Managed Long Term Care

State Complaint Number for MLTC Problems - 1-866-712-7197

- **e-mail mltctac@health.ny.gov and put "COMPLAINT" in subject line**
- **For enrollment complaints - call NY Medicaid Choice -**
  - **1-855-886-0570** (Advocates line)
  - **1-888-401-6582** (Consumers line)

Managed Long Term Care (MLTC) plans are insurance plans that are paid a monthly premium ("capitation") by the New York Medicaid program to approve and provide Medicaid home care and other long-term care services (listed below) to people who need long-term care because of a long-lasting health condition or disability. The MLTC plans take over the job the local CASA or Medicaid offices used to do - they decide whether you need Medicaid home care and how many hours you may receive, and arrange for the care by a network of providers that the plan contracts with.. They also approve, manage and pay for the other long-term care services listed below.

In addition to this article, for latest updates on MLTC --see this NEWS ARTICLE on MLTC Implementation.

And see this article for Know Your Rights Fact Sheets and free webinars

November 2021 WARNING: See changes in Transition Rights that take effect on Nov. 8, 2021 - see separate article here

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- **Appeals and Hearings - Appealing an Adverse Plan Determination**

    - **REDUCTIONS & Discontinuances - Procedures and Consumer Rights under Mayer and Granato** (link to article on Personal Care services, but rights also apply to CDPAP)
    - NEW NOV. 8, 2021 - New regulations allow MLTC plans to reduce hours without proving a change in medical condition or circumstances -- but only in limited circumstances for those who were required to enroll in the MLTC plan after receiving Medicaid home care services from the local DSS, a mainstream plan, or from an MLTC plan that closed. These members had Transition Rights when they transferred to the MLTC plan. See more here.
- **Changing Plans - New "Lock-in" Rule for New Enrollments in any MLTC Plan starting Dec. 1, 2020 - after the first 90 days may change plans only for good cause**
- **When an MLTC plan closes - click here and here for updates**
- **Spend-Down or Surplus Income - Special Warnings and Considerations**
- **NEW SEPT. 2013 -** Spousal Impoverishment Protections Apply in MLTC
- **The New Housing Disregard - Higher Income Allowed for Nursing Home Residents to Leave the Nursing Home by Enrolling in MLTC**
- **GETTING HELP WITH MLTC - click here**

In General -- NYS Shift from a Voluntary Option to Mandatory Enrollment in MLTC

New York has had managed long term care plans for many years. Before, however,

enrollment was voluntary, and MLTC was just one option of several types of Medicaid home care one could choose. Other choices included personal care services, approved by the local CASA/DSS office, Lombardi program or other waiver services, or Certified Home Health Agency services. On Sept. 4, 2012, the federal government Medicaid agency "CMS" approved the state's request for an "1115 waiver" that will allow NYS to require that all *dually eligible* (those who have Medicare and Medicaid) adults age 21+ now receiving -- or who will apply for -- community-based long-term care services -- particularly personal care/home attendant services, long-term Certified Home Health Agency services, Consumer-Directed Personal Assistance program services (CDPAP), private duty nursing and medical adult day care -- to enroll in a Managed Long-Term Care (MLTC) plan. The MLTC plan will now control access to, approve, and pay for all Medicaid home care services and other long-term care services in the MLTC service package. This is the only way to obtain these services for adults who are dually eligible, unless they are exempt or excluded from MLTC.

If they do not choose a MLTC plan then they will be auto-assigned to a plan.

LAW, 1115 Waiver Documents, Model Contracts, AND OTHER AUTHORITY:

- **NYS Law and Regulations - New York Public Health Law Â§ 4403(f)** -- this law was amended by the state in 2011 to authorize the State to request CMS approval to make MLTC mandatory. The State submitted the waiver request on April 13, 2011 1115 waiver request - posted at http://www.health.ny.gov/health_care/managed_care/appextension/ -- all under the first heading labeled *Amendment to Implement Medicaid Redesign Team Changes to the 1115 Waivers. The details on the Managed Long Term Care expansion request begin at Page 3 of the* Summary of MRT changes. In April 2018, the law was amended to lock-in enrollees into a plan after a 90-day grace period after enrollment. Discussed more here.

In 2020 this law was amended to restrict MLTC eligibility -- and eligibility for all personal care and CDPAP services -- to those who need physical assistance with THREE Activities of Daily Living (ADL), unless they have dementia, and are then eligible if they need supervision with TWO ADLs. The same law also requires a battery of new assessments for all MLTC applicants and members.

NYLAG Evelyn Frank program webinar on the changes conducted on Sept. 9, 2020 can be viewed here (and download the Powerpoint).

In July 2020, DOH proposed to amend **state regulations to implement these restrictions --** posted here. In Sept. 2020 NYLAG submitted extensive comments on the proposed regulations. A summary of the comments is on the first few pages of the PDF.

- **Federal law and regulations** 42 U.S.C. Â§ 1396b(m)(1)(A)(i); 42 C.F.R. Part 438 (Medicaid managed care(amended 2016), 42 CFR Part 460 (PACE)
- **MLTC is authorized under an 1115 waiver. The CMS Special Terms & Conditions** set out the terms of this waiver -- which is an sgreement between the State and CMS governing MLTC and Medicaid managed care. Posted with other waiver documents on the NYS 1115 Waiver Information Webpage (click on **MRT Plan Current STCs** -

    - NY STCs Effective (PDF) - 1.9.24
    - CMS STC Approval Letter (PDF) - received 1.9.24
- CMS Website on Managed Long Term Services and Supports (new May 2013)

  Additional resources for MLTSS programs are available in a CMS Informational Bulletin released on May 21, 2013

NYS DIRECTIVES, CONTRACTS, POLICY GUIDANCE -- Medicaid Redesign Team **MRT 90** page - Click on

- Health Plans, Providers, & Professionals heading: Has **MODEL CONTRACTS** between the MLTC plans and the State Dept. of Health, Plan Directory
- MLTC Policies - Key Policy Directives for MLTC plans

- NYS MLTC website
- **2 State websites on NYI Independent Assessor -** Maximus website - https://nyia.com/en (also in Espanol) (launched June 2022) and STATE website on Independent Assessor with government directives here

What is "Capitation" -- What is the difference between *Fully Capitated* and *Partially Capitated* Plans? What are the different types of plans?

The monthly premium that the State pays to the plans "per member per month" is called a "capitation rate." The amount of this premium is the same for every enrollee, but it is not a cap on the cost of services that any individual enrollee may receive. Instead, the plan must pool all the capitation premiums it receives. The rate is supposed to be enough for the plan to save money on members who need few services, so that it can provide more services to those who need more care. To make it more confusing, there are two general types of plans, based on what services the capitation rate is intended to cover:

I. "Partial Capitation" -- Managed Long-Term Care Plans - "MLTC" - Cover certain Medicaid services only

"Managed long-term care" plans are the most familiar and have the most people enrolled. They provide Medicaid long-term care services (like home health, adult day care, and nursing home care) and ancillary and ambulatory services (including dentistry, optometry, audiology, podiatry, eyeglasses, and durable medical equipment and supplies), and receive

Medicaid payment only, with NO Medicare coverage.

These plans DO NOT cover most primary and acute medical care. Members continue to use their original Medicare cards or Medicare Advantage plan, and regular Medicaid card for primary care, inpatient hospital care, and other services. The MLTC plan does not control or provide any Medicare services, and does not control or provide most primary MEDICAID care. Managed long-term care plan enrollees must be at least age 18, but some require a minimum age of 21. See state's chart with age limits.

It is this partially capitated MLTC plan that is becoming mandatory for adults age 21+ who need Medicaid home care and other community-based long-term care services. But consumersl have the option of enrolling in "fully capitated" plans as well -- so it's important to know the differences. A summary chart is posted here.

II. "Full Capitation" - Plans cover *all* Medicare & Medicaid services -- PACE & Medicaid Advantage Plus

PACE and Medicaid Advantage Plus plans provide ALL Medicare and Medicaid services in one plan, including primary, acute and long-term care. All care must be in plan's network (hospitals, doctors, nursing homes, labs, clinics, home care agencies, dentists, etc.). For these plans, your need for daily care must be such that you would be eligible for admission to a nursing home. When you join one of these plans, you give up your original Medicare card or Medicare Advantage card. Instead, you use your new plan card for ALL of your Medicare and Medicaid services. There are 2 types of FULL CAPITATION plans that cover Medcaid long-term care:

(1) PACE "Programs of All-Inclusive Care for the Elderly" plans - must be age 55+ See CMS PACE Manual. Link to federal PACE regs - 42 CFR Part 460. and other guidance on PACE :

(2) MEDICAID ADVANTAGE PLUS [MAP] - age requirements vary among plans from 18+ to 65+

NOTE: MEDICAID ADVANTAGE PLANS are a slight variation on the **MEDICAID ADVANTAGE PLUS** plans. They provide and control access to all primary medical care paid for by MEDICARE and MEDICAID, EXCEPT that they do not cover most long-term care services by either Medicaid or Medicare. *Anyone who needs Medicaid home care should NOT join this 3rd type of plan!*

Read about unique Integrated Appeals process in MAP plans here - with advantages and disadvantages.

See this chart summarizing the differences between the four types of managed care plans described above. The chart also includes a **5th** type of managed care plan - **Medicaid Managed Care -** these plans are mandatory for most Medicaid recipients who do NOT have Medicare. The capitated payment they receive covers almost all Medicaid

services, including personal care and CHHA home health aide services, with some exceptions of services that are not in the benefit package.

See this chart of plans in NYC organized by insurance company, showing which of the different types of plans are offered by each company as of Feb. 2013

Lists of Plans - NYC and Rest of State:

- NYS DOH MLTC Plan Directory
- Enrollment statistics are updated monthly by NYS DOH here -- Monthly Medicaid Managed Care Enrollment Report The monthly changes in enrollment by plan in NYS is posted by a company called Public Signals. On the Health Care Data page, click on "Plan Changes" in the row of filters. Then select filters for "Plan Type" (to see MLTC select "Partial MLTC") and, if desired, "Economic Region" and "Comparison Years."
- http://www.nymedicaidchoice.com/program-materials - NY Medicaid Choice lists - same lists are sent to clients with 60-day Choice letters. **CAUTION -- Look only at the *Long Term Care* plan**s - ("Health Plans" are Mainstream managed care plans, which are NOT for Dual Eligibles)
- See more enrollment numbers - for various NYS plans that provide Medicare and Medicaid services for dual eligibles, including Medicare Advantage plans - here.

Who must enroll in MLTC? And when?

WHO MUST ENROLL -- Medicaid recipients who:

1. Are **dually eligible** - they have Medicare AND Medicaid, AND
2. Are **age 21 or older**, AND
3. **Are Functionally eligiible.** This criteria will be changing under statutory amendments enacted in the state budget April 2020 (scheduled to be immplemented in Oct. 1, 2020, they will likely not be implemented until 2021).

    1. U**ntil the 2020 changes are implemented -** Determined by NY Medicaid Choice or local DSS/HRA to need community-based long-term care for more than 120 days -- As of Oct. 2017, these services include:

- Private Duty Nursing Services
- Long-term Certified Home Health Agency (CHHA) services (> 120 days),
- Adult Day Care - medical model and social model - but must need personal care, CDPAP or pirvate duty nursing in addition to day care services. Not enough to enroll in MLTC if only need only day care.
- Consumer Directed Personal Assistance Program (CDPAP), t
- Personal Care Services (it is not enough to need only Level I "Housekeeping services")

- NO LONGER eligible for MLTC - if need long term nursing home care- See this article

Must not be "exempt" or "excluded" from enrolling in an MLTC plan. See below.

Medicaid recipients still excluded from MLTC: - People in Assisted Living Program, TBI and Nursing Home Transition and Diversion Waiver Programs -will eventually all be required to enroll. TBI and NHTDW now scheduled for Jan. 1, 2022 (Just extended from 2019 per NYS Budget enacted 4/1/2018). ALP delayed indefinitely.

2. **2020 CHANGES in FUNCTIONAL ELIGIBILITY - likely won't be implemented until 2023.** Will require that new enrollees need "physical maneuvering with more than two" ADL's, or for persons with dementia or Alzheimer's diagnosis, need "at least supervision with more than one ADL." (People already receiving MLTC services before 10/1/2020 will be "grandfathered" in). See more info on these changes in this article. See DOH proposed regulations and NYLAG comments (9/8/2020)

Phase -In of mandatory MLTC -

MLTC was phased in beginning in Sept. 2012 in New York City through July 2015 gradually rolling out to all counties in NYS, and including all of the services listed above. See details of the phase in schedule here.

WHO DOES NOT HAVE TO ENROLL IN MLTC? (Exemptions & Exclusions)

WHO MAY NOT ENROLL IN A MLTC? (Who is EXCLUDED from MLTC?)

Download New York Medicaid Choice MLTC Exclusion Form - must be signed by physician

- Individuals in Certain Waiver Programs. These include: Nursing Home Transition & Diversion (NHTD) waiver, Traumatic Brain Injury (TBI) waiver, Office for People with Developmental Disabilities waiver, and individuals with complex mental health needs receiving services through ICF and HCBS waiver. (Note NHTW and TBI waivers will be merged into MLTC in January 1, 2022, extended from 2019 per NYS Budget enacted 4/1/2018).
- **NEW**: Nursing home residents in "long term stays" of 3+ months are excluded from enrolling in MLTC plans. SEE this article.
- Medicaid Assisted Living Program residents - still excluded, but will be carved into MLTC (carve-in indefinitely postponed)

- Persons receiving **hospice** services (they may not enroll in an MLTC plan, but someone already in an MLTC plan who comes to need hospice services may enroll in hospice without having to disenroll from the MLTC plan. See NYS DOH MLTC Policy 13.18: MLTC Guidance on Hospice Coverage (June 25, 2013) Those who are in hospice and need supplemental home care may still apply to CASA/DSS for personal care services to supplement hospice;
- Residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Alcohol & Substance Abuse Long Term Care Residential Program, adult Foster Care Home, or psychiatric facilities.
- People who receive or need ONLY **"Housekeeping"** services ("Personal Care Level I" services under 18 NYCRR 505.14(a)). Until 10/1/20, state law authorizes these services but they are limited to 8 hours per week if that's the only personal care service you need. They are for people who do not need assistance with Activities of Daily Living (ADL) - personal care such as bathing, grooming, walking but do need help with household chores because of their disabilities. Until 10/1/20, they apply for these services through their Local Medicaid Program (in NYC apply to the Home Care Service Program with an M11q. See --

    - MLTC Policy 13.15: Refining the Definition of CBLTC Services
    - MLTC Policy 13.16: Questions and Answers Further Clarifying the Definition of CBLTC Services
    - MLTC Policy 13.21: Process Issues Involving the Definition of Community Based Long Term Care. (State directed MLTC plans to disenroll these individuals and transition them back to DSS). See NYC HRA MICSA Bulletin -- Disenrolled Housekeeping Case Consumers (MLTC) 8-13-13.pdf

Effective Oct. 1, 2020, or later if postponed, new applicants will be barred from applying for Housekeeping-only services. This is under the budget amendments enacted 4/1/20. Those changes restrict eligibility for personal care to people who need assistance with ADLs. See above. Since Houskeeping is for people who are independent with ADLs, this stand-alone service will no longer be authorized for new applicants. We understand existing recipients will be grandfathered in.

- **If needs only Social Adult Day Care** -this is not enough to be eligible to receive MLTC --- must also need some home care. In April 2013, one plan - VNS CHOICE - was suspended from taking any new enrollees - because plans were enrolling people recruited to join these social adult day care centers who do not need long-term care services. Since plans receive the same monthly rate for ALL members, plans have an incentive to enroll these individuals. On May 8, 2013, DOH released MLTC Policy 13.11: Social Day Care Services Q&A and Letter from State Medicaid Director Helgerson to MLTC Plans on SADC which answers questions arising from the scandal in which a NYS Assemblyman was arrested for allegedly taking a bribe from an operator of a social adult day care center. The May 2013 Q&A references the Letter sent by the state Director of Medicaid, Jason Helgerson, to MLTC Plans on April 26, 2013. and supplements an earlier February 28, 2013 Directive -- MLTC Policy 13.05: Social Daycare Services Q&A. See also

- ♦ MLTC Policy 13.16: Questions and Answers Further Clarifying the Definition of CBLTC Services
- ♦ MLTC Policy 13.15: Refining the Definition of CBLTC Services
- ♦ MLTC Policy 13.14: Questions Regarding MLTC Eligibility

- Children under age 18
- NOTE - 2013 New York Medicaid Choice MLTC Exclusion Form excludes an individual certified by physician to have a **developmental disability.**

SOURCE: Special Terms & Conditions, NY STCs Effective (PDF) - 1.9.2024 Table 4..

- CMS STC Approval Letter (PDF) - received 1.9.24

(Be sure to check here to see if the ST&C have been updated - click on MRT 1115 STC)

WHO MAY ENROLL IN MLTC BUT IS NOT REQUIRED TO? (WHO is EXEMPT FROM MLTC?)

- Native Americans;
- **Dual eligible individuals age 18- 21** who require home care or other long-term care services, and require a "nursing home level of care," meaning they could be admitted to a nursing home based on their medical and functional condition;
- **Adults over age 21 who have Medicaid but not Medicare** (If they require a "nursing home level of care") -- If they are not yet enrolled in a a mainstream Medicaid managed care plan they may opt to enroll in an MLTC plan if they would be functionally eligible for nursing home care. If they enroll in an MLTC, they would receive other Medicaid services that are not covered by the MLTC plan on a fee-for-service basis, not through managed care (such as hospital care, primary medical care, prescriptions, etc.).

    - ♦ However, if they are already enrolled in a mainstream Medicaid managed care plan, they must access personal care, consumer-directed personal assistance, or private duty nursing from the plan. They may only switch to MLTC if they need adult day care, social environmental supports, or home delivered meals - services not covered by Medicaid managed care plans. See MLTC Policy 14.01: *Transfers from Medicaid Managed Care to Managed Long Term Care*

- Working Medicaid recipients under age 65 in the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program (If they require a "nursing home level of care").
- SOURCE: Special Terms & Conditions NY STCs Effective (PDF) - 1.9.2024 Table 5.(Be sure to check here to see if the ST&C have been updated)

    - ♦ CMS STC Approval Letter (PDF) - received 1.9.24
    - ♦ (Be sure to check here to see if the ST&C have been updated - click on MRT 1115 STC)

New York Independent Assessor - Replaces Conflict Free (CFEEC) Assessment to ENROLL IN MLTC

Since May 16, 2022, adults newly requesting enrollment into an MLTC plan must call the new NY Independent Assessor in order to schedule TWO assessments required to enroll in MLTC plans. To schedule an evaluation, call **1-855-222-8350 - t**he same number used before to request a Conflict Free assessment. NYIA is run by the same company that ran the Conflict Free Assessments - Maximus, known as NY Medicaid Choice in NYS.

There are 2 official NYIA websites:

- Maximus WEBSITE ON NYIA - https://nyia.com/en **a**lso in Espanol)
- NYS DOH website on NYIA - https://www.health.ny.gov/health_care/medicaid/redesign/nyia/ - see all DOH guidance on NYIA in the Document Repository

The new NYIA process to enroll in an MLTC has TWO instead of only ONE assessments:

1. **Independent Assessment (IA) a/k/a Community Health Assessment (CHA) by a Nurse from *NY Medicaid Choice* --** this is the same Uniform Assessment (UAS)that NY Medicaid Choice has long done for the Conflict Free Eligibility and Enrolllment Center. Now, this will be the sole nurse assessment. The plans and Local DSS must use this assessment instead of doing their own.
2. **Independent Practioner Panel (IPP) or Clinical Assessment (CA).** - exam by PHYSICIAN, physician's assisant or nurse practitioner from *NY Medicaid Choice, who prepares a* ***Physician's Order (P.O.)*** In MLTC, this is NEW. Doctor's orders (M11q) had not been required.

    - Note: the IPP/CA may wish to clarify information about the consumer's medical condition by consulting with the consumer's provider. The consumer must give provider's permission to do this. **NYIA has its own online Consent Form f**or the consumer to sign. See NYLAG fact sheet explaining how to complete and submit this form.

WHERE - the 2 assessments above must be conducted in the home, hospital or nursing home, but also can be done by telehealth.

WHEN - BOTH of the 2 above assessments are SUPPOSED to be scheduled in 14 days. See the DOH guidance posted in the Document Repository. Even if assessments are scheduled to use Telehealth, instead of In Person , NYIA rarely if ever meets the 14-day deadline.

- Unlike the CFEEC, DOH policy says the 2 above assessments may not be even scheduled, let alone conducted, until Medicaid is active. Before, the CFEEC could be scheduled with Medicaid pending. State FAQ (Q13) This restriction causes

further delays, and goes beyone what DOH's own regulation says, which is that eligibility must be established before services are authorized or reauthorized. 18 NYCRR 505.14(b)(4)(i).

WHY - NYIA was authorized by the FY 2020 NYS Budget, upon recommendation of the NYS Medicaid Redesign Team 2 The State wanted an "independent physician" to determine eligibility, rather than the consumer's physician, who the State apparently believed was biased. See more about the various MRT-2 changes and their status here.

If consumer faces DELAYS in scheduling the 2 above assessments, or cannot get an in-person assessment instead of a telehealth one, see **WHERE TO COMPLAIN.**

3. **Once these two assessments are done, NYIA sends an "Outcome Notice**" which says that the consumer is, is not , or may or may not be eligible to enroll in an MLTC plan. Since this new procedure is new, we have not seen many notices but they are confusing and you might need help deciphering them. See where to get help here.

The Outcome Notice might refer the consumer back to call NYIA for counseling on finding an MLTC plan. The consumer can also contact MLTC plans on her own to be assessed for potential enrollment. The MLTC Plan she selects will decide on the plan of care, obtaining as much additional information as they need. If the consumer agrees to this plan of care, she can enroll.

However, if the MLTC plan determines that a prospective enrollee needs more than 12 hours/day on average (generally this means 24/7 care) then they must refer it back to NYIA for a third assessment - the **Independent Review Panel (IRP)** described below**.** However, the consumer can go ahead and enroll in the plan while the IRP referral is pending. They do not have to wait til this 3rd assessment is scheduled and completed before enrolling.

Unlike the CFEEC, a NYIA inding of eligibility is good for ONE YEAR - it no longer expires after 75 days -You must enroll in a plan and the plan must submit your enrollment form to DSS and Maximus.

4. **INDEPENDENT REVIEW PANEL (IRP)** - The 2020 MRT II law authorizes DOH to adopt standards, by emergency regulation, for extra review of individuals "whose need for such services exceeds a specified level to be determined by DOH." DOH's regulations draw this line at those needing more than 12 hours/day of home care on average. The assessor will review whether the consumer, "with the provision of such services is capable of safely remaining in the community in accordance with the standards set forth in Olmstead v. LC by Zimring, 527 US 581 (1999) and consider whether an individual is capable of safely remaining in the community." (Sec. 2, 20). Again, this is a panel run by New York Medicaid Choice. This review is done on paper, not an actual direct assessment.

For more information on NYIA see this article. - including NYLAG advocacy on NYIA,

NYLAG's slide deck here on NYIA (current as of July 11, 2022), WHERE TO COMPLAIN about delays, and other problems.

NYLAG's Guide and Explanation on the CFEEC and MLTC Evaluation Process - while this is no longer a CFEEC, the same tips apply to the NYIA nurse assessment.

WHICH SERVICES ARE PROVIDED BY THE MLTC PLANS - Benefit Package of "Partially Capitated" Plans

MLTC plans must provide the services in the MLTC Benefit Package listed below. Once you are enrolled in a MLTC plan, you may no longer use your Medicaid card for any of these services, and you must use providers in the MLTC plan's network for all of these services, including your dentist. The providers will be paid by the MLTC plan, rather than billing Medicaid directly.

MLTC Benefit Package (Partial Capitation) (Plan must cover these services, if deemed medically necessary. Member must use providers within the plan's provider network for these services).

- **Home Care**, including:
  - Personal Care (formerly known in NYC as "Home attendant." If you need ONLY Housekeeping services (Level I services and not Level II under 18 NYCRR 505.14, NOT eligible for MLTC)
  - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Program
- **Adult Day Health Care** (medical model and social adult day care)
- Personal Emergency Response System (**PERS**),
- **Nutrition** -- Home-delivered meals or congregate meals
- Home modifications
- **Medical equipment** such as wheelchairs, medical supplies such as incontinent pads, prostheses, orthotics, respiratory therapy
- **Physical, speech, and occupational therapy** outside the home
- **Hearing Aids and Eyeglasses**
- Four Medical Specialties:
  - **Podiatry**
  - **Audiology** + hearing aides and batteries
  - **Dental**
  - **Optometry** + eyeglasses
- Non-emergency **medical transportation** to doctor offices, clinics (ambulette) - NOTE This service will be "carved out" of the MLTC benefit package effective Oct. 1, 2021, unless further delayed - see DOH website here
- **Nursing home** care only up to 3 months, then disenrolled once determined eligible for nursing home Medicaid.

SOURCE: NYS DOH Model Contract for MLTC Plans (See Appendix G) - Find most recent version of model contract on the MRT 90 WEBPAGE also see CMS Special Terms & Conditions, (eff. 9/2016), at p. 119 of PDF -- Attachment B

NOTE WHICH SERVICES ARE *NOT COVERED* BY MLTC PARTIALLY CAPITATED PLANS -- but *are covered* by "fully capitated" Medicaid Advantage Plus or PACE plans

- Primary and acute medical care, including all doctors other than the Four Medical Specialties listed above, all hospital inpatient and outpatient care, outpatient clinics, emergency room care, mental health care
- Lab and radiology tests
- Prescription drugs
- Assisted living program
- Hospice services - MLTC plans do not provide hospice services but as of June 24, 2013, an MLTC member may enroll in a hospice and continue to receive MLTC services separately. Before s/he had to disenroll from the MLTC plan. PACE plans may not give hospice services. See NYS DOH MLTC Policy 13.18: MLTC Guidance on Hospice Coverage (June 25, 2013)

HOW DO PEOPLE IN MLTC Partial Capitation Plans Receive services not covered by the plans? These use -

- Original Medicare OR Medicare Advantage plan AND
- Regular Medicaid

WHAT SERVICES ARE "MEDICALLY NECESSARY?" The Federal Medicaid statute requires that all managed care plans make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. Â§ 1396b(m)(1)(A)(i); 42 C.F.R. Â§Â§ 438.210(a)(2) and (a) (4)(i). The NYS DOH Model Contract for MLTC Plans also includes this clause: "Managed care organizations may not define covered services more restrictively than the Medicaid Program"

ENROLLMENT: What letters are sent in newly mandatory counties to people receiving Medicaid home care services through county, CHHA, etc -- 60 days to choose MLTC PLAN

You will receive a series of letters from New York Medicaid Choice (www.nymedicaidchoice.com), also known as MAXIMUS, the company hired by New York State to handle MLTC enrollment. See PowerPoint explaining Maximus/NY Medicaid Choice's role in MLTC enrollment (this is written by by Maximus)

1. **"ANNOUNCEMENT " LETTER - Important Medicaid Notice**-- This "announcement letter" is sent to people with 120 days left on their authorization period for Medicaid personal care, certified home health agency, private duty nursing, CDPAP, and medical model adult day care, or LOmbardi services, telling

them "MLTC" is coming letter sent in English and Spanish. It does not state that they have to enroll yet.. just says that it is coming and to expect a letter.

- **Mailing includes --**

  - **I**mportant Medicaid Notice or Aviso importante de Medicaid - Spanish version
  - Multi-Language Card -- card in 18 languages instructing people to call the toll-free number for assistance
  - Envelope

2. **MANDATORY ENROLLMENT PACKET** - Sent by NY Medicaid Choice 30 days after the 1st "announcement" letter - stating recipient has 60 days to select a plan OR will be assigned to an MLTC plan. The first packets were sent in Manhattan in July 2012, telling them to select a plan by September 2012, later extended to October 2012. The Packet includes:

   - Form Letter to Personal Care/Home Attendant recipients (at this link with sample envelope) -- It also includes the toll-free number of the enrollment broker, NY Medicaid Choice, for consumers to call with questions about MLTC and help picking a plan..: **888-401-6582**.
   - Official Guide to Managed Long Term Care, written and published by NY Medicaid Choice (Maximus)
   - **List of Long Term Care Plans in New York City - 3 lists mailed in packet, available online -** http://nymedicaidchoice.com/program-materials - NOTE: At this link, do NOT click on the plans listed as "Health Plans" - those are mainstream Medicaid managed care plans that are NOT for people with Medicare. Look for the "Long Term Care" plans for your area - NYC, Long Island, or Hudson Valley.

NYC lists -

MLTC Medicaid Plans - New York City

Medicaid Advantage Plus - New York City

Program of All-Inclusive Care for the Elderly (PACE)

CHOOSING & ENROLLING IN A PLAN -

CLICK HERE FOR TOOLS FOR CHOOSING AN MLTC PLAN.

***CONTINUITY OF CAR*E -- One important factor in choosing a plan is whether you can keep your aide that worked with you when CASA/DSS, a CHHA, or a Lombardi program authorized your care before you enrolled in the MLTC plan.** When MLTC began, the plans were required to contract with all of the home care agencies and

Lombardi programs that had contracts with the local DSS for personal care/ home attendant services, and pay them the same rates paid by the local DSS in July 2012. That requirement ended March 1, 2014.

If you don't select and enroll in a plan, midway through the 60-day period to select a plan, you will receive a letter with the name of the MLTC plan to which you will be randomly assigned if you do not select a plan. You will still have til the third Friday of that month to select his/her own plan. For example, the first assignment letters to lower Manhattan residents were sent Oct. 2, 2012. If those individuals enrolled in a different plan by Oct. 19, 2012, their own selection would trump the auto-assignment, and they would be enrolled in their selected plan as of Nov. 1, 2012.

HOW DO I ENROLL IN A PLAN --

ONCE you select a plan, you can enroll either directly with the Plan, by signing their enrollment form, OR if you are selecting an MLTC Partially Capitated plan, you can enroll with NY Medicaid Choice. If you are selecting a Medicaid Advantage Plus (MAP) or PACE plan, you must enroll directly with the plan.

WHEN IS MY ENROLLMENT IN AN MLTC PLAN EFFECTIVE?

Enrollment in MLTC, MAP and PACE plans is always effective on the 1st of the month. The plan is paid its "capitation" rate or premium on a monthly basis, so enrollment is effective on the 1st of the month.

If you enrolled late in the month (after the third Friday of the month), the enrollment will not be effective -- and the new plan will not take charge of your care -- until the first of the *second* month after you enroll.

NEW APPLICANTS -- If you were not previously receiving Medicaid personal care, CDPAP, CHHA Lombardi, private duty nursing or adult day care program services --

Must request a Conflict-Free Eligibility assessment. Click here for more information.

"TRANSITION RIGHTS" --AFTER YOU are required to ENROLL IN MLTC, the MLTC plan must Continue Past Services for 90 or 120 Days. NOV. 8, 2021 - Changes in what happens after the Transition Period. See Separate article including

- **After Involuntary Disenrollment see Grounds for Involuntary Disenrollment - (separate article)**
- **What happens after Transition Period is Over? BEWARE These Rules Changed Nov. 8, 2021** (separate article)

HOW DOES THE PLAN ASSESS MY NEEDS?

The Federal Medicaid statute requires that all managed care plans make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. Â§ 1396b(m)(1)(A)(i); 42 C.F.R. Â§Â§ 438.210(a)(2) and (a) (5)(i). The NYS DOH Model Contract for MLTC Plans states: "Managed care organizations may not define covered services more restrictively than the Medicaid Program." This is language is required by 42 C.F.R. Â§Â§ 438.210 (a) (5)(i). Therefore all of the standards that apply for assessing personal care and CDPAP services through the local DSS/HRA also apply to the plans. Click on these links to see the applicable rules for

A.. Standards for 24-Hour Care - Definition of Live-in and Split Shift - MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA)

B. Standards for Assessing Need and Determining Amount of Care - discusses MLTC Policy 16.07: *Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services .*

In April 2020, State law was amended changing both the eligibility criteria for personal care and CDPAP services and the assessment procedures to be used by MLTC plans, mainstream Medicaid managed care plans, and local districts (DSS/HRA). These changes were scheduled to be implemented Oct. 1, 2020, but have been postponed.

- Until these changes go into effect, the Plan's nurse conducts the needs assessment using a standardized Uniform Assessment System Tool (UAS-NY Community Assessment) -- MRT 69. The UAS collects demographic information, diagnosis, living arrangements, and functional abilities. This tool does not determine the number of hours. Most plans use their own proprietary "task" form to arrive at a number of hours.
- The 2020 state changes, once implemented, will change the assessment process:

    1. The UAS Nurse assessment will be conducted by a nurse from NY Medicaid Choice, not by the Plan.
    2. A new added physician's review will be conducted after the UAS nurse assessment, by a physician under contract with NY Medicaid Choice.
    3. Based on these assessments, the Plan will develop a plan of care.
    4. If the plan determines the consumer needs more than 12 hours/day, a third outside assessment is conducted by a medical panel through NY Medicaid Choice to determine if the proposed care plan is appropriate.
    5. By mid-2021, the State will develop a "tasking tool" for MLTC plans to develop a plan of care based on the UAS assessment.

DOH has proposed to amend state regulations to implement these changes in the assesment process -- regulations are posted here.

NYLAG submitted extensive comments on the proposed regulations. A summary of the concersn is on the first few pages of the PDF.

The State issued guidelines for "mainstream" Medicaid managed care plans, for people who have Medicaid but not Medicare, which began covering personal care services in August 2011 -- Guidelines for the Provision of Personal Care Services in Medicaid Managed Care.

All decisions by the plan as to which services to authorize and how much can be appealed. See **Appeals & Greivances in Managed Long Term Care.**

If I need new services, or request an increase in services from the MLTC plan, when does the plan need to decide my request?

See this article (new article July 2022)

When can you change Plans - New LOCK-IN Rules Scheduled to Start Dec. 1, 2020 -limit right to change plans after 90-day grace period.

Lock-In Starts Dec. 1, 2020 - For the first time since MLTC became mandatory in 2012, members who enroll in a new plan after Dec. 1, 2020 will be allowed to change plans in the first 90 days, then will be locked in. This means they are barred from changing plans for the next 9 months except for good cause. This change was enacted in the NYS Budget April 2018. NY Public Health Law Â§ 4403-f, subd. 7(b)(vii) but not approved by CMS until December 2019.

DOH GUIDANCE issued August 4, 2021: DOH MLTC Policy 21.04: *Managed Long Term Care Partial Capitation Plan Enrollment Lock-In and*

- Lock-In Policy Frequently Asked Questions - (Web) - (PDF)

Beginning on Dec. 1, 2020, .people who enroll either by new enrollment or plan-to-plan transfer after that date will have a 90-day grace period to elect a plan transfer after enrollment. They then will be locked in to that plan for nine months after the end of their grace period. After the 9-month lock-in period ends, enrollees may transfer to another MLTCP at any time for any reason. However, the lock-in period applies 90-days after each new enrollment into an MLTCP plan. People who were enrolled in an MLTC plan before Dec. 1, 2020 may still change plans after that date when they choose, but then will be locked in to the new plan for 9 months after the 90th day after enrollment.

In October 2020, MLTC plans sent their members letters informing them of the new "lock-in" rules that begin December. 1st. Download a sample letter and the insert to the

Member Handbook explaining the changes.

WHICH PLANS - This rule applies to transfers between MLTC plans. This change does not impact the integrated (fully capitated) plans: Fully Integrated Duals Advantage-Intellectually Developmentally Disabled (FIDA-IDD), Medicaid Advantage Plus (MAP) and the Program of All-Inclusive Care for the Elderly (PACE). Enrollees will have the ability to enroll into an integrated plan at any time, and the integrated plans do not have a lock-in period. Mainstream plans for those without Medicare already had a lock-in restriction. Lock-in does not apply to dual eligible enrollees age 18 to 20, or non-dual eligible enrollees age 18 and older. See more about MAP in this article..

GOOD CAUSE - EXCEPTION TO LOCK-IN --After the initial 90-day grace period, enrollees will have the ability to disenroll or transfer if NY Medicaid Choice determines they have good cause. **G**ood cause includes the following - see **DOH MLTC Policy 21.04** for more detail.

- the enrollee is moving from the plan's service area - see more detail in **DOH MLTC Policy 21.04** about the process.
- it is determined the member did not consent to the enrollment
- The plan has failed to furnish accessible and appropriate medical care, services, or supplies to which the enrollee is entitled as per the plan of care
- Current home care provider does not have a contract with the enrollee's plan (i.e. home care agency no longer contracts with plan)
- The plan and enrollee agree that the transfer is appropriate and would be in the best interest of the enrollee.
- The State determines that the plan has failed to meet its contractual obligations with the State and that such failure directly impacts enrollees

Plans will retain the ability to involuntarily disenroll for the reasons specified in their contract, which includes:

- failure to pay spend-down,
- hospitalization for greater than 45 days, or
- the enrollee was absent from the service area for more than 30 consecutive days.

After the completion of the lock-in period, an enrollee may transfer without cause, but is subject to a grace period and subsequent lock-in as of the first day of enrollment with the new MLTC partial capitation plan.

WARNING ABOUT CHANGING PLANS during 90-day "grace period" or for Good Cause - NO TRANSITION RIGHTS:

Don't sign up for a new plan unless the new plan confirms that it will approve the services you want and the hours you need. You may call any plan and request that they send a nurse to assess you and tell you what services they would provide. You have the right to receive the result of the assessment in writing. When you change plans voluntarily, even if

you have "good cause," you do not have the same right to "continuity of care," also known as "transition rights," that consumers have when they were REQUIRED to enroll in the MLTC plan. See more about transition rights here. This means the new plan may authorize fewer hours of care than you received from the previous plan. While you have the right to appeal this authorization, you do not have the important right of "aid continuing" and other rights under MLTC Policy 16.06 because the plan's action is not considered a "reduction" in services.

- **IF A PLAN CAN ONLY BEGIN SERVICES ON THE 1ST OF ANY MONTH, WHAT DO I DO IF I NEED SERVICES RIGHT AWAY, or WHEN I GET OUT OF THE HOSPITAL OR A REHAB CENTER?**

Use the Immediate Need procedure to request personal care or CDPAP services from the local DSS/HRA, which can be approved within 1-2 weeks. After 120 days of receiving these services, the individual will be required to enroll in an MLTC plan. She will have "transition rights," explained here.

Spend-Down or Surplus Income and MLTC - Special Warnings and Procedures

- **I HAVE A SPEND-DOWN (SURPLUS INCOME). WHAT HAPPENS IF I DON'T PAY IT?** The MLTC plan will bill you for the spend-down. If you don't pay it, the MLTC plan may disenroll you. If you live in NYC or another mandatory county, you will not be able to get Medicaid home care or other long-term care services.

MLTC's may Disenroll Member for Non-payment of Spend-down - The HRA home attendant vendors were prohibited by their contracts from stopping home care services for someone who did not pay their spend-down. Similarly, CHHA's are prohibited by state regulation from stopping services based on non-payment. FN 4. MLTC programs, however, are allowed to disenroll a member for non-payment of a spend-down. See model contract p. 15 Article V, Section D. 5(b). While the State's policy of permitting such disenrollment is questionable given that federal law requires only that medical expenses be incurred, and not paid, to meet the spend-down (42 CFR 435.831(d)), the State's policy and contracts now allow this disenrollment.

SPEND-DOWN TIP 1 --For this reason, enrollment in pooled or individual supplemental needs trusts is more important than ever to eliminate the spend-down and enable the enrollee to pay their living expenses with income deposited into the trust. For more information about pooled trusts see http://wnylc.com/health/entry/6/.

SPEND-DOWN TIP 2 - for new applicants who will have a Spend-Down - Request *Provisional Medicaid Coverage* -- When someone applies for Medicaid and is determined to have a spend-down or "excess income," Medicaid coverage does not become effective until they submit medical bills that meet the spend-down, according to complicated rules explained here and on the State's website. Many people applying for Medicaid to pay for

long-term care services can't activate their Medicaid coverage until they actually begin receiving the services, because they don't have enough other medical bills that meet their spend-down. This creates a catch-22, because they cannot start receiving MLTC services until Medicaid is activated. If they apply and are determined eligible for Medicaid with a spend-down, but do not submit bills that meet their spend-down, the Medicaid computer is coded to show they are not eligible. As a result, an MLTC plan could refuse to enroll them -- because they do not have active Medicaid. To address this problem, HRA recently created a new eligibility code for "provisional" Medicaid coverage for people in this situation. This is explained in this Medicaid Alert dated July 12, 2012. Applicants who expect to have a spend-down should attach a copy of this Alert to their application and advocate to make sure that their case is properly coded.

- A Medicaid Recipient who submits medical bills from a Provider to meet the spenddown will receive an OHIP-3183 "Provider/Recipient Letter" indicating which medical expenses are the responsibility of the Recipient (and which the Provider should not bill to Medicaid). When the Recipient is enrolled with an MLTC, the Recipient and the MLTC will receive an OHIP-0128 "MLTC/Recipient Letter" indicating the amount that the Recipient owes to the MLTC (after deducting the medical expenses/bills from the spenddown). See this Medicaid Alert for the forms.

The Housing Disregard - Higher Income Allowed for Nursing Home or Adult Home Residents to Leave the Nursing Home by Enrolling in MLTC

See this article

For the latest on implementation of MLTC in 2013 see these news articles:

- **MLTC Roll-Out - Expansion to Nassau, Suffolk & Westchester / and to CHHA, Adult Day Care and Private Duty Nursing in NYC (update 1/25/13 - more details about transition to MLTC)**

â History: Roll-Out Schedule in NYS from 2013 - 2015

PHASE 1 - Sept. 2012 in New York City adult dual eligibles receiving Medicaid personal care (home attendant and housekeeping) were "passively enrolled" into MLTC plans, if they did not select one on their own after receiving "60-day letters" from New York Medicaid Choice, giving them 60 days to select a plan.
See enrollment information below. Over the end of 2012 and through mid-2013, NYC recipients of CDPAP, CHHA, adult day care, Lombardi, and private duty nursing services begin receiving 60-day enrollment letters to select an MLTC plan in 60 days. See enrollment information below.

See HRA Alert. and DOH Directive Approved Long Term Home Health Care Program (LTHHCP) 1915 (c) Medicaid Waiver Amendment

August 2013 - THose individuals needing solely housekeeping services (Personal Care Level I), who were initially required to join MLTC plans, are no longer eligible for MLTC. New applicants may again apply at the local DSS and those already receiving MLTC are transitioned back to DSS. See MLTC Poliucy 13.21

Phase II WHERE: Nassau, Suffolk, and Westchester counties

WHO: Dual eligibles age 21+ who need certain community-based long-term care services > 120 days newly applying for certain community-based Medicaid long-term care services.

WHICH SERVICES: Medicaid personal care, CDPAP, Medicaid adult day care, long-term certified home health agency (CHHA), or private duty nursing services, and starting in May 2013, Long Term Home Health Care Waiver Program (LTHHCP) or ("Lombardi") **participants,** must enroll in these plans. Those already receiving these services begin receiving "Announcement" and then "60-day letters" from New York Medicaid Choice, giving them 60 days to select a plan. See enrollment information below.

See Approved Long Term Home Health Care Program (LTHHCP) 1915 (c) Medicaid Waiver Amendment

Also in Jan. 2013, for **New York City** -- mandatory enrollment expands beyond personal care to adult dual eligibles receiving medical m**odel adult day care, private duty nursing**, or **certified home health agency (CHHA)** services for more than 120 days, and in May 2013, to Lombardi program.. These individuals begin receiving "announcement" and then 60-day enrollment notices.. described below.

Phase III (September 2013) (Postponed from June 2013): **Rockland and Orange** counties - "front door" closed at local DSS offices Sept. 23, 2013 - after that Medicaid recipients must enroll directly with MLTC plan to obtain home care.

Phase IV (December 2013): **Albany, Erie, Onondaga and Monroe** counties - See below explaining timeline for receiving letters and getting 60-days to enroll.

Phase V (2014) Roll-out schedule for mandatory MLTC enrollment in upstate counties during 2014, subject to approval by CMS. , **Source: NYS DOH** Updated 2014-2015 MLTC Transition Timeline (PDF, 88KB) (MRT e-mails) NYS DOH Policy & PLanning Updates January 2015 and February 2015

Month	New Schedule	"MLTC Announcement" letter sent	60-day "Choice" letters sent	"Front door" closed - no new Personal Care applications at local Medicaid office

9/2012 - 12/2013	NYC, Albany, Erie, Monroe, Nassau, Onondaga, Orange, Rockland, Suffolk, Westchester			
Jan 2014	Columbia, Putnam, Sullivan, Ulster	April 2014	early May 2014	May __ 2014
June 2014	Cayuga, Herkimer, Oneida, and Rensselaer	Week of May 23, 2014	week of June 2, 2014	May 30th
July 2014	Greene, Saratoga, Schenectady, and Washington	Week of June 30th	Week of July 14	July 7, 2014
August 2014	Dutchess, Montgomery, Broome, Fulton, Schoharie	Week of Aug. 29th	Week of Sept. 22nd	September 8, 2014
September 2014	Delaware, Warren	Sept. 15th	Oct. 1st	Sept. 22nd
October 2014	Niagara, Madison, Oswego	Week of Oct. 27, 2014		Oct. 20th
November 2014	Chenango, Cortland, Livingston, Ontario, Steuben, Tioga, Tompkins, Wayne	November 2014?		
December 2014	Genesee, Orleans, Otsego, Wyoming	Week of December 29, 2014		Jan. 5, 2015
January 2015	Chautauqua, Chemung, Seneca, Schuyler, Yates, Allegany, Cattaraugus			
February 2015	Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence			February 2015
July 2015	Allegany, Clinton, Franklin, Jefferson, Lewis, and St. Lawrence.			July 3, 2015

For more information please see:

- Applying for Medicaid Personal Care Services in New York City - BIG CHANGES SEPTEMBER 2012 - explains new procedures in NYC
- **Appeals & Grievances in Managed Long Term Care**
- **Tools for Choosing a Medicaid Managed Long Term Care Plan**

- **New York Medicaid Choice (Maximus) Website - this is State Enrollment Broker - under contract with NYS to handle all mandatory enrollment into MLTC and in Mainstream Medicaid managed care**
- **Long Term Care Community Coalition MLTC page including Transition To Mandatory Managed Long Term Care: The Need for Increased State Oversight - Brief for Policy Makers.**

Consumer Concerns on Mandatory Enrollment in Managed Long Term Care

- **2020-2022 - See this link for comments on the MRT2 CHANGES - Independent Assessor, ADL minimum requirements, lookback, etc.**
- **In August 2012,** a letter was sent from The Legal Aid Society, Empire Justice Center, NYLAG, CIDNY, and other consumer, disability rights and community-based organizations asking for further protections in rolling out MLTC. Consumers ask that MLTC be rolled out more gradually, so that it starts with new applicants seeking home care only, rather the tens of thousands of people already receiving personal care/home attendant services. Consumers also express concerns about appeal rights being limited if and when MLTC plans reduce services compared to what the individual previously received from the Medicaid program. See the letter for other issues.
- In March 2012, consumer advocacy organizations proposed **Incentives for Community-Based Services and Supports in Medicaid Managed Long TermCare: Consumer Advocate Recommendations for New York State.**
- On December 27, 2011, Legal Aid Society, New York Lawyers for the Public Interest, and many other organizations expressed concerns to CMS in this letter. These concerns include violations of due process in fair hearing appeals.
- On May 2, 2011, Selfhelp Community Services led numerous organizations in submitting these comments, explaining numerous concerns about the expansion of MLTC
- **The Long Term Care Community Coalition published** Transition To Mandatory Managed Long Term Care: The Need for Increased State Oversight - Brief for Policy Makers. and other information on its MLTC website.
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Consumer Advocates Call for Further Protections in Medicaid Managed Long Term Care

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