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

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Acronyms -Vocabulary
Dual Eligible = Someone who has Medicare & Medicaid

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

Managed Care Concepts – in Dual Eligible plans
• Full Capitation – Rate covers all Medicare & Medicaid services (PACE & Medicaid Advantage Plus)
• Partial Capitation – Rate covers only certain Medicaid services – MLTC package of long term care services
More Acronyms!

**TYPES OF SERVICES**
- CBLTC - Community-Based Long-Term Care services
- LTC – Long Term Care generally
- PCS or PCA – Personal care services – Personal Care Aide
- CDPAP or CDPAS – Consumer Directed Personal Assistance Program
- CHHA – Certified Home Health Agency
- ADHC – Adult Day Health Care (medical model)
  - SAD or SADC – Social Adult Day Care
- PDN – Private Duty Nursing

**“Waiver” programs** – Home & Community Based Services (HCBS)
- Lombardi – Long Term Home Health Care Program
- TBI – Traumatic Brain Injury waiver
- NHTDW – Nursing Home Transition & Diversion Waiver
- OPWDD – Office of Persons with Developmental Disabilities Waiver

### 4 big changes – Managed care & LTC

<table>
<thead>
<tr>
<th>Change</th>
<th>Description</th>
<th>Federal Approval</th>
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<tbody>
<tr>
<td>MLTC – Managed Long Term Care</td>
<td><strong>Dual eligibles</strong> access to most home care services is solely through an MLTC, PACE or Medicaid Advantage Plus plan in NYC &amp; 9 other counties</td>
<td>CMS approved 1115 Waiver expansion 9/2012, rolling out 2013-14</td>
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<tr>
<td>Nursing home care “carved into” managed care package</td>
<td>Both <strong>Dual eligibles in MLTC plans and non-duals in Mainstream</strong> Medicaid managed care plans must access nursing home care through plan, rather than fee for service.</td>
<td>CMS approval pending for 2014-15 roll-out</td>
</tr>
<tr>
<td>Mainstream managed care – carve-in PCS, CDPAP, PDN</td>
<td><strong>Non-dual eligibles</strong> in mainstream Medicaid managed care must get personal care, CDPAP, private duty nursing thru MC plans</td>
<td>CMS approved for PCS/CDPAP eff 8/2011, nursing home will start 10/2014</td>
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<tr>
<td>FIDA – Fully Integrated Dual Advantage</td>
<td><strong>Dual Eligible MLTC</strong> members in NYC, Long Island &amp; Westchester will be “passively enrolled” into FULL CAPITA-TION FIDA managed care plans that control all Medicare &amp; Medicaid services</td>
<td>11/13 CMS reached “Memorandum of Understanding” with SDOH. CMS now doing “Readiness review” of 25 FIDA plans.</td>
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### BASICS: THE TYPES OF MANAGED CARE PLANS IN MEDICAID AND MEDICARE

<table>
<thead>
<tr>
<th></th>
<th>Fee for Service</th>
<th>Managed Care</th>
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<tbody>
<tr>
<td>Who does provider bill?</td>
<td>Bills Medicare or Medicaid directly</td>
<td>Bills the managed care plan, which in turn is paid a monthly capitation rate from Medicare or Medicaid</td>
</tr>
<tr>
<td>How Medicare or other payor pays</td>
<td>Pays each provider fee for each service rendered</td>
<td>Pays flat monthly fee (capitation) to insurance plan</td>
</tr>
<tr>
<td>Providers available</td>
<td>Any provider who accepts the insurance (e.g. Medicare)</td>
<td>Only providers in the insurance plan’s network</td>
</tr>
<tr>
<td>Permission needed for services?</td>
<td>Sometimes. In Medicaid, need approval for personal care, CDPAP, etc. but not for all medical care.</td>
<td>Often. Plan may require authorization to see specialists, or for many services. May not go out of network.</td>
</tr>
<tr>
<td>Policy – incentive to give too much/too little care?</td>
<td>Incentive to bill for unnecessary care. But offset when authorization needed for services like Medicaid personal care.</td>
<td>Plan has incentive to DENY services, and keep part of capitation rate for profit.</td>
</tr>
<tr>
<td>Which services available?</td>
<td>All services covered by payor/insurance. Original Medicare = all Medicare services.</td>
<td>Package of services may be “partial” (MLTC) or full (PACE = all Medicare &amp; Medicaid services).</td>
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</table>
Managed care in Medicare & Medicaid

<table>
<thead>
<tr>
<th>Service package</th>
<th>Fee For Service Model</th>
<th>Managed Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid services</td>
<td>Regular Medicaid</td>
<td>1. Mainstream Medicaid Managed Care – ONLY for non-dual eligibles (mostly families,</td>
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<td></td>
<td></td>
<td>kids but also SSI-only).</td>
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<tr>
<td></td>
<td></td>
<td>2. MLTC – for dual eligibles who need long term care. Covers LTC only (partial</td>
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<tr>
<td></td>
<td></td>
<td>capitation). Use Medicare card separately.</td>
</tr>
<tr>
<td>Medicare services</td>
<td>Use 2 cards:</td>
<td>1. Medicaid Advantage plan (enrollment is voluntary)* - usually includes Part D</td>
</tr>
<tr>
<td></td>
<td>1. Original Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Part D plan</td>
<td></td>
</tr>
<tr>
<td>Both Medicaid AND</td>
<td>Use 3 cards:</td>
<td>Use ONE card - EITHER</td>
</tr>
<tr>
<td>Medicare Services</td>
<td>1. Original Medicare</td>
<td>1. Medicaid Advantage</td>
</tr>
<tr>
<td></td>
<td>3. Part D plan</td>
<td>3. PACE, OR</td>
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<td>4. Coming in 2014 - FIDA</td>
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* 30% of NYS Medicare ben’ies are in these plans. Attractive because cheaper than paying a Medigap premium, control other out-of-pocket costs. Tradeoff is must be in-network and get plan approvals.

2 Models for Medicaid Long Term Care: Full or Partial Capitation

1. If client wants to keep all of her current doctors, hospitals, clinics, etc., then choose **Partial Capitation – MLTC**
   - Most primary and acute medical care is not in the MLTC service package, so client keeps her regular Medicare card (or Medicare Advantage plan) for all Medicare primary/acute care.

2. **FULL CAPITATION – PACE or Medicaid Advantage Plus (MAP)**
   - Plan controls all Medicare as well as Medicaid services. Must be in-network for all services. Plan may require approval of many Medicare services.
   - **PACE vs. Medicaid Advantage Plus (MAP):**
     - **PACE** provides services through a particular site – a medical clinic or hospital. Because all providers are linked, potentially more opportunity for coordinated care.
     - **MAP** is a traditional insurance model - Insurance plan contracts with various providers to provide care. **CAUTION:** Medicaid Advantage Plus (MAP) is not the same as Medicaid Advantage (MA). Both include all Medicare services PLUS
     - MAP = Medicaid with long term care.
     - MA - Medicaid without LTC. If client needs home care – must join MAP or MLTC.
Managed Long Term Care (MLTC) Benefit Package
ALL are Medicaid services – No Medicare

- 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

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

How NYS Dual Eligibles Access LTC, Other Medicare/Medicaid Services

<table>
<thead>
<tr>
<th>Which county?</th>
<th>How access personal care, CDPAP, CHHA, Adult Day care</th>
<th>How access primary medical care, acute hospital stays, lab, xrays, all other medical</th>
</tr>
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<tbody>
<tr>
<td>Mandatory MLTC counties:</td>
<td>If needs personal care or other CB-LTC services for more than 120 days, must enroll in EITHER: MLTC plan, Medicaid Advantage Plus or PACE plan</td>
<td>If joined MLTC plan, has choice of either: 1. Original Medicare or 2. Medicare Advantage. Plus use Medicaid card for Medicaid services not covered by MLTC.</td>
</tr>
<tr>
<td>NYC, Long Island, Westchester, Orange, Rockland, Albany, Erie, Onondoga, Monroe</td>
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<tr>
<td>Rest of State</td>
<td>• PCS, CDPAP through Local DSS. • Private duty nursing through State DOH. • Adult day care directly through provider</td>
<td>MEDICARE – has choice of 1. Original Medicare or 2. Medicare Advantage. MEDICAID – regular card</td>
</tr>
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BACKGROUNDER –
What is “Mainstream” Medicaid Managed Care (MMC)?

For 20 years NYS has had mandatory enrollment of most Medicaid recipients in Medicaid HMOs – called “mainstream” Medicaid managed care (MMC) plans. Only this year is this now in every county in NYS.

• Now 3.48 million New Yorkers enrolled – 12/2013 – 10% of these are SSI recipients – Aged/Disabled but without Medicare

• Those in elder law biz not familiar with it because many of our clients were EXCLUDED from MMC – including
  • All Dual Eligibles – anyone with Medicare.
  • All people with a Spend-down/ surplus
  • SSI recipients without Medicare USED to be excluded but have been required to enroll since 2011 – now 10% of all MMC population.
  • Most other exemptions eliminated since 2011 (MR/DD, chronic health conditions, mentally ill, AIDS/HIV, Lombardi)

“Mainstream” managed care [MMC] and LTC

• Until 8/2011, the only LTC service covered by Mainstream managed care plans were short-term Certified Home Health Agency (CHHA)(visiting nurse, PT/OT & home health aide). Members obtained personal care/ CDPAP/ or Lombardi through their local DSS/CASA outside of the MMC plan.

• Since 8/2011, Personal Care, CDPAP, and Private Duty Nursing must be accessed through MMC plans, using in-network providers.

• Nursing home care - Until now, mainstream MMC plans covered only up to 60 days of nursing home care – once in permanent placement status, one was disenrolled from plan and had regular institutional Medicaid.

• Current MMC members who need long-term nursing home placement after 3/1/14 in NYC, Long Island & Westchester (and after 9/1/14 elsewhere) will no longer be disenrolled from the MMC plan. They must select a NH in the MMC plan’s network, and plan must pay for the care.

• If someone enters a NH after 3/1/14 (9/1/14 upstate) and not in a plan, will have 60 days to pick a plan, or will be assigned to plan with that NH in network.

DOH Powerpoint on NH transition
Mainstream managed care – Problem when “Ages into” Medicare at 65

• If someone who did not have Medicare was in a mainstream Medicaid managed care plan, s/he will be disenrolled automatically when she obtains Medicare – either by reaching 65 or because of disability.
• If that person received personal care or other LTC through the MMC plan, disruption of services is likely.
• Advocates demanded a seamless transition – whether back to DSS/CASA or, in mandatory MLTC areas, to MLTC plans. There are still problems, but the temporary procedure is for the MMC plan to refer the case back to LDSS which should start services. See DOH Personal Care Guidelines for Managed Care Plans* 5/31/13 (Referral forms are last 4 pages). You must be proactive in contacting MMC plan and demanding that they refer case, and contacting LDSS to accept case. Contact NYLAG if problems. In several cases, DOH has simply assigned person to MLTC plan – violating their right to choose a plan, but at least ensuring continuity of the aide.

Managed Care for Dual Eligibles - Nutshell

<table>
<thead>
<tr>
<th>What</th>
<th>• Mandatory Managed Long Term Care (MLTC)</th>
<th>• FIDA – Fully Integrated Dual Advantage</th>
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<tbody>
<tr>
<td>Who</td>
<td>• Dual eligibles &gt; age 21 who need Medicaid long-term care (&gt; 120 days)</td>
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<tr>
<td>FIDA: Where?</td>
<td>• NYC, Nassau, Suffolk, and Westchester only</td>
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<tr>
<td>FIDA: When?</td>
<td>• MLTC members &amp; applicants in the community –</td>
<td>• Nursing home residents –</td>
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<tr>
<td>WHY?</td>
<td>• Coordinate care</td>
<td>• Government wants to save money, transfer risk to insurance plans</td>
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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

Which Dual Eligibles Must join MLTC plans?

TWO FACTORS control whether they must join MLTC.

1. WHERE DO THEY LIVE?
   MLTC is mandatory for some adult Dual Eligibles in NYC, Long Island, Westchester, Orange, Rockland, Albany, Erie, Onondoga, Monroe. In other counties, NOT required to enroll in MLTC YET – but State says it will be statewide by end of 2014!!!! Meantime, apply for home care as before.

2. Does client need Community-Based Long-Term Care > 120 days? Includes personal care/ CDPAP/CHHA/adult day care, private duty nursing. If so and if lives in mandatory county MUST enroll in MLTC.
   - DUALS living in mandatory counties WHO DO NOT NEED HOME CARE DO NOT HAVE TO JOIN ANY MLTC PLAN! They apply for Medicaid as always and get a regular Medicaid card, to supplement their original Medicare or Medicare Advantage plan, and to receive “Extra Help” to subsidize their Part D plan.
   - Some exceptions – see below.
Who may but does not have to join MLTC?
(they are exempt from MLTC)

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

Who is EXCLUDED from MLTC?

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

*All DOH guidance at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
Lombardi recipients must enroll in MLTC

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

Who may not join MLTC (cont’d)

**Clients who only need Housekeeping or Social Adult Day Care**

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

* See MLTC Policy 13.21 posted on [http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm)
Coming in 2014 – Nursing home residents must enroll in MLTC in mandatory counties

- Nursing home (NH) residents may arrange to LEAVE a nursing home and enroll in an MLTC plan effective on their date of discharge (see more below). But permanent NH residents have not, until now, generally been required to enroll in MLTC plans.
- In NYS’ move to “managed care for all,” all adult Medicaid recipients over age 21 in NHs or permanently entering nursing homes will be required to enroll in MLTC (dual eligible) or in main-stream Medicaid managed care plan (those without Medicare)
- Only if CMS approval received (not given yet as of Jan. 10th), this transition begins March 1, 2014:
  - NYC, Nassau, Suffolk and Westchester counties – 3/1/14 – begins with 6-month voluntary enrollment period, followed by auto-assignment to plans beginning 9/1/2014
  - September 1, 2014 – 6-month voluntary enrollment begins in rest of state

More on Nursing Homes being “carved into” MLTC/ mainstream Medicaid Managed Care

- CONTINUITY GUARANTEED – NO ONE WILL BE FORCED TO MOVE - People already in nursing homes as permanent residents on 3/1/2014 are grandfathered in – don’t have to enroll in MLTC or mainstream MMC plan - can stay in their nursing home with Medicaid paying as before.
- Nursing home care will be carved into the mainstream MMC benefit package AND people in nursing homes will be required to enroll.
- Nursing home care was ALREADY part of the MLTC benefit package. But MTLC plans were disenrolling members who needed NH care. This will stop because new NH residents after 3/1/14 must join an MLTC plan.
- Transfer Penalties – and 5-year lookback still applies -.
- New nursing home residents who become permanently placed after 3/1/14 will have 60 days to select an MMC or MLTC plan or be auto-assigned to the plan that contracts with their NH
- Complicated issues re payment, division of care mgmt between plan and NH (ie who decides if need to be hospitalized?)
Nursing Homes in MLTC/Managed Care plans – Network Requirements

How many nursing homes must be in the plan’s network?

- 8 – Nassau, Suffolk, Westchester, Monroe, Erie
  NYC – Queens, Bronx, Brooklyn only
- 5 – Manhattan, Staten Island
- 4 - Oneida, Dutchess, Onondaga, Albany
- 3 - Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster
- 2 - All other counties (or 1 if only one NH in county)
- 2 – Specialty NHs (AIDS/ vent) unless county has less, may change plans for preferred NH

WHEN MLTC COMES TO YOUR COUNTY

How does Mandatory Enrollment work?
How to select a plan?
What are members’ rights?
Counties new to MLTC – What happens?

12/2013 – Albany, Erie, Onondaga and Monroe became mandatory, following Rockland and Orange in 9/13. More counties coming in 2014!

• “Front door” at DSS closes to new applicants for PCS/CDPAP/Lombardi
  Must first apply for and be approved for MEDICAID, then enroll in MLTC plan.
• TWO NOTICES to people already receiving PCS, CDPAP, CHHA, Adult Day
  Health Care (medical model), Lombardi & Private-Duty Nursing :
    1. “Announcement” notice* from State DOH giving heads up about MLTC.
    2. “60-day Choice” letter** sent by NY Medicaid Choice 2-4 weeks later
      (January 2014 in 4 new counties) giving 60 days to pick a plan. Letter
      includes list of local plans and state brochure on MLTC. Download list and
      brochure at http://nymedicaidchoice.com/program-materials

• AUTO-ASSIGNED randomly to an MLTC plan if you don’t select and enroll in one within the 60-day choice period.

*Sample at http://www.health.ny.gov/health_care/medicaid/redesign/docs/1_1-am_notice-english_unenrolled.pdf
** http://www.wnylc.com/health/download/318/


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Choosing a Plan:
(1) Choose Model: Full or Partial Capitation

1. If client wants to keep all of her current doctors, hospitals, clinics, etc., then choose Partial Capitation – MLTC
   • Most primary and acute medical care is not in the MLTC service package, so client keeps her regular Medicare card (or Medicare Advantage plan) for all Medicare primary/acute care.

2. FULL CAPITATION – PACE or Medicaid Advantage Plus (MAP)
   • Plan controls all Medicare as well as Medicaid services. Must be in-network for all services. Plan may require approval of many Medicare services.
   • PACE vs. Medicaid Advantage Plus (MAP):
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       • MAP = Medicaid with long term care.
       • MA - Medicaid without LTC. If client needs home care – must join MAP or MLTC.
Enrollment: The basics

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

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**
  - Generally, if you switch plans by the 20th of the month, the enrollment in the new plan will take effect the first of the next month.
  - No mid-month pick-up dates
  - However, contract appears to give plans ability to drag out disenrollment until first of the second month.
  - **Should be no gap in services!**
- **Disenrollment** – Plan may disenroll for not paying spend-down! Also other reasons. Have right to fair hearing.
Choosing a Plan (2) Continuity of care – will plan continue existing services and providers?

- Clients most concerned about
  - Keeping their familiar aides and other providers
  - Keeping the same amount of care and services they had
- KEEPING SAME MEDICAL PROVIDERS – CONTINUITY OF CARE
  - If in an MLTC plan and not PACE or MAP, this is not an issue except for dentists, podiatrists, audiologists and optometrists.
  - Continuity of aide – see next slide.
- KEEPING SAME AMOUNT OF SERVICES – TRANSITION RIGHTS
  - DOH POLICY 13-10* May 8, 2013 requires plans to continue previous level of services for 90 days or until the plan’s new assessment whichever is LATER. This was increased from 60 days.
  - During the 90-day period, Plan assesses needs and proposes a new care plan, which could involve a REDUCTION in hours or services – see appeal rights later.

Choosing a Plan (2) Continuity of Care – Keeping Aide con’d

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


Link posted http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm/
Choosing a Plan (3) Ask Plan to Assess Client before enrolling

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

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

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Choosing a Plan (4) – Advocate against illegal denials of adequate hours

- New applicants for home care who have Medicaid, or recipients of home care now required to transition to MLTC, must contact MLTC plans individually, or be referred to one by NY Medicaid Choice.
- The PLANS, not HRA/DSS or another entity, decide if eligible for home care (needs LTC > 120 days, capable of remaining in the home without jeopardy to health/safety, has someone to “direct” care if not self-directing)
- Plan has incentive to avoid enrolling clients who need a lot of care or who are complicated (dementia & other mental impairments). But they don’t formally deny care – they use pretexts to discourage enrollment. Common pretexts --
  - You need family to cover night-time care
  - We can’t give 24-hour care / our budget doesn’t allow.
  - You aren’t safe at home.
  - You need family to be a “backup” i.e. supplement care
  - We’re not right plan for you.
State tackles plan behavior in turning away high need people

- Advocates brought this problem to DOH attention, as reported in New York Times on May 1, 2013.
- On May 8, 2013, DOH released MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care* which attempts to bar plans from discouraging prospective members from enrolling.
  - “The MLTC plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party.”
- Recourse if denied enrollment – No appeal rights if not yet an enrollee! Client has to shop around to find a plan to accept her – 25 plans in NYC alone! But – technically plan should notify Maximus (NY Medicaid Choice) if denying enrollment.
- BACK-UP AGREEMENTS --Policy 13.10 says plan cannot obligate informal caregiver to provide backup assistance.

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

- Before end of 90-day period, Plan must send client a written notice of new care plan to take effect on Day 91 (or later). That plan of care may reduce services below what the DSS/ CASA/ CHHA/Lombardi program had authorized previously.
  - Notice to client must explain appeal rights. Client has right to “Aid Continuing” if challenges reduction in plan’s 1st authorization after the transition period. DOH Policy 13.10
  - “Aid Continuing” is the right to receive services in the same amount as PREVIOUSLY authorized while a hearing is held and decided about a PROPOSED reduction in services.
- NEW – MUST EXHAUST INTERNAL APPEAL – In MLTC, client must first request an Internal Appeal within the Plan. Only if she loses that may she request a state fair Hearing.

posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
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 definitions for live-in and 24-hour split-shift. See [GIS 12 MA/026](#).
- All managed care plans must make services available to the same extent they are available to recipients of fee-for-service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a) (4)(i). The NYS DOH Model Contract for MLTC Plans also states: “Managed care organizations may not define covered services more restrictively than the Medicaid Program.”

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

- MLTC plans must follow rules established re Medicaid personal care in NYS, e.g.,
  - can’t use task-based-assessment when client has 24-hour needs (“Mayer-III”) 18 NYCRR 505.14(b)(5)(v)(d)
  - 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)
  - Cannot terminate services when hospitalized or in rehab, *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996))
  - Cannot reduce services without justification. *Mayer v Wing*

Special Problems of New Applicants for Medicaid and Home Care in NYC & Mandatory MLTC Counties

1. Spend-down complicates Enrollment/ Spousal Impoverishment can relieve problem
2. Difficulties Applying for MLTC from a Rehab or Nursing Home Stay

New Applicants for Home Care in Mandatory MLTC Counties – Medicaid enrollment delays

• In mandatory counties – All new applicants age 21+ who need home care must first apply for Medicaid at local DSS. Once approved for Medicaid, they are redirected to enroll in MLTC plan.
• MLTC plans can’t give services Medicaid-pending.
• In NYC and other mandatory counties, there have been huge delays because of systems problems and poor procedures for activating Medicaid – especially for applicants who will have a Spend-down.

How do you apply for Medicaid and home care – problems with Spend-down

- MLTC plan cannot enroll until applicant is approved for Community Medicaid w/CBLTC coverage AND Medicaid is active.
- If Medicaid not approved until after the 20th, it is too late to enroll for the 1st of the next month. Enrollment will be delayed a full extra month.
- Some MLTC plans will submit the Medicaid application for a prospective enrollee, as a marketing service, gambling that that individual will ultimately enroll in their plan.
- CAUTION: Not all plans understand the Medicaid rules and procedures. First develop a relationship with a plan to see if you can trust them to file the application properly. Best if YOU prepare the application and all documents to give the plan OR file it yourself.
- Complications arise for Applicants with a Spend-Down.
- When DSS approves Medicaid application with a spend-down, Medicaid is not ACTIVE until client MEETS the spend-down with paid or incurred bills.

** See HRA MICSA Alert 9/6/12 and related info at [http://wnylc.com/health/entry/176/](http://wnylc.com/health/entry/176/)

ALERT: Applicants with a Spend-down

- DSS may CODE applications with a spend-down as “DENIED” or “INACTIVE” – leading MLTC plan to DENY enrollment. This is partly the result of antiquated “WMS” Medicaid computer systems that don’t show the nuance that applicant approved with a spend-down but has not met it yet.
- TIP: Request DSS to use “Code 06” which approves Medicaid PROVISIONALLY. Should NOT have to “Pay In” Spend-down!!.
Spousal Impoverishment Protections – Strategy for Eliminating Spend-down

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

• MARV is in MLTC. His income is $2000/month. His wife DORIS is not on Medicaid. Her income is $1273. Before, he had to use a pooled trust for his excess income over $820, and she had to do a spousal refusal.
• Now, DORIS may keep their combined income up to $2931.
• MARV may keep $381/month as his personal needs allowance. Total allowed combined is $3312. They may keep ALL INCOME without any spend-down or spousal refusal.
• ASSETS: Marv may have $14,550. Doris may have $74,820

Spousal Impoverishment - Choices

Married applicants have a choice of budgeting:

1. Spousal Impoverishment budgeting – as in previous slide
   1. Use this where Applicant’s income is above $829. If both spouses’ combined income is under $3312, applicant will have no spend-down and will not need spousal refusal. MAY NOT use pooled trust with this model
   2. ASSETS – may use Spousal Impoverishment limits

2. OR Budget applicant as if s/he were Single, and ignore spouse’s income.
   1. Use this where Applicant’s income is under $829 – regardless of amount of spouse’s income, or
   2. If non-applying spouse’s income is more than CSMIA allowance ($2,931) – this choice is probably better, because spouse’s income is ignored. S/he will not have to do a spousal refusal. Applicant may have a spend-down to extent own income exceeds $829. Can use pooled trust if applicant’s income is high.
   3. Must use regular community asset limits – not spousal impoverishment.
Spousal Impoverishment – Post-Eligibility only

- DOH GIS 13/ MA-018 says that the spousal impoverishment rules are used in POST-eligibility budgeting.
- It is unclear whether this means that DSS must initially process an application for a married person WITH a spend-down, causing all of the coding problems described above, and only use spousal protections after the application is approved. Too early to tell.
- Since this is new, and very little direction has been given to local DSS staff, you must advocate for the spousal protections.

How to Enroll in MLTC from a NH

- Because MLTC plans are paid a monthly rate, a consumer cannot enroll in an MLTC plan if they have spent even ONE DAY in the nursing home in the month of enrollment. So – you must work hard to arrange for a plan to assess the client in a nursing home, agree to enroll her, and work with local DSS so that Medicaid code is “converted” from institutional to community Medicaid effective the 1st of the next month. For that to happen, must generally be done well before the end of the preceding month
- HRA Medicaid Alert of Feb. 14, 2013 “MLTC Submissions of Nursing Home Enrollments” explains enrollment in NYC*
  - Alert details what MLTC must submit to HRA Home Care HCSP for manual processing for conversion of codes.
  - Enrollment paperwork* can be submitted up until the last day of the month prior to the enrollment month.

* http://www.wnlylc.com/health/download/439/
Special Income Standard for Housing Expenses for Individuals Discharged from NF to an MLTC Plan

- **MLTC Policy 13.02: MLTC Housing Disregard** -- Medicaid budget uses a Special Income Standard if recipient has a housing expense -- *can reduce/ eliminate spend-down*

- NYS GIS 13 MA/04 -- 2013 - $1003 NYC, $1045 Long Isl, $805 N. Metro (Westch., Orange, Rockland), $368 Central (Onondaga), $408 NE (Albany), $380 Rochester (Monroe)

- To be eligible, must:
  - Be approved for participation in MLTC
  - Have been in a nursing home for at least 30 days
  - Medicaid has made a payment toward the cost of care in nursing home
  - Have a housing expense
  - Not be using spousal impoverishment budgeting
  - Submit MAP-3057 form with enrollment

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Snapshot enrollment growth - MLTC

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MLTC BECOMES FIDA IN 2014

FIDA – Fully Integrated Dual Advantage

WHAT IS FIDA – Fully Integrated Dual Advantage FIDA Demonstration

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

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

WHERE? NYC, Nassau, Suffolk and Westchester only

WHO? Adult dual eligibles – estimated 180,000 - living in the demonstration area who are receiving or applying for either:

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

WHY FIDA? $$

- Feds and State want to **control costs** of dual eligibles. The Affordable Care Act included money for states to develop Dual Demonstration programs. Plans must reduce costs compared to FFS by 1% in Year 1, 1.5% in Year 2 and 3% in Year 3.
- CMS approved NYS as one of 19 state demo’s now being launched.
- Hoped that enhanced “person centered” **care coordination** will both improve outcomes and save money.
- Aims to control perverse financial incentives of FFS Medicaid/Medicare system, such as frequent hospital readmissions, revolving door between hospitals and rehabilitation centers/nursing facilities, FFS incentives to bill for unnecessary care. Providers in plan network will NOT be paid FFS by plan – will be bundled or paid for performance.

PASSIVE ENROLLMENT

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

• 25 plans were approved by the State to be FIDA plans. The federal government is now conducting a “Readiness Review” of these plans to make sure their systems, procedures, and networks are ready. Some plans may drop out. See list in appendix.

• Most of the downstate MLTC plans are becoming FIDA plans, so that FIDA can be considered an MLTC plan with an added benefit package of all Medicare services. See list showing types of plans offered by each insurance company, indicating which will be FIDA plans, posted at http://www.wnylc.com/health/download/429/.

• “Intelligent assignment” – State will use algorithm that will select a plan based on existing plan affiliation and historic provider utilization -- most likely will assign them to the FIDA plan sponsored by their MLTC plan.

• WARNING. While assignment to the FIDA plan linked to their MLTC plan will promote continuity of their home care providers and other MLTC providers (dentist, adult day care program, etc.), the FIDA plan may not contract with all of their MEDICARE providers - physicians, specialists, hospital, physical therapy clinic, etc. So continuity of care is not assured.

Timing of FIDA enrollment -updated 1/16/14

In the demonstration area (NYC, Long Island & Westchester), FIDA was initially being phased in 2 stages – with MLTC members first followed by nursing home residents later. On 1/16/2014 DOH announced both phases will be merged but moved back 6 months. NEW SCHEDULE:

1.WHO – Dually eligible adults over age 21 who are EITHER
   1. Currently MLTC members or newly applying for MLTC living in the community on or after 10/1/2014 OR
   2. Nursing home residents –permanently residing as of 10/1/14 or become new residents after that date

2.WHEN
   • Oct. 1, 2014 – Marketing begins to both above groups – MLTC and nursing home – may enroll on a voluntary basis to be effective Jan. 1, 2015 - BE ALERT for misinformation – plans will tell them MUST enroll in order to keep their aide, etc. but may OPT OUT!!
   • Jan. 1, 2015 –
     • Effective coverage begins for those who voluntarily enrolled since Oct. 1, 2014.
     • Notices to MLTC members that must enroll or opt out by Jan. 1, 2015
     • Passive enrollment/ “intelligent” auto-assignment begins of MLTC members and nursing home residents who did not “opt-out.” They may still disenroll but won’t be effective immediately.
Right to OPT OUT of Demonstration

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

Transition/Continuity of care

1. New enrollees in FIDA will face the loss of access to many physicians, other medical providers, and even prescription drugs. If they were in Original Medicare, they had full access to any Medicare provider. Now they must see only in-network doctors.
   - The FIDA plan will also function as a Part D plan, and may have a more limited formulary than the previous Part D plan.
2. FIDA plans must allow participants to maintain ALL current providers and service levels, including prescription drugs, at the time of enrollment for at least the later of 90 days after enrollment, or until a care assessment has been completed by the FIDA plan.
   - FIDA plan has 60 days to complete an assessment for people who transitioned from MLTC, and 30 days for new applicants who never had MLTC.
3. FIDA plans must allow nursing home residents who were passively enrolled to stay in the same NH for the duration of the demonstration – they cannot make them transfer to a different nursing home. So FIDA plans must contract with ALL nursing homes.
More on continuity of old providers

- NY’s 90-day transition requirement is less than California’s, where plans must allow use of previous:
  - MEDICARE providers and services for 6 months and
  - MEDICAID providers & services for 12 months.
- Advocates asked for longer period... not successful
- DOH announced on January 10th, 2014 that the continuity period for behavioral health care will be more than 90 days – for the duration of the period of care, but this was not clearly defined.

Integrated Appeal Process

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

Ombudsman Program & other Consumer Protections

- **OMBUDSMAN** - Though the state declined federal funding for an Ombudsman program, NYS has committed to including an Ombudsman program to assist and advocate for consumers navigating FIDA.
  - An RFP is supposed to be issued any day. Until that is issued, no details are known.
- **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.
Info on FIDA

• **National resources on CMS Guidance on the Duals Demonstrations**, the demo’s in other States, best practices (enrollment, quality metrics, rate setting etc.)
  www.dualsdemoadvocacy.org (Natl. Senior Citizens Law Center)

• **NYS FIDA website** – includes Memorandum of Understanding between CMS and DOH, FAQ, other guidance –
  Subscribe to state listserv
  http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm
  FAQ, Sept 2013

• **NYS Coalition to Protect the Rights Of New York’s Dually Eligible**
  – includes NYLAG, Medicare Rights Center, Legal Aid Society, Empire Justice Center – check for updates at
  http://www.wnylc.com/health/news/33/

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**Requesting Additional or New Services from MLTC Plans**
Service Authorizations

- **Prior Authorization**
  - 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**
  - 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.

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.
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 never passes the request on to the appropriate personnel, or gives no notice of appeal rights. Must be assertive and file internal appeals

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

Appeals and Grievances
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,
  - delay in approving services, e.g. can’t get dental appointment
  - Transportation delayed in taking to or from MD, day care
  - no response to request for increase in hours
- **Appeals** – Object to AMOUNT or TYPE of service approved,
  - Denial or termination of enrollment for allegedly being “unsafe” at home
  - Denial, reduction or termination of any service.
  - Failure to process or respond to request


Plans must give 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**

NEW: Must Request Internal Appeal First Before Fair Hearing

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

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

Expedited Appeals / Grievances

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

42 CFR § 438.410;
Model Contract, Appendix K, ¶¶ (1)(A) & (B) [pp.103, 106 of PDF]
Aid Continuing for Clients Transitioning from CASA/DSS FFS

- When a plan decides to reduce or discontinue your services, you have the right to continue receiving the prior level of services while awaiting a decision on your appeal.

- Transition Period
  - For changes immediately after the 90-day transition period, plan must provide aid continuing until a decision on the internal appeal, or Fair Hearing if it goes to that stage.

- Post-Transition
  - For all subsequent changes, State says aid continuing only goes through the end of the current authorization period. Advocates disagree – you should request aid continuing and refer cases.

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

Aid Continuing for Non-Transitioning MLTC Recipients

- In addition to the 90-day Transition Period, Plan must continue benefits unchanged 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 original period covered by the original authorization has not expired (NOTE: Advocates disagree about this limitation!) and
  - the enrollee must expressly REQUEST Aid Continuing!

- If enrollee loses internal appeal, but requests fair hearing within 10 days of mailing of notice of decision on internal appeal, plan must continue benefits unchanged pending fair hearing.

42 CFR § 438.420
Reinstating Personal Care at NH Discharge

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

Advocacy Tips:

- If there is no notice or notice is unclear, request a fair hearing with the State immediately and request aid continuing. [http://otda.ny.gov/oah/FHReq.asp](http://otda.ny.gov/oah/FHReq.asp)
  - Plans rarely give proper notice! Always request an *internal appeal* if a plan representative tells you services will be reduced...
- Call the MLTCP and file an internal appeal and a grievance.
- Call NYS Department of Health Complaint Hotline 1-866-712-7197 and cc mltcworkgroup@health.state.ny.us
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
  - [http://www.nymedicaidchoice.com/program-materials](http://www.nymedicaidchoice.com/program-materials) - Scroll down to *Long Term Care plans* - separate lists for NYC, Nassau-Suffolk, and Westchester, with separate list for each of the 3 types of plans - MLTC/MAP/PACE
- **http://tinyurl.com/MLTCguide**

- **NYS Dept. of Health MLTC Complaint Hotline**  1-866-712-7197 and cc mltcworkgroup@health.state.ny.us

- Related online articles on [http://nyhealthaccess.org](http://nyhealthaccess.org):