, diagnostic tests, durable medical equipment, and pharmacy.
- **Most** Medicaid recipients are now required to join managed care plans.

Child Health Plus

- State health insurance program for uninsured children under the age 19. Higher income levels and no resource test.
- Covers children who are above the Medicaid limits or who are ineligible for Medicaid because of their immigration status. Enrollees may have to pay a monthly premium depending on their income
- All enrollees receive **one year of guaranteed coverage**.
- All applicants/recipients must enroll in a managed care plan and all services are provided through the plan. Enrollees receive primary, preventive, specialty and inpatient care.

Family Health Plus

- Covers uninsured adults between the ages of 19 and 64 who have higher income.
- Enrollees receive primary, preventive, specialty and inpatient care. Dental benefits depending on health plan enrollment.
- Co-payment requirements for many services. Though providers can bill, services cannot be denied if the enrollee cannot afford the co-pay. Use NY State Benefit card get pharmacy benefits.
- Enrollees have **guaranteed coverage for their first six months of enrollment.**

Services for the Undocumented

- New York residents who are undocumented are eligible for Medicaid coverage for the treatment of an emergency condition, PCAP and Hospital Financial Assistance.
- Undocumented children are eligible for Child Health Plus B.

What is Medicaid Managed Care?

Medicaid Managed Care

- Medicaid managed care is a program that provides healthcare services through health maintenance organizations or managed care plans.
- Unlike in regular Medicaid, where Medicaid beneficiaries can see any doctor that accepts Medicaid, in Medicaid managed care most beneficiaries must:
  - join a managed care plan
  - follow the plan's rules for accessing services

How Does Managed Care Differ From Regular Medicaid?

- Enrollee must choose a health plan and personal doctor or Primary Care Provider (PCP)
- Enrollee must see doctors who are in the plan's network (some exceptions apply)
- Enrollee must get permission - called a referral - to see other doctors or providers
  - Enrollee must ask his or her PCP for a referral to see a specialist or to be admitted into the hospital in non-emergency.
  - No referral is required if enrollee has an emergency.
  - Generally enrollee must see specialists in the plan's network.

New Mandatory Medicaid Managed Care Populations

- Most Medicaid recipients in NYC and upstate are now required to join managed care plans.
- All of NYC and most upstate counties mandate enrollment for people on SSI or considered SSI-related.
- Seriously and Persistently Mentally Ill Adults and Seriously Emotionally Disturbed Children are no longer exempt if on SSI or SSI-related

Medicaid Managed Care- Exemptions & Exclusions

- Two groups of people do not have to join Medicaid managed care plans. These people are either **exempt** or **excluded.**
  - **Exempt** -- People who **can** join a Medicaid managed care plan if they want to, but are not required to join.
  - **Excluded** -- People who **cannot** join a Medicaid managed care plan, even if they want to.

Mandatory Enrollment Process

- New York Medicaid Choice is the enrollment broker for New York's Mandatory Managed Care Program.
- Responsibilities include:
  - Sending mandatory enrollment notices and advising Medicaid beneficiaries that they must enroll in a health plan unless they meet the criteria for an exemption.

Mandatory Enrollment Process

- Mailers to Medicaid beneficiaries:
  - 1st mailer notifies beneficiaries that they must join a managed care plan.
  - 2nd mailer: **Mandatory Enrollment Package**
    - Letter with auto-assignment date
    - Brochure describing managed care program, enrollment forms, list of health plans
- Persons receiving SSI or who are considered SSI-related have 90 days to enroll, all others have 60 days.

Mandatory Enrollment Process

- During this period, beneficiary should receive:
  - Reminder postcard
  - Reminder notice
  - **Intent to default notice**: Warning that if beneficiary does not sign up for a plan, they will be randomly auto-enrolled into a plan.
  - Phone calls to beneficiary by New York Medicaid Choice to try to assist with plan selection.
  - **Auto-assignment notice:** If beneficiary does not choose a health plan, they will receive a notice with the name of the plan they were auto-enrolled in and the effective date of enrollment.

New York Medicaid Choice

- Assistance with:
  - Information about health plans
  - Phone enrollment and/or assistance with completing enrollment forms
  - Selection of PCP including determining which providers participate in which plans
  - Requesting disenrollment, plan transfer, exemptions/exclusions

- **NY Medicaid Choice Help-Line**
  1- 800-505-5678
  1- 800-774-4241 (SSI Help-line)

Automatic Enrollment For Those Who Do Not Choose

- When beneficiaries are enrolled, either by choice or automatically, they can change plans anytime within the first 90 days of enrollment.
- After first 90 days of enrollment beneficiaries are “locked-in” the plan for the next 9 months and can not switch plans unless they have “good cause”.

Medicaid Managed Care Exemptions

Exemptions- Who Is Not Required to Join?

- Types of Exemptions
  1. Barriers to Accessing Care
  2. Individual's Status
  3. County Option
  4. Commissioner's Choice – DOH/OMH

Exemptions Based on Barriers

- Medicaid plan provider is not geographically or linguistically accessible.
- Treatment for a chronic medical condition including pregnancy, or scheduled major surgery with a provider who does not participate in any Medicaid plan.

Exemptions Based on Status

- Resident of alcohol/substance abuse long term treatment program
- Resident of an intermediate care facility for the mentally retarded (or have similar health needs)
- Developmental or physical disability and receive Home and Community Based or Care-at-Home Services through Medicaid Waiver (or have similar health needs)

Exemptions Based on Status

- Seriously and Persistently Mentally Ill Adults and Seriously Emotionally Disturbed Children, if not on SSI.
- Dually eligible for Medicare & Medicaid
- Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and not paying a premium

Exemptions Based on County's Choice

- In New York City:
  - Homeless
  - Foster Children (excluded in NYC but exempt state-wide)

Exemptions in Place until Lifted by DOH/MH

- Dually eligible for Medicaid & Medicare
- HIV+ recipients
- End Stage Renal Disease (ESRD)

Exemption Durations

- Once granted, no renewal required: Native American, HIV+, developmental disability, ESRD, duals
- Most exemptions granted for 1 year period and must be renewed: homeless, SPMI/SED, chronic illness
- Less than 1 year:
  - Pregnancy: period of pregnancy + 2 months post partum
  - surgical need

“Good Cause” Exemption

- Examples can include:
  - Multiple specialists who do not participate in the same plan
  - Language barrier
  - Treatment for a chronic condition with a specialist who do not participate in any plan
  - Enrollee has been treated by a PCP who do not participate in any plan for more than one year

Medicaid Managed Care Exclusions

Exclusions- Who Cannot Join?

- Beneficiaries with limited eligibility i.e., without full Medicaid coverage
- Beneficiaries with specific circumstances

Exclusions Due to Limited Eligibility

- Excess Income Program
- Restricted Recipient
- Eligible for less than 6 months of coverage (i.e. for the treatment of an emergency condition)
- Coverage limited to TB related services, FPBP, Breast and Cervical Cancer Early Treatment Program
- Individuals with other comprehensive insurance
- Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and paying a premium

Exclusions Due to Circumstances

- Resident of nursing home, state-operated psychiatric facility, or residential treatment facility for children
- Receiving care through Long Term Home Health Care Program
- Receiving hospice services

Help managing your managed care plan

What is Managed Care?

- In Managed Care, an enrollee joins a health plan which coordinates his or her medical care.
- All health plans have 4 main rules that their enrollees must follow.

Primary Care Provider (PCP)

- **Enrollee must choose a Primary Care Provider (PCP) from the plan's provider directory. PCP:**
  - Coordinates most of the enrollee's health care services
  - Conducts baseline and periodic health examinations
  - Diagnoses and treats conditions not requiring the services of a specialist
  - Arranges for inpatient care
  - Refers enrollee to a specialist if medically necessary
  - Maintains a current medical record for the enrollee
  - Provides child/teen health services including EPSDT to children under 21

In-Network Treatment

- **All the enrollee's doctors are supposed to be in the plan's network (provider directory).**

  The plan will only pay doctors, hospitals and other providers that participate in the plan's network – exceptions apply under certain circumstances.

  – **All enrollees have the right to go to the emergency room in accordance with the "Prudent Lay Person" standard.**

Referral for specialty services

- **Enrollee must get permission - called a referral - to see other doctors or providers.**
  - Enrollee must ask his or her PCP for a referral to see a specialist or to be admitted to the hospital in a non-emergency.
  - No referral is required if enrollee has an emergency.
  - Usually specialists should be in the plan's network.

Prior Authorization

- Enrollees must get prior authorization or pre-certification for most medical services, unless they are an emergency.
- For example, enrollees must get prior authorization for hospitalization, surgery, skilled nursing services, and durable medical equipment.

How to choose the right plan and access care upon enrollment

Physical Health Benefit for SSI or SSI-related

- Medicaid beneficiaries who are on SSI or are SSI-related must choose a plan for their physical health benefits only!
- Behavioral health benefits and other services are “carved out” of the managed care benefit package.

“Carved-Out” Services

- Prescriptions
- COBRA Case Management
- Medicaid Services Coordination, Day Treatment and Long Term Care Services for the developmentally disabled
- Mental health services for SSI recipients
- Personal Care Services
- Methadone Maintenance
- Dental services (if not covered by specific plan)
- HIV Adult Day Treatment

Information Prior to Enrollment

- **Enrollees have the right to information before they join a plan:**
  - Covered services
  - How to use the plan
  - What member services does
  - Definition of medical necessity
  - Requirements for referral and prior authorization
  - Grievance, Appeal, Utilization Review and External Appeal procedures and time frames.

Who are your current doctors and providers?

- Make a list of all of your child's current providers, including all primary and specialty care doctors, specialty therapy providers, home care service providers and durable medical equipment vendors.
- Find out which providers accept which plans and try to find a common plan.

Example

- John sees a cardiologist who accepts HIP and Well Care, he sees an endocrinologist who accepts HIP, HealthFirst and MetroPlus, gets durable medical equipment from a vendor who accepts MetroPlus, HIP and Americhoice, and his home care agency accepts HIP only.
- John should choose the common plan, HIP!

Health Assessment Form & Plan Contact

- Helps the plan better serve a new enrollee. Tell NY Medicaid Choice or the plan:
  - all your child's medical needs and service providers
  - any specialized care or treatment your child receives
  - special accommodations your child may need to access services.

Post-Enrollment

- Enrollees are entitled to receive all medically necessary services previously provided by Fee-for-Service Medicaid.
- Most services are received through the Medicaid Managed Care Plan, except for “carved-out” services.

Transitional Care Upon Enrollment

- New enrollees receiving an ongoing course of treatment for a medical condition or disease which is either life-threatening, or degenerative and disabling, have the right to receive transitional care with an out-of-network provider for up to 60 days from their date of enrollment, or until their new managed care plan can make an in-network plan of care.

Accessing Care for People with Disabilities or Chronic Conditions

Accessing Care for People with Disabilities or Chronic Conditions

- Specialist as PCP
- Standing referrals
- Out-of-network coverage
- Continue with doctor for up to 90 days if she leaves plan network
- Access to Specialty Care Center/Center of Excellence
- Case management services
- Sufficient primary and specialty capacity

Specialist as PCP

Right to have a specialist as enrollee's PCP:

- If enrollee is diagnosed with a disease or condition which is either life-threatening, or degenerative and disabling and requires prolonged specialized medical care, he or she can have a specialist or a sub-specialist assigned as his or her PCP, when the health plan determines that it is medically appropriate and specialist agrees to act as the PCP.

Standing Referral

Right to a standing referral:

- An enrollee who needs ongoing care from a specialist may receive a standing referral to such a specialist if the plan or PCP in consultation with the plan's medical director deems it appropriate.

Out-of-Network Services

Right to go "out-of-network" for specialty care:

- If the plan does not have a provider with the experience and training necessary to meet the enrollee's needs, the enrollee must be referred out of network at no extra cost.

Continuity of Care

Right to continuity of care:

- The following new enrollees have the right to receive transitional care with an out-of-network provider for up to 60 days from their date of enrollment:
  - Enrollee who is receiving an ongoing course of treatment for a medical condition or disease which is either life-threatening, or degenerative and disabling
  - Enrollee who has entered her second trimester of pregnancy
  - Enrollee whose provider left the plan's network

Specialty Care

Right to go to a Center of Excellence/ Specialty Care Center:

- If enrollee is diagnosed with a disease or condition which is either life-threatening, or degenerative and disabling and requires prolonged specialized medical care, he or she must be referred to an out-of-network specialty care center with expertise in treating the disease or condition at no extra cost, if the plan does not have one in network.

Exemption, Enrollment & Continuity of Care Issues

- Wrongly denied exemptions
- Access to CHHA/ Long-Term Care Services
- Access to transportation services
- Access to specialized providers
- No written notice of denial, termination or reduction of benefits upon enrollment

Problem Solving in Managed Care

Chart of Dispute Resolution Options

Type of Insurance:	Medicaid Fair Hearing	Internal Plan Grievance	Internal Plan Utilization Review	External Plan Utilization Review
Regular Medicaid	X			
Medicaid Managed Care	X	X	X	X (but FH Trumps Ext)
Family Health Plus	X	X	X	X (but FH Trumps Ext)
Child Health Plus		X	X	X
Commercial Managed Care		X	X	X

What is a Fair Hearing?

- A **Fair Hearing** is a hearing before an independent State Administrative Law Judge (ALJ)
  - The enrollee has an opportunity to tell the ALJ why they think Medicaid made a mistake.
  - If Medicaid has reduced or discontinued a benefit, they have to prove that their decision was correct; if they denied a benefit the enrollee must prove why they were wrong;
  - Then Medicaid has an opportunity to tell the ALJ why they think that they made the correct decision.
  - The ALJ must make a decision within 90 days of the date the hearing was requested.

Aid-to-Continue: If enrollee asks for a Fair Hearing within 10 days of the day that Medicaid gives notice that they are going to terminate or reduce a benefit, the enrollee has the right to get that service or benefit pending the fair hearing decision.

Requesting a Fair Hearing

- Four options to request a Fair Hearing:
  - **Phone:** (212) 417-6550.
  - **Write:** NYSDOH, Office of Administrative Hearings P.O. Box 1930, Albany, NY 11201-1930.
  - **Fax:** Written request to: 518-473-6735.
  - **Internet:** www.otda.state.ny.us/oah/default.asp

Contact Information

- **The Legal Aid Society**
  Health Law Unit
  Health Law Help-line: (Open Tuesdays)
  212-577-3575