NEW YORK LEGAL ASSISTANCE GROUP

EVELYN FRANK LEGAL RESOURCES PROGRAM
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MANAGED LONG-TERM CARE UPDATE - TRAINING APPENDIX JUNE 2014

A. Lists of Plans

B. State Policy Directives

C. Press

D. Advocacy on Expansion of MLTC to Require Nursing Home Residents to Enroll

E. SAAM Data – Nursing Home Use by MLTC plans

F. FIDA

2. Draft Notice to Dual Eligibles to Select a FIDA plan – Given 60 Days before Passive Enrollment (Draft by Consumer Coalition in response to State Draft notice – to see all drafts by State and consumers see http://www.wnylc.com/health/entry/196/ 47

Managed Long Term Care Complaint Line 1-866-712-7197

AVAILABLE ONLINE

STATE MLTC POLICIES http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

DOH FIDA website http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

NYHEALTHACCESS.org http://wnylc.com/health/entry/169/ (tools to select a plan)
http://wnylc.com/health/entry/114/ (about MLTC)
http://wnylc.com/health/entry/176/ (new procedures for applying for home care)
http://www.wnylc.com/health/news/41/ - News on MLTC updated monthly
http://www.wnylc.com/health/news/33/ - News about FIDA
http://www.wnylc.com/health/entry/184/ - Grievances & Appeals in MLTC
http://www.wnylc.com/health/entry/196/ - Advocacy on FIDA
http://www.wnylc.com/health/news/39/ - Advocacy on MLTC

NY Medicaid Choice http://nymedicaidchoice.com/program-materials for Contact LISTS of plans by region and BROCHURE on MLTC for consumers. **1-855-886-0570**

New York City – Enrollment in MLTC, MAP and PACE Plans Mar. 2014

MEDICAID ADVANTAGE PLUS	
1. HealthFirst	2,404
2. Elderplan	832
3. HIP of Greater New York	518
4. Guildnet	500
5. VNS Choice Plus	244
6. NYS Catholic Health Plan	86
7. Senior Whole Health	22
8. HHH Choices	0
9. AmeriGroup	7
10. WellCare	0
NYC Total MAP	4,613
MLTC PACE PLANS	
1. ARCHCARE SENIOR LIFE	304
2. COMPREHENSIVE CARE MGMT	3,370
Total MLTC PACE Enrollment	**3,674**
MLTC PARTIAL CAPITATION PLANS	
1. VNS CHOICE	16,520
2. GUILDNET	11,209
3. SENIOR HEALTH PARTNERS INC	10,683
4. ELDERPLAN	10,041
5. ELDERSERVE	9,908
6. CENTERLIGHT	8,956
7. FIDELIS CARE AT HOME	5,664
8. WELLCARE	5,393
9. INDEPENDENCE CARE SYSTEMS	5,009
10. AMERIGROUP/HealthPlus	2,807
11. VILLAGE CARE MAX	2,703
12. HHH CHOICES	2,229
13. AGEWELL NEW YORK (Parker Jewish)	2,060
14. AETNA BETTER HEALTH	1,905
15. ARCHCARE COMMUNITY LIFE	1,412
16. CENTERS PLAN FOR HEALTHY LIVING	1,208
17. HIP OF GREATER NEW YORK	1,000
18. INTEGRA (Personal Touch)	863
19. SENIOR WHOLE HEALTH	781
20. UNITED HEALTHCARE	649
21. METROPLUS	505
22. ALPHACARE (Magellan)	318
23. NORTH SHORE-LIJ HEALTH PLAN	300
24. EXTENDED MLTC	205
25. MONTEFIORE HMO	158
TOTAL NYC MLTC	102,486

Data from
http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Contact information for plans at
http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm and at

http://nymedicaidchoice.com/program-materials (Long Term Care Plans by region)

Mandatory rollout – 8/2012 – NYC. 1/2013 - Nassau, Suffolk, and Westchester, Sept. 2013 - Orange and Rockland
Dec. 2013 -- Erie, Onondoga, Monroe and Albany -- all require MANDATORY enrollment in MLTC plans, with option of choosing MAP or PACE instead, for ADULT (>21) dual eligibles who need Medicaid community-based long term care services.

NOTE MAP and PACE are options but these plans combine Medicare Advantage with MLTC and Medicaid, and would control ALL access to primary and acute care paid for by Medicare AND Medicaid. In order to keep your own doctor and pay with Medicare, join an MLTC plan.

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[1] **BOLD** = Mandatory county as of February 2014. GREY = MAP or PACE plan

Medicaid Managed Long Term Care Plans Offered (Dec. 2013) by Company
MLTC, MAP, PACE & Proposed FIDA plan (Fully Integrated Dual Advantage)
THIS DOCUMENT AVAILABLE AT http://www.wnylc.com/health/download/429/ - check for updates

Company	MLTC PLAN	Medicaid Advantage PLUS	PACE	Medicaid Advantage *** NO HOME CARE!![1]	Main-stream managed care	FIDA Plan	# counties MLTC out-side NYC (not MAP)
PLANS THAT OPERATE IN NYC ONLY -- OR -- in NYC and other counties (list showing plans by county at http://www.wnylc.com/health/download/371/)							
Aetna	1. Aetna Better Health[%]					x	2
Affinity				Affinity*	x		
AgeWell (Parker Jewish)	2. AgeWell New York *					x	3
AlphaCare (Magellan)	3. AlphaCare* **NEW**					x	1
Amerigroup (HealthPlus)	4. HealthPlus/Amerigroup	HealthPlus MAP			x HealthPlus	x	NONE
AmidaCare					X SNP		
Archcare**	5. Archcare Community Life		Archcare Senior Life**			x	2
CenterLight (formerly CCM)	6. CenterLight Select		Center-Light PACE			x	4
Centers Plan for Healthy Living	7. Centers Plan for Health Living MLTC					x	3
Elderplan (HomeFirst)	8. HomeFirst MLTC (ElderPlan)	ElderPlan Plus LTC		ElderPlan Medicaid Advantage (HMO SNP)		x	13
ElderServe	9. ElderServe					x	3
Extended (CHHA)	10. Extended MLTC						2
Fidelis	11. Fidelis Care at Home	Fidelis MAP		Fidelis Dual Advantage NYC	x	x	45
Guildnet	12. Guildnet	Guildnet Gold*		Guildnet Health Advantage HMO-POS SNP		x	3

Company	MLTC PLAN	Medicaid Advantage PLUS	PACE	Medicaid Advantage *** NO HOME CARE!![1]	Main-stream managed care	FIDA Plan	# counties MLTC out-side NYC (not MAP)
HHH Choices	13. HHH Choices Health Pl*	HHH Choices Gold				x	1
EmblemHealth (HIP)	14. HIP/Emblem MLTC	EmblemHealth MLTC PLus		EmblemHealth Medicare Choice Value/ HIP	x	x	3
Independence Care System	15. Independence Care Sys*					x	NONE
Integra (Personal Touch)	16. Integra MLTC					x	3
Liberty Health				Liberty Health Advantage			
Managed Health (see Senior Health Partners				Managed Health			
MetroPlus	17. MetroPlus MLTC*			MetroPlus MA Advantage*	x	x	NONE
Montefiore HMO	18. Montefiore HMO **NEW**					x	1
North Shore-LIJ Health	19. North Shore LIJ **NEW**					x	2
	20.						
Senior Health Partners (Healthfirst/ Managed Health)	21. Senior Health Partners (Healthfirst)	HealthFirst Complete Care		HealthFirst Maximum*/ Managed Health	X Health-first PHSP	x	2
Senior Whole Health	22. Senior Whole Health MLTC*	Senior Whole Health M/M Plus*				x	NONE
Touchstone Health				Touchstone Prestige$			
United Healthcare	23. United Healthcare Personal Assist			United Healthcare Dual Advantage	x	x	8
VillageCare	24. VillageCareMAX*					x	NONE
VNSNY	25. VNSNY Choice	VNSNY Choice Plus		VNSNY TOTAL	X SNP	x	28
Wellcare	26. Wellcare Advocate MLTC	Wellcare Advocate Complete*		Wellcare Liberty MA#	x	x	8

Contact Info for all plans posted at http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

and http://www.nymedicaidchoice.com/program-materials (look under Long Term Care plan headings ONLY)

FIDA plans listed in http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013_09_fida_faq.pdf Q6

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[1] **Warning:** The second to the last column shows **Medicaid Advantage Plans** – which are different than Medicaid Advantage Plus plans. Both offer Medicaid and Medicare services, but the Medicaid services offered by PLUS plans include Medicaid long-term home care, adult day care, etc. are offered. The regular Medicaid Advantage Plans – without the PLUS – do not offer any long-term care. Any dual eligible needing home care or long term care should not join these plans. One cannot enroll in both a Medicaid Advantage and MLTC plan.

Also, many of these companies ALSO offer **Medicare Advantage** Plans, which cover solely Medicare services, and mainstream **Medicaid Managed Care** plans, for Medicaid recipients *without Medicare*. The names may sound alike – be sure to check the type of plan. A Medicaid recipient who needs Medicaid home care MAY join a Medicare Advantage plan for his/her Medicare services. That same person may additionally enroll in an MLTC plan for her Medicaid long-term care services.

Prepared by Valerie Bogart, New York Legal Assistance Group, updated April 21, 2014 vbogart@nylag.org

THIS DOCUMENT AVAILABLE AT http://www.wnylc.com/health/download/429/ - check for updates

PLAN LIST ORGANIZED BY COUNTY http://www.wnylc.com/health/download/371/

G:\Research\homecare\MLTC Managed LTC\Plan Lists\MLTC-MAP-PACE Plan List by Company - NYC april 2014.doc

PROVIDER ID NUMBERS AND PLAN CODES
(That Do Not Cover Permanent RHCF Placement)

Human Resources Administration
Department of Social Services

MAPDR-05 01/16/2014

Medicaid Managed Care Plan	Provider ID	BP	eMedNY Code	Telephone Number	Boroughs	Products MA, CHP, FHP
Affinity Health Plan	00477156	02	82	800-553-8247	All	All
Emblem Health (Formerly Health Insurance Plan of Greater NY [GHI/HIP])	00313979	07	99	800-447-8255		
HealthFirst PHSP, Inc.	01479670	01	SF	866-463-6743		
HealthPlus, an Amerigroup Company	01617894	66	KP	800-950-7679		
Metro-Plus (Metropolitan Health Plus)	00894519	03	92	800-303-9626	All, except SI	
NY State Catholic Health Plan/Fidelis	01751046	66	SP	888-343-3547	All	
United Healthcare Community Plan	01403176	01	MO	800-396-7177		
Wellcare of New York, Inc	01182503	66	WC	800-288-5441	All, except SI	

	Plan Name	Provider ID	eMedNY Code	Telephone Number	Boroughs
HIV Special Needs Plans (SNP) ➔	Amida Care Inc.	02191582	OD	800-556-0689	All
	Metro Plus	02191362	OM	800-303-9626	All, except SI
	VNSNY Choice Select	03420871	VS	866-265-7306	

Medicaid Advantage/Dual Eligible Plans (BP Code = 71)	Provider ID	eMedNY Code	Customer Service	TTY/TDD	Boroughs
Affinity	02802899	YY	866-247-5678	800-662-1220	All
Elderplan, Inc MA	03186129	YJ	718-921-7979	800-662-1220	
Emblem Health (Formerly Health Insurance Plan)	02707899	YC	800-447-9733	877- 208-7920	
Emblem Health Medicare Choice Value (Formerly Group Health Insurance)	02591073	Y4	866 -557-7300	877- 208-7920	
Fidelis Dual Advantage NYC	02738989	YD	800-247-1447	800-695-8544	
Healthfirst Maximum	02594847	Y8	888-260-1010	800-662-1220	All, except SI
Liberty Health Advantage, Inc.	02660144	Y9	866- 542-4269	800- 662-1220	All
MetroPlus MA Advantage	02922750	YM	800-303-9626	800-881-2812	All, except SI
Senior Whole Health of New York Medicaid Advantage	02872888	YR	877-353-0185	711	All, except SI
Touchstone Health (Prestige Plan)	02902761	YT	888-777-0204	888-777-0301	All, except Manhattan
UnitedHealthcare Dual Advantage	03238240	YU	800-514-4912	877-486-2048	All
Wellcare Liberty (Medicaid Advantage Plan)	02645710	YW	800-650-4359	877-247-6272	Brooklyn, Bronx, Queens

MA ADVANTAGE PLUS PLANS

PLAN NAME	PLAN ADDRESS	BOROUGHS	PLAN TEL. NO.	TTY/TDD	PROVIDER ID	eMedNY CODE	BP
Elderplan, Inc	745 64th Street Brooklyn, NY 11220	All	866-386-9437	800-662-1220	03173113	YL	72
Emblem Health (Formerly Health Insurance Plan)	55 Water Street New York, NY 10041	All	800-447-9161	888-447-4833	03239801	ZH	72
Fidelis	95-25 Queens Blvd. Rego Park, NY 11374	All	877-533-2404	800-558-1125	02927631	YF	72
Guildnet Gold, Inc.	15 West 65th Street, 4th Fl New York, NY 10023	All, except Staten Island	800-932-4703	800-662-1220	02942923	YG	72
HealthFirst CompleteCare	100 Church Street New York, NY 10007	All	888-260-1010	888-542-3821	03420808	MH	72
HealthPlus, an Amerigroup Company	241 37th St, 4th Fl. Brooklyn, NY 11232	All	866-805-4589	800-855-2880	03173080	YO	72
Senior Whole Health of New York Medicaid Advantage Plus	450 7th Avenue Suite 1601 New York, NY 10001	All, except Staten Island	877-353-0185	711	02932896	YH	72
VNSNY CHOICE Total	1250 Broadway, 11th Fl. New York, NY 10001	All	866-597-6674	711	02914056	YN	72

PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) PLANS

PLAN NAME	PLAN ADDRESS	BOROUGHS	PLAN TEL. NO.	PROVIDER ID	eMedNY CODE	BP
ArchCare Senior Life	155 E. 56th Street 2nd Fl. New York, NY 10022	Bronx, Manhattan, Staten Island	866-263-9083	03114514	AC	75
Centerlight Healthcare PACE	612 Allerton Avenue Bronx, NY 10457	All	877-226-8500	01234037	C7	75

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MANAGED LONG TERM CARE (MLTC) PARTIAL CAP PLANS

PLAN NAME	PLAN ADDRESS	BOROUGHS	PLAN TEL. NO.	PROVIDER ID	eMedNY CODE	BP
Aetna Better Health	55 West 125th Street, 13th Fl. New York, NY 10027	Brooklyn, Manhattan, Queens	855-456-9126	03458546	AH	66
Agewell	271-11 76th Avenue New Hyde Park, NY 11040	All, except Staten Island	866-586-8044	03481927	AG	66
AlphaCare	335 Adams Street, 26th Fl. Brooklyn, NY 11201	All, except Staten Island	888-770-7815	03560441	AL	66
Archcare Community Life	205 Lexington Avenue New York, NY 10016	All	855-467-9351	03466800	AP	66
Centerlight Healthcare Select	612 Allerton Avenue Bronx, NY 10457	All	877-226-8500	02710185	TF	66
Centers Plan For Healthy Living	75 Vanderbilt Avenue, Suite 600 Staten Island, NY 10304	All	855-270-1600	03506989	CP	66
ElderServe Health Inc.	5901 Palisades Avenue Riverdale, NY 10471	All	800-370-3600	03234044	EH	66
Extended	21 Penn Plaza, Suite 304 New York, NY 10001	All	855-299-6492	03549135	EC	66
Fidelis Care at Home	95-25 Queens Blvd. Rego Park, NY 11374	All	800-688-7422	01788325	GD	66
Guildnet, Inc.	15 West 65th Street, 4th Fl. New York, NY 10023	All	800-932-4703	01827572	GN	66
HealthPlus, an Amerigroup Company	241 37th St, 4th Fl. Brooklyn, NY 11232	All	800-600-4441	02644562	KX	66
HHH Choices Health Plan, LLC (Co-op Care Plan)	2100 Bartow Avenue, Suite 310 Bronx, New York 10475	All, except Staten Island	866-745-8111	01750476	AN	01
HIP/Emblem MLTC	55 Water Street New York, NY 10041	All	888-447-9161	03416231	HP	66
HomeFirst, Inc	6323 Seventh Avenue Brooklyn, NY 11220	All	866-389-2656	03253707	ED	66
Independence Care System	257 Park Avenue South, 2nd Fl. New York, NY 10010	All, except Staten Island	877-427-2525	01865329	IX	66
Integra	2701 Emmons Avenue Brooklyn, NY 11235	All	855-661-0002	03475427	IT	66
MetroPlus	160 Water Street, 3rd Fl. New York, NY 10038	All, except Staten Island	855-355-6582	03466906	MP	66
Montefiore HMO	200 Corporate Boulevard South Yonkers, NY 10701	Bronx	855-556-6683	03594052	MF	66
North Shore LIJ	145 Community Drive Great Neck, NY 11021	All, except Bronx	855-421-3066	03580307	NS	66
Senior Health Partners A Healthfirst Company	100 Church Street, 17th Fl. New York, NY 10007	All	866-585-9280	02104369	H1	66
Senior Whole Health of New York MLTC	450 7th Avenue, Suite 1601 New York, NY 10001	All, except Staten Island	877-353-0185	03459881	SW	66
UnitedHealthcare Personal Assist	77 Water Street, 14th Fl. New York, NY 10005	All	877-512-9354	03439663	UH	66
VillageCareMax	154 Christopher Street New York, NY 10014	All, except Staten Island	800-469-6292	03420399	VL	66
VNSNY CHOICE	1250 Broadway New York, NY 10001	All	888-867-6555	01750467	VC	66
WellCare Advocate	11 West 19th Street, 2nd Fl. New York, NY 10011	All	866-661-1232	02825230	WN	66

Office of Health Insurance Programs

Division of Long Term Care

Managed Long Term Care Policy 13.10: MLTC Policy Guidance – Communication with Recipients Seeking Enrollment and Continuity of Care

Date of Issuance: May 8, 2013

The purpose of this policy is to establish clear expectations for plan communication with Medicaid recipients who either contact a plan directly expressing interest, or who are being transitioned from fee-for-service to Managed Long Term Care (MLTC). The policy will also apply to recipients who approach a plan seeking information on plan to plan transfer.

In dealing with interested parties, plan representatives are permitted to screen out potential enrollment only with regard to establishing residency in the plan's approved service area and/or plan specific age requirements. Medicaid eligibility issues are to be referred to the Local Department of Social Services / Human Resources Administration.

For Medicaid recipients who are in receipt of services and are transitioning to MLTC, plan representatives may inquire about the recipient's current plan of care and service provider only for informational purposes to assist with the required in home assessment process. 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.

Communication is defined as phone inquiries and / or web-based inquiries. At no time should the MLTC utilize such communication as a mechanism to substitute for an assessment.

Within a Mandatory District, any Medicaid recipient that is being transitioned from fee-for-service to MLTC shall be enrolled in their plan of choice, without regard to the recipient's plan of care. The Department has determined that all recipients who are currently in receipt of fee-for-service community based long term care (CBLTC) services are appropriate for transition into MLTC.

Effectively with the release of this policy, each enrollee who is receiving services must continue to receive those services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the Plan, whichever is later. In addition, the recipient / workers relationship shall be preserved for the same 90 days period. This change is the result of an amendment to the Special Terms and Conditions of the State's 1115 Waiver with CMS.

As a reminder, any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's

right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal.

Therefore plans must treat **all** enrollees (age 21 and over eligible for Medicaid and Medicare) in mandatory counties transitioning from fee for service Medicaid in the same manner related to continuity of care and access to aid to continue through the appeal and fair hearing process.

This means that, for any individual receiving fee for service Medicaid community based long term services and supports and enrolling under any circumstance, the plan must provide 90 days of continuity of care. Further, if there is an appeal or fair hearing as a result of any proposed Plan reduction, suspension, denial or termination of previously authorized services, the Plan must comply with the appropriate actions. In particular, if the enrollee requests a State fair hearing to review a Plan adverse determination, aid-to-continue is to be provided until the fair hearing decision is issued.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 14.04: MLTCP Potential Enrollee Assessments

Date of Issuance: May 22, 2014

This policy guidance is intended to clarify the current required potential enrollee assessment process conducted by a Managed Long Term Care Plan (MLTCP) prior to a consumer's actual enrollment.

A Potential Enrollee means a Medicaid recipient who is eligible to enroll in a managed long term care plan, but is not yet an Enrollee of a Managed Long Term Care Plan.

An initial assessment may be conducted at an institutional residence, such as a residential health care facility (nursing home).

When a MLTCP receives a prospective enrollment referral from a nursing home on behalf of a Medicaid recipient, the MLTCP must assess the consumer in a timely manner, within 30 days of receiving the referral. The MLTCP should assess the consumer where the consumer is located at the time of the referral, i.e., the nursing home. The assessment conducted in the nursing home setting will include and consider: diagnoses; current Plan of Care; discharge plan; proposed community residence; tentative discharge date; and need for community based long term care services.

In addition to the assessment conducted in the nursing home, the MLTCP must also assess the potential enrollee's proposed community residence which must be available for viewing prior to the date of discharge. A home visit by the MLTCP is required to determine the potential enrollee's health and safety in the actual residence, identify any risk factors, and develop an effective and efficient Plan of Care. The potential enrollee does not need to be at the proposed residence during the home visit.

As the MLTCP is responsible for the consumer's health and safety beginning on the enrollment date, the assessment process must be completed, the final definitive Plan of Care established, and MLTCP services must be in place for the consumer on day of discharge to the community setting.

TO: Local District Commissioners, Medicaid Directors

FROM: **Mark Kissinger, Director**
Division of Long Term Care

SUBJECT: Availability of 24-Hour Split-Shift Personal Care Services

EFFECTIVE DATE: Immediately

CONTACT PERSON: Margaret Willard, 518-474-5888

The Department has been directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicted and for Medicaid recipients whose only nighttime need is turning and positioning.

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

    - The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;
    - The specific task or tasks with which the person requires frequent assistance during the night;
    - The frequency at which the person requires assistance with these tasks during the night;
    - Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;
    - The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;
    - The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and
    - Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

If you have any questions concerning this policy, please contact Margaret Willard at the above number.

TO: Local District Commissioners, Medicaid Directors

FROM: Mark Kissinger, Director
Division of Long Term Care

SUBJECT: 06 to 30 Conversion for MLTC Enrollees

EFFECTIVE DATE: Immediately

CONTACT PERSON: Loretta Grose, Bureau of Managed Long Term Care
(518)474-5271

As a component of the continuing state-wide Medicaid Redesign Initiative, individuals requiring more than 120 days of community based long term care services (CBLTCS) must receive those services through enrollment in a Managed Long Term Care Plan (MLTCP). CBLTCS include personal care, consumer directed personal care, home health care, services provided by a Certified Home Health Agency, Adult Day Health Care, private duty nursing, and services provided through a Long Term Home Health Care Program (LTHHCP).

Recipients with 06 Provisional Coverage requiring or receiving the services noted above must enroll in a MLTCP. Currently, 06 Provisional Coverage is not compatible with MLTCP enrollment and a 06 Provisional recipient cannot immediately convert to a Medicaid coverage type that is compatible with enrollment into a MLTCP. The current process of changing the coverage code is labor intensive and requires a manual change to the case file at the LDSS level. To effectuate immediate MLTC enrollment for 06 Provisional recipients, modifications have been made to the WMS Prepaid Capitation Plan subsystem.

Effective April 28, 2014, for 06 Provisional Coverage cases that are requesting enrollment into a partially capitated MLTC Plan and have an RVI Indicator of 1, 2, or 4, WMS will allow input of a PCP subsystem entry indicating enrollment into a specific partially capitated MLTCP. Input of the enrollment line in the PCP subsystem (WMS) will trigger a conversion of the 06 Provisional Coverage Code to a Coverage Code of 30 PCP - Full Benefits Coverage.

A recipient with 06 Provisional Coverage requesting enrollment into a partially capitated MLTCP will meet the spenddown requirement of an incurred medical expense on the first day of each month enrolled in the MLTCP. The spenddown liability is the MLTCP's responsibility as the monthly PCP capitation rate is established net of spenddown. As the excess income is owed to the MLTCP each month and collection of the incurred spenddown is the MLTCP's responsibility, the consumer's Medicaid Coverage Code may be converted from 06 to 30. For these recipients the Excess Income will be included on the monthly Roster, the Interim Report and the Secondary Roster for each Managed Long Term Care Plan.

When a Managed Long Term Care Plan enrollment is ended, with no new enrollment, the recipient Medicaid Coverage Code will revert back to 06 Provisional Coverage. The Excess Income Amount will no longer be included on the Primary Roster, The Interim Report, and the Secondary Roster.

The 06 to 30 conversion is operational for enrollments into a partially capitated MLTC Plan; the conversion is not operational for enrollments into Medicaid Advantage Plus (MAP) Plans or PACE Plans.

Please submit any questions to the Managed Long Term Care Bureau Systems Mailbox at mltcsys@health.state.ny.us.

The New York Times

April 30, 2013

Advocates Say Managed-Care Plans Shun the Most Disabled Medicaid Users

By NINA BERNSTEIN

Managed-care companies in New York have come under fire for signing up vigorous older adults referred to them by social day care centers, customers whose health needs are relatively small.

But on Tuesday, legal advocates for the disabled told the state's Medicaid director that the most seriously impaired people were getting the opposite treatment.

Among the examples reported to the director, Jason A. Helgerson, in a meeting were cases in which the advocates said representatives of the managed-care plans deterred people who were bedbound or affected by dementia from enrolling in a plan, often by refusing to do an assessment at all, or by falsely saying that the plan's budget or policies did not allow as much care as the person needed.

The meeting was closed to the news media, but Mr. Helgerson vowed to hold plans accountable, participants said, and some said they were encouraged that he worked with them to come up with a list of quick fixes, including a dedicated complaint line.

But the issues raised at the meeting illustrated again the difficulties as Gov. Andrew M. Cuomo, through the state Department of Health, moves tens of thousands of Medicaid recipients who need long-term care, like personal aides or nursing homes, into managed-care plans.

Medicaid pays the privately run managed-care plans roughly $3,800 a month for each person they enroll in New York City, regardless of how many services they need. The idea, borrowing from the use of health maintenance organizations to deliver health insurance, is to save money and harness competition among private plans to provide better, more efficient community care than under costly and fraud-ridden fee-for-service models.

But representatives from a dozen advocacy organizations for disabled people warned Mr. Helgerson that they were seeing a systemic problem: some of the neediest people were not being allowed to enroll, or were being denied the hours of service they need without a meaningful chance to appeal.

"The plan's incentive to enroll low-need people creates a conflict of interest and opens to Medicaid fraud —see adult day care," advocates wrote in an 18-page document for the meeting.

They were referring to the state's new scrutiny of the relationship between the plans and

proliferating day care centers that send the plans new customers from a largely healthy elderly clientele. The same financial incentives cause plans to deny enrollment to those with high needs, advocates contended.

In an e-mail statement after the meeting, Mr. Helgerson said the move to mandatory managed long-term care had been successful in meeting its goals for patient care and lowering costs across the Medicaid system. “As I have made clear, we will continue to move quickly and aggressively to stamp out and prevent fraud, and address implementation issues,” he wrote.

Valerie Bogart, a lawyer with the New York Legal Assistance Group who was at the meeting, said advocates were encouraged. “Jason promised more transparency on quality measures, and more meaningful oversight,” she said.

Last week Mr. Helgerson suspended all new enrollment in VNS Choice, the largest managed-care plan, and other plans run by Visiting Nurse Service of New York pending an investigation into its use of social adult day care centers like R&G in Bensonhurst, where a stream of agile older people had been recently seen picking up free takeout food there and walking or bicycling away with it.

Managed-care plans pay adult day care centers out of their Medicaid allotment to provide supervised activities and meals to plan members. But the centers also refer new customers to the plans.

Medicaid fraud investigators are also looking into allegations that R&G and other centers used illegal inducements to lure new clients, like cash gifts and grocery vouchers, and that a VNS executive rebuffed complaints about such practices.

At R&G on Monday afternoon, a man who had previously identified himself as a receptionist said he was in fact the owner, Wei Xin Liang. He denied that the center had used such inducements, and contended that people seen leaving the center with stacks of just-delivered takeout food were taking leftovers home or just stepping out for a smoking break.

Mr. Liang, 28, said that members eager to attend his center every day chose to enroll in VNS Choice, because unlike other plans, it regularly allowed its members to attend social day care six or seven days a week, at $85 for each four-hour session, with door-to-door transportation. “We didn’t force them,” he said.

At the other end of the spectrum, advocates reported to Mr. Helgerson that a VNS Choice nurse had acknowledged that one of her clients needed two 12-hour shifts of home care each day, but claimed that VNS would only provide half that much, and the impaired woman would have to privately pay for the rest. She has no funds and no family, her advocates said, and it took lawyers four months to obtain the care she was entitled to.

"VNSNY CHOICE recognizes its obligations under New York and Federal law and does not discriminate on the basis of health, frailty or any other circumstance," a spokesman for VNS, Richard Rothstein, said in an e-mail statement.

The daughter of a bedbound 87-year-old woman complained to advocates that after being promised two shifts of 12-hour care by another plan, Fidelis, a Fidelis nurse told her that the rules had changed, that Fidelis would not provide that much care, and that her mother should look for another plan.

"Nobody can leave her for 10 minutes," said Bella Zaltsman, director of Social Services at the United Jewish Council of the East Side, who interceded for the woman with Fidelis. "She doesn't walk. She sleeps at night, but has to be changed five or six times."

Darla Skiermont, a spokeswoman for Fidelis, said that although she could not comment on an individual member, "We would not inappropriately reduce the level of care or service provided to a member, and an individual's care is never influenced by financial considerations."

NEW YORK LEGAL ASSISTANCE GROUP

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March 14, 2014

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RE: Delay Needed in NYS 1115 Waiver Expansion to Include Nursing Home Population – Mainstream Medicaid Managed Care and Managed Long Term Care

Dear Ms. Mann, Mr. Helgerson, et al.,

We write to highlight some of our concerns with the impending carve-in of nursing home (NH) residents into the mandatory mainstream Medicaid managed care (MMC) population and mandatory enrollment into managed long term care (MLTC) plans, which is pending CMS approval to begin on April 1, 2014. Many unresolved systems and policy issues demonstrate the roll out of this initiative must be delayed.

On March 10, 2014, the New York State Department of Health (DOH) held a meeting to present details of the roll-out to nursing home providers, managed care plan representatives, and consumer advocates. This meeting underscored both the unanswered questions and the high demand for more information on this initiative; over 600 people attempted to attend the webinar, crashing the online system as a result. Fortunately, a few consumer advocates were permitted to attend the March 10th meeting in person, but there was limited time to address all consumer concerns. As such, this letter serves as a list of outstanding questions and concerns that still need to be addressed. Please note that this letter is not intended to be exhaustive.

Below is a list of our principle concerns; details follow.

1. **People in nursing homes who are not enrolled in MMC or MLTC must be protected from marketing pressures to enroll into plans without fully understanding the implications of enrollment.**
2. **Policies that clearly identify responsibility for protecting Medicaid and SSI benefits to ensure that return to the community is financially feasible must be developed.**
3. **Procedures and policies must be developed that promote community integration and ensure due process rights when a plan determines to place a member in a nursing home.**
4. **Exceptions to in-network requirements are necessary due to concerns about the adequacy of network's MLTC members.**
5. **Contracts and Readiness Review are essential.**
6. **29-day short-term rehabilitation benefit must be included as part of the benefit package.**

We believe that the nursing home transition to managed care must be delayed. Inclusion of the NH in the MMC and MLTC benefit provides an opportunity to improve the delivery of LTSS to New York's Medicaid beneficiaries. However, we fear that without more planning this massive transition may inflict needless harm to a vulnerable population.

1. People in nursing homes who are not enrolled in MMC or MLTC must be protected from marketing pressures to enroll into plans without fully understanding the implications of enrollment.

The mandatory enrollment of thousands of individuals who newly become permanent residents in nursing homes must include robust consumer protection from potential marketing abuse. Similarly, even though current nursing home residents are protected by being grandfathered into FFS, and may stay in their current nursing homes, they are still vulnerable to marketing pressures; in six months, their *exclusion* from enrollment in MLTC plans will change to an *exemption* from enrollment – and they will also be vulnerable to misleading or pressured marketing.

There is no guidance on enrollment marketing tailored to the special circumstances of nursing home residents, who are disproportionately impaired by cognitive and other mental impairments. DOH policy requires only that after long term eligibility is approved by the Local Department(s) of Social Services (LDSS) for new people who become NH residents, the individual will be "contacted by NY Medicaid Choice to assist with enrollment in order for the beneficiary to stay at the current NH."[1] If the individual does not enroll within 60 days s/he will be auto-assigned to an MMC or MLTC plan that contracts with that nursing home. During that "choice" period, various plans and/or the nursing home, serving as the plans' contractor, often engage in marketing, which has the potential for abuse.

[1] NYS DOH Office of Health Insurance Programs, "Transition of Nursing Home Population and Benefit to Managed Care" (January 2014) hereafter referred to as "DOH NH Transition Policy."

a. **Given that a high percentage of NH residents have cognitive and other mental impairments, any so-called "voluntary" enrollment into a *fully capitated* plan should be prohibited**. Most companies that sponsor MLTC plans are also sponsoring Medicaid Advantage Plus (MAP) or PACE plans and have applied for approval of FIDA plans. These companies—or the nursing home contracting with them—often market their full-capitation MAP/PACE plans, resulting in "voluntarily" enrollment in the fully capitated MAP/PACE plans rather than the MLTC plans. Few if any residents will understand that their Medicare providers are now restricted to a closed network. While NY Medicaid Choice may not auto-assign them to a fully capitated plan, the marketing pressure to "voluntarily" enroll in these plans will be high. Just as home care recipients were told they would lose their aides unless they enrolled in a particular MLTC plan, NH residents will be told they will have to move to another NH if they do not enroll in certain plans.

   i. **RECOMMENDATION: Plans should not be permitted to market fully capitated plans to nursing home residents. No "voluntary" enrollment should be permitted.**

   ii. **RECOMMENDATION**: At a minimum, a written acknowledgement of a family member or other personal representative should be required to confirm understanding that the plan will now control access to Medicare services, that all Medicare providers must be in the plan's network, and understanding that that the individual has the option of enrolling in a partially capitated plan that does not cover Medicare services.

b. **Enrollment procedures must include reasonable accommodations and verified informed consent.** Many NH residents have cognitive or other mental impairments and are entitled to reasonable accommodations in the manner they receive information on enrollment. No guidance has been publically provided on this issue, nor have advocates had the opportunity to review draft notices or consumer education materials. Many questions about NY Medicaid Choice's role remain: How will NY Medicaid Choice contact nursing home residents? How will NY Medicaid Choice be available for counseling of nursing home residents—many of whom have multiple impairments and do not have phones—to assist with plan selection and enrollment?

   Further, informed consent of enrollees must be required. Nursing home residents are entitled to a designated representative.[2] The "designated representative" must receive copies of notices from NY Medicaid Choice. NY Medicaid Choice must develop a system to obtain the contact information to communicate with these representatives. To assure that consumers are properly advised, and properly informed of these "consumer centered" services, there must be a way to accurately confirm that their rights have been upheld and that the system is working the way it was intended. The primary tool for providing this crucial level of accountability is through documented, verifiable (preferably witnessed) notifications and informed consent.

[2] See 10 NYCRR Part 415

c. **Procedures must protect resident confidentiality**. What policies have been developed that protect the rights of residents to confidentiality?

2. **Policies must be developed that clearly delegate responsibility for protecting Medicaid and SSI benefits to ensure that return to the community is financially feasible.**

With all the attention paid to the goals of community integration, some very mundane steps are necessary regarding Medicaid and SSI benefits to ensure that the individual can pay rent or other expenses to maintain their home during a temporary hospital and nursing home stay. No mention has been made as to whether the NH or the MMC/MLTC plan is responsible for taking these steps.

a. **Continuation of SSI benefits.** After an SSI recipient is in a hospital and/ or nursing home for a full calendar month, his or her SSI benefits may only continue if a physician certifies in writing that his or her medical confinement will not last for more than 90 consecutive days. This form must be submitted to the Social Security office before the 90th day of the institutionalization or before the discharge home, whichever is earlier. If submitted, SSI benefits may continue for three months. This is called "Temporary Institutionalization" benefits.[3] Over 300,000 MMC members in NYS, and some MLTC members, rely on SSI benefits to pay their rent. Part of care management must be obtaining and filing these forms for both MMC and MLTC members who receive SSI. Whether the MMC/MLTC plan fulfills this duty or delegates it to the nursing home, it must be made clear in contracts. In absence of any such contractual language, DOH must clarify that the plans have this responsibility.

b. **Community Medicaid budgeting.** Similarly, Medicaid recipients admitted to a nursing home who expect to be discharged home have the right to "community budgeting," which allows them to keep the same income allowance they would have in the community ($829/month in 2014 for singles), during the temporary nursing home stay.[4] Without this budgeting, the individual may keep only $50/month of their income, with the rest paid toward the cost of nursing home care. As such, "community budgeting" is critical in allowing Medicaid recipients to pay rent and maintain their housing during a temporary nursing home stay.

In order to access this budgeting, the nursing home must submit a form to the LDSS with the institutional Medicaid application, on which a physician certifies that discharge home is expected.[5] If this form is not submitted, there is a presumption that every nursing home stay is permanent, and beginning with the very first full calendar month of the nursing home stay, the resident may keep only $50/month of income. Failure to follow the proper

[3] See Social Security Administration, POMS Section SI 00520.140, available at http://policy.ssa.gov/poms.nsf/lnx/0500520140

[4] See 18 NYCRR §§ 360-1.4(k), 360-4.9.

[5] The MAP-259d form used by NYC HRA is available at http://www.wnylc.com/health/download/132/.

procedure can also lead to participants being personally and inappropriately billed substantial amounts – and to losing their homes.

Even now, nursing homes often do not advise their short-term residents of their right to request community budgeting and fail to submit the necessary forms. With an MMC or MLTC plan now responsible for care management and for ensuring discharge back to the community where possible, responsibility for filing the requisite forms must be specifically assigned to the plans.

3. **Procedures and policies must be developed that promote community integration and ensure due process rights when a plan determines to place a member in a nursing home.**

   a. **Clear procedures and notice templates are needed to ensure that "long-term placement" determinations are made with adequate notice including notice of appeal rights.** The DOH NH Transition Policy is not sufficiently clear about the MCO/MLTC plan's duty to provide notice of the determination to place a member into a nursing home, with notice of appeal rights, and about *when* notice must be provided. DOH has recently recognized that mainstream managed care plans have not been compliant with notice and transition requirements in providing various LTSS services, and is taking steps to reinforce these vital requirements. Now, before there is time to implement these changes, nursing home care is being added to the benefit package of LTSS services. Adequate notice is more important than ever, given that the plan's determination that placement in a nursing home is medically necessary can obviously be cataclysmic, and has major *Olmstead* implications.

   Model notices should be developed with input of various stakeholders, including consumers. The timing of notices also must be addressed. A series of notices is needed in most cases: one notifying of a temporary nursing home placement for rehabilitation or sub-acute care – most commonly following a hospital stay, and a second one when the plan determines that a temporary nursing home stay should become permanent. The DOH NH Transition Policy vaguely talks about nursing home transitions as if a determination to place an individual in a nursing home happens at one moment during a hospital stay. The reality is that for both MLTC and MMC the majority of nursing home admissions are short term. [6] In many cases, the MCO/MLTC cannot determine until after a period of rehabilitation whether a long-term placement is medically necessary. Written notice with appeal rights must be provided at both times –at the temporary admission and when a decision is made for permanent placement. A copy should also be provided to the individual's "designated representative" in the nursing home. The content of these notices must be carefully developed with stakeholder input, not left to each plan.

[6] See Thomas H. Dennison, New York's Nursing Homes: Shifting Roles and New Challenges (United Hospital Fund August 2013) at pp 5-6 (ratio of short-stay to long-stay residents doubled over the decade from 2000 to 2010 from about 1:2 in 2000 to 1:1 in 2010, but because the short-stay residents go home, the number of short-stay admissions is far greater than admissions for long-stay).

i. **Discontinuance of home care service plan prior to the hospital/rehab stay requires advance notice and aid continuing rights**. When a member was receiving community-based long term care services (home care) prior to a hospital and/or nursing home stay, the plan's determination not to reinstate those services – and instead to make a permanent nursing home placement is also a DISCONTINUANCE of the prior community-based service plan. As such, the notice to the consumer must provide the right to request a hearing and "aid continuing," which in this context means discharge home with reinstatement of the prior service plan pending a hearing. *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996).[7]

b. **Capabilities Matrix should be shared with the public**. The DOH NH Transition Policy on discharge planning from hospitals identifies a "standardized capability matrix" that will include each nursing home's specialty services and populations, and that will be updated, to help hospitals and MCOs identify appropriate NHs for short- or long-term nursing home stays.[8] This matrix must be publicly available with updates posted online.

c. **PASSR Screenings.** The purpose of a PASSR screen is to determine not only that the person meets nursing home level of care requirements, but that the particular facility is properly equipped to address the individual needs of the person in regard to their mental disorder. The DOH NH Transition Policy stated position is that the PASSR screen will be performed "as it is today."[9] Since a PASSR screening can have a direct impact on what facility is appropriate for a particular individual, how that will be addressed in terms of MCO enrollment must be explained. Nursing home admission for those with serious mental disorders is different than for the general population, a fact that PASSR screening is intended to address. The role of the PASSR screen in the determination by the nursing home and MCO for long term care placement must be addressed.

d. **Incentives to arrange for least restrictive setting.** In the DOH NH Transition Policy includes a section on Transition Planning which states:

> … Discharge planning must be patient centered and should focus on the needs of the enrollee. Creating incentives to NHs and MCOs in arranging for the least restrictive setting based upon the enrollee's health care needs would help to assure this occurs…[10]

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[7] NYS DSS 99 OCC-LCM-2 (Apr. 20, 1999) available at http://www.wnylc.net/pb/docs/99OCCLCM2.pdf, reaffirming effectiveness of 96-MA-023, "New Notice, Aid-Continuing and Related Procedures Applicable to Hospitalized MA Recipients Who Received Personal Care Services Immediately Prior to Hospitalization," implementing *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996), available at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/96ma023.pdf.

[8] DOH NH Transition Policy Policy Section II(1)(e)(iii) at p. 10.

[9] DOH NH Transition Policy, Section I at p. 3.

[10] Id., Sec. II (1)(b) at p. 9.

DOH needs to articulate the incentives for arranging for the least restrictive setting. It is insufficient to articulate the lofty goal of patient-centeredness and community integration that lack sufficient specific policy or procedural details that make it a reality.

e. **MLTC and MCO plans must assess nursing home residents for potential discharge home, including those not yet enrolled in the plans but seeking enrollment for discharge home.** As we have previously brought to DOH's attention, many MLTC plans have refused to send assessors to a nursing home to assess a nursing home resident who is not yet in a plan for potential enrollment, in order to be discharged back to the community with services. DOH has promised to issue clarifying guidance on this, since there is some ambiguity in existing contract and policy language. No clarification has been issued and these problems still exist. This setting presents an opportunity to create incentives for NHs and MCO/MLTC plans – but none have been established. Of course as more long-term nursing home residents are enrolled in managed care plans while remaining in the nursing home, they must also have a clear procedure to request that the plan assess them for potential discharge to the community with necessary supports, and an appeal procedure for plan determinations to deny services in the community.

f. **Consumer rights in discharge planning and education of consumers as well as hospital discharge planning staff**. The consumer and his or her designated representative must be fully apprised of his or her rights during each type of transition to and from a NH. Now that nursing home care will be part of the MMC and MLTC benefit packages, the model member handbooks must be revised and consumer educational materials prepared, translated and distributed. And again, plans and providers must obtain informed consent during transitions from the consumer, or in some cases, his or her designated representative.

Before rolling out this huge change, DOH must ensure that hospitals and other community-based health care providers, and other organizations that provide services to this population are educated about these changes. Just in the last week we have been invited by two major New York City hospitals to train their social work and discharge planning staff on the myriad changes involving MLTC and managed care – they asked us because no one else is doing it. Other than the arcane policy information on the state's MRT website, there is no clear information about these changes for the public. Education of the vast network of professionals who work with dual eligibles as well as Medicaid managed care members is a vital part of readiness to implement these changes.

4. Exceptions to in-network requirements are necessary due to concerns about the adequacy of networks and access to care.

Please confirm that prior policy continues per DOH FAQ dated 8/16/2012,[11] that the MLTC plan must pay the member's Medicare coinsurance for rehabilitation services provided in an SNF, regardless of whether the facility is in the MLTC plan's nursing home network. This should continue, since Medicare pays for most NH admissions for MLTC members, which are for short-term rehab stays.

a. **Out of Network Coverage Should Continue During Balance of Short-Term Stay, After Medicare Coverage Ends**. If the MLTC member is in an out-of-network NH and Medicare coverage ends, the MLTC plan under existing guidance is required to help the member transfer to an in-network facility.[12] This FAQ mistakenly presumes that any stay after the period of Medicare coverage is a "long-term" stay. As many attendees stated at the March 10th meeting, the reality is that short-term nursing home stays often continue after Medicare coverage ends; reasons may include the need for additional rehabilitation or medical stabilization, or time needed to plan for services upon discharge. It would be extremely disruptive to require an individual to transfer to an in-network nursing home for what may be a short period. The MLTC plans must be required to continue to cover the out-of-network stay if discharge back to the community is reasonably expected. Even if the individual could transfer to an MLTC plan that does contract with the NH, since enrollment is effective only on the 1st of the next month, and often not until the 1st of the second following month, it is impractical to require individuals slated for short-term stay to change plans. Also, if they had home care services through the MLTC plan prior to the hospital and rehab stay, the same MLTC plan can reinstate these prior services after discharge home. It would disrupt continuity of care to require changing MLTC plans.

b. Out-of-network NH discharges for MMC Members. A hospital could discharge a Medicaid-only MMC member into an out-of -network NH without the member having any knowledge or control. In such a case, there must be a clear policy in regard to who will pay for the cost of care and ensures that member will not be forced to move to a different NH or be liable for the cost of care.

c. Adequacy of nursing home networks. In many upstate counties, we understand individuals often seek placement in nursing homes in adjoining counties, not just their own county. This is also true for the two Long Island counties and five boroughs in NYC. We continue to be concerned that the network requirements are inadequate to ensure consumer choice and continuity of care.

[11] http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-16_mltc_faq.pdf, see Question 42.
[12] Id. 8/16/12 FAQ at Question 49.

Further, there is no requirement that every Medicaid-certified nursing home contract with MMC and/or MLTC plans. **Nursing homes should be required to contract with at least two of each type of plan, in order to provide adequate consumer choice.**

d. **Specialty nursing homes.** The requirement that plans contract with at least two nursing homes of each type in the county, where available, is not adequate. Outside of NYC and Nassau County, no county has more than 2 homes of any specialty type. As we understand the policy, the plans must grant member requests to receive services at a non-participating NH. However, we are concerned that members will not be informed of their right to access these out-of-network nursing homes. Given that 37 upstate counties do not have a specialty nursing home, and another 6 upstate counties have only one specialty NH—ventilator beds—plans in upstate counties should be required to contract with every specialty nursing home, at least in a multi-county region. Additionally, plans should be required to provide the option of 12-24 hour/day home care at the appropriate level (personal, home health, private duty, Consumer-directed) in the community to members that do not have access to in-network specialty nursing homes.

   In NYC, the minimum of two nursing homes in any specialty fails to take into account the variation in capacity among different facilities. In Queens, for example, while eight nursing homes have ventilator beds, the number of beds in these eight facilities ranges from 10 to 80 (see attached spreadsheet, which adds data from DOH website showing number of specialty beds). A plan could satisfy the network requirement with 2 nursing homes that have only 20 vent beds between them. Additional utilization data should be used to determine the adequate number of beds required for each specialty nursing home type given enrollment. Again, plans should be required to provide members with the option of 12-24 hours of personal care in the community if an in-network nursing home is at capacity. Of course, the option of in-home services must always be considered to comply with community integration requirements.

5. **Contracts and Readiness Review**

From the vocal participation of nursing home representatives at the March 10th meeting, it was clear that the system is far from ready to go live on April 1st. Many aspects of contracting between nursing homes and plans are not even finalized. Contracts that may have existed before must now be updated since the nursing home benefit is being dramatically changed. Just as important as the contracts are the systems for billing and for communicating authorizations for care and many other elements of a complex system. Indeed, in NYC there are 25 MLTC plans, 12 MAP and PACE plans, and 10 MMC plans, so it is not surprising that nursing homes as well as hospitals are scrambling to set up these systems for literally dozens of plans. Nursing homes asked the State to establish templates for many of the terms that must be established, but DOH indicated it would leave this to the plans and nursing homes.

All of this uncertainty and lack of readiness impacts consumers. Consumers can be pressured to transfer to a different plan, or to a different nursing home, or to pay part of a bill if the systems fail.

Their discharge back to the community can be delayed or blocked altogether if plan authorizations for home care cannot be obtained. Moreover, if a nursing home is not paid for the care provided consumers will likely suffer the adverse effects of declining quality in the facility overall.

All of these contract and systems details must be assessed carefully in a readiness review by the DOH before this system goes live. From the comments made the March 10th meeting, it seems that DOH does not find it necessary to conduct a detailed readiness review and is instead relying on the "good faith" of the plans and nursing homes to take care of these details. We believe much more oversight from the State is needed to ensure that these complex systems are ready to go live and that consumers receive quality care.

6. **Benefit Package -- 29-day short-term rehabilitation benefit.**

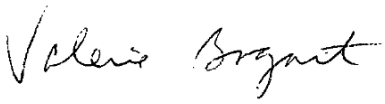
After Medicare coverage of an SNF stay ends, the NYS Medicaid 29-day rehabilitation benefit[13] should cover additional days of NH care without requiring a full application for chronic care/institutional Medicaid coverage. (Example: If Medicare covered 20 days, Medicaid should pay nine days under short-term rehabilitation benefit without requiring the five-year look-back). Individuals without Medicare in MMC plans should not be referred to the LDSS for a full five-year look-back until this 29-day benefit is exhausted. Since one purpose of this 29-day period is to simplify Medicaid coverage for short-term NH stays, anyone eligible for this benefit should receive coverage under community-based Medicaid. Guidance is needed to require that MLTC and MMC plans are responsible for paying for this benefit. As a practical matter, even under FFS we have not seen this benefit utilized as much as it could be, and people have been required to submit the full five-year look-back application even when it should not be necessary, since coverage should be available under this benefit. Now, eligibility for the 29-day benefit should delay the requirement to enroll in a managed care plan, since by definition this coverage is short-term.

The above unresolved questions and concerns demonstrate that the transition of the nursing home benefit to managed care must be delayed. The inclusion of this benefit in the MMC and MLTC plans poses the opportunity to improve the delivery of LTSS to New York's Medicaid beneficiaries. However, we fear that without more planning this vulnerable population will face needless harm. The undersigned organizations remain willing to assist in development of improved policies and procedures to make the transition a success.

[13] Section 366-a(2) of the Social Services Law, 04 OMM/ADM-6 (July 20, 2004).

We look forward to your response and an opportunity to discuss these and other concerns.

Sincerely,



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On behalf of:

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Empire Justice Center
MFY Legal Services, Inc.
NYC Long Term Care Ombudsman Program
New York Lawyers for the Public Interest
Southern Tier Independence Center

Enc. Nursing Home Network Requirements by County - (combines charts provided by DOH and data from http://nursinghomes.nyhealth.gov/)

cc: Melissa Seeley, CMS Medicare-Medicaid Coordination Office, Melissa.Seeley@cms.hhs.gov
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Nursing Homes Network Requirements by County (9-23-13 draft) (Combined by Valerie Bogart)
NYS DOH - Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight

	General Beds		SPECIALTY Nursing Homes (Blank = 0) (Minimum of 2 if exists)					Specialty BEDS*				
County	Number of Nursing Homes ("NHs")	Minimum # of Participating NHs required Per Plan	Pediatric	AIDS	Vent	Behavioral	TBI	Pediatric	AIDS	Vent	Behavioral	TBI
QUEENS	55	8	1		8		2	95		210		40
BRONX	43	8		5	7				417	139		
SUFFOLK	43	8	1	0	2		1	41		48		20
KINGS	42	8		1	5				120	133		
ERIE	38	8	1		2			13		39		
WESTCHESTER	38	8	2		2			180		23		
MONROE	35	8			2	1				30	15	
NASSAU	35	8		1	6				20	124		
ONEIDA	17	4										
NEW YORK	16	5	1	4	1			21	430	20		
DUTCHESS	13	4			2					146		
ONONDAGA	13	4			1		1			13		20
ALBANY	12	4	1					58				
BROOME	10	3								12		
NIAGARA	10	3										
ORANGE	10	3										
RICHMOND	10	5		1	3	1	1		80	136	72	21
ROCKLAND	10	3			2					40		
RENSSELAER	9	3										
CHAUTAUQUA	8	3										
SCHENECTADY	7	3	1		1		1	36		8		70
ULSTER	7	3			2	1	1			61	20	180
ONTARIO	6	2			1							
ST LAWRENCE	6	2										
STEUBEN	6	2			1					8		
CATTARAUGUS	5	2										
CAYUGA	5	2										
CHEMUNG	5	2										
CHENANGO	5	2										
COLUMBIA	5	2			1					40		
MONTGOMERY	5	2										
OSWEGO	5	2										
TOMPKINS	5	2										
ALLEGANY	4	2										
CLINTON	4	2										
GENESEE	4	2										
HERKIMER	4	2										
JEFFERSON	4	2										
MADISON	4	2			1					11		
SARATOGA	4	2										
SULLIVAN	4	2										
WARREN	4	2										
WASHINGTON	4	2										
WAYNE	4	2			1	1				10	20	
CORTLAND	3	2										
ESSEX	3	2										
FRANKLIN	3	2										
FULTON	3	2										
LIVINGSTON	3	2										
ORLEANS	3	2										
OTSEGO	3	2										
DELAWARE	2	2										
PUTNAM	2	2										
SENECA	2	2										
TIOGA	2	2										
WYOMING	2	2										
YATES	2	2				1					20	
GREENE	1	1										
LEWIS	1	1										
SCHUYLER	1	1										

* Source: http://nursinghomes.nyhealth.gov/

Specialty Nursing Homes by County			
Specialty	**County**	**Provider Name**	**No. beds**
Pediatric	ALBANY	ST MARGARETS CENTER	58
AIDS	BRONX	BRONX-LEBANON SPECIAL CAR	120
AIDS	BRONX	CASA PROMESA	108
AIDS	BRONX	HELP/PSI INC	66
AIDS	BRONX	HIGHBRIDGE-WOODYCREST	90
AIDS	BRONX	ST BARNABAS REHABILITATIO	33
Ventilator	BRONX	CONCOURSE REHABILITATION	22
Ventilator	BRONX	DAUGHTERS OF JACOB NURSIN	24
Ventilator	BRONX	EASTCHESTER REHABILITATIO	16
Ventilator	BRONX	FIELDSTON LODGE CARE CENT	10
Ventilator	BRONX	SPLIT ROCK REHABILITATION	27
Ventilator	BRONX	ST BARNABAS REHABILITATIO	22
Ventilator	BRONX	WAYNE CENTER FOR NURSING	18
Ventilator	BROOME	BRIDGEWATER CENTER FOR RE	12
Ventilator	COLUMBIA	WHITTIER REHABILITATION &	40
Ventilator	DUTCHESS	WINGATE AT ST BEACON	120
Ventilator	DUTCHESS	WINGATE OF DUTCHESS	26
Pediatric	ERIE	HIGHPOINTE ON MICHIGAN HE	13
Ventilator	ERIE	ELDERWOOD HEALTH CARE OAK	20
Ventilator	ERIE	ERIE COUNTY MEDICAL CENTE	19
AIDS	KINGS	SCHULMAN AND SCHACHNE INS	120
Ventilator	KINGS	CONCORD NURSING HOME INC	17
Ventilator	KINGS	FOUR SEASONS NURSING AND	20
Ventilator	KINGS	PALM GARDENS CENTER FOR N	38
Ventilator	KINGS	RUTLAND NURSING HOME CO I	30
Ventilator	KINGS	SCHULMAN AND SCHACHNE INS	28
Ventilator	MADISON	ONEIDA HEALTHCARE CENTER	11
Behavioral	MONROE	THE HIGHLANDS AT BRIGHTON	15
Ventilator	MONROE	THE HIGHLANDS AT BRIGHTON	20
Ventilator	Monroe	UNITY LIVING CENTER	10
AIDS	NASSAU	A HOLLY PATTERSON EXTENDE	20
Ventilator	NASSAU	A HOLLY PATTERSON EXTENDE	20
Ventilator	NASSAU	COLD SPRING HILLS CENTER	24
Ventilator	NASSAU	MEADOWBROOK CARE CENTER I	10
Ventilator	NASSAU	SOUTH SHORE HEALTHCARE	24
Ventilator	NASSAU	TOWNHOUSE CENTER FOR REHA	20
Ventilator	NASSAU	WOODMERE REHABILITATION A	16
AIDS	NEW YORK	(THE) ROBERT MAPPLETHORPE	28
AIDS	NEW YORK	RIVINGTON HOUSE-THE NICHO	206
AIDS	NEW YORK	ST MARYS CENTER INC	40
AIDS	NEW YORK	TERENCE CARDINAL COOKE HE	156
Pediatric AIDS	NEW YORK	INCARNATION CHILDRENS CEN	21

Ventilator	NEW YORK	ISABELLA GERIATRIC CENTER	20
TBI	ONONDAGA	ST CAMILLUS RESIDENTIAL H	20
Ventilator	ONONDAGA	JAMES SQUARE HEALTH AND R	5
Ventilator	ONTARIO	CLIFTON SPRINGS HOSPITAL	8
Pediatric	QUEENS	ST MARYS HOSPITAL FOR CHI	95
TBI	QUEENS	PARK TERRACE CARE CENTER	20
TBI	QUEENS	QUEENS NASSAU REHABILITAT	20
Ventilator	QUEENS	CLIFFSIDE REHABILITATION	38
Ventilator	QUEENS	DR WILLIAM O BENENSON REH	20
Ventilator	QUEENS	FRANKLIN CENTER FOR REHAB	12
Ventilator	QUEENS	LONG ISLAND CARE CENTER I	10
Ventilator	QUEENS	PROMENADE REHABILITATION	20
Ventilator	QUEENS	RESORT NURSING HOME	10
Ventilator	QUEENS	ROCKAWAY CARE CENTER	20
Ventilator	QUEENS	SILVERCREST	80
AIDS	RICHMOND	Richmond Center (formerly ST ELIZABETH ANNS)	80
Behavioral	RICHMOND	Richmond Center (formerly ST ELIZABETH ANNS)	72
TBI	RICHMOND	SEA VIEW HOSPITAL REHABIL	21
Ventilator	RICHMOND	NEW VANDERBILT REHABILITA	28
Ventilator	RICHMOND	Richmond Center (formerly ST ELIZABETH ANNS)	28
Ventilator	RICHMOND	SILVER LAKE SPECIALIZED R	40
Ventilator	ROCKLAND	FRIEDWALD CENTER FOR REHA	12
Ventilator	ROCKLAND	NORTHERN MANOR GERIATRIC	28
Pediatric	SCHENECTADY	PATHWAYS NURSING AND REHA	36
TBI	SCHENECTADY	PATHWAYS NURSING AND REHA	70
Ventilator	SCHENECTADY	PATHWAYS NURSING AND REHA	8
Ventilator	STEUBEN	MCAULEY MANOR AT MERCYCAR	8
AIDS	SUFFOLK	JOHN J FOLEY SKILLED NURS	CLOSED
Pediatric	SUFFOLK	AVALON GARDENS REHABILITA	41
TBI	SUFFOLK	ST JOHNLAND NURSING CENTE	20
Ventilator	SUFFOLK	GURWIN JEWISH GERIATRIC C	28
Ventilator	SUFFOLK	MEDFORD MULTICARE CENTER	20
Behavioral	ULSTER	NORTHEAST CENTER FOR SPEC	20
TBI	ULSTER	NORTHEAST CENTER FOR SPEC	180
Ventilator	ULSTER	NORTHEAST CENTER FOR SPEC	40
Ventilator	ULSTER	WINGATE OF ULSTER	21
Behavioral	WAYNE	WAYNE HEALTH CARE	20
Ventilator	WAYNE	WAYNE HEALTH CARE	10
Pediatric	WESTCHESTER	ELIZABETH SETON PEDIATRIC	136
Pediatric	WESTCHESTER	SUNSHINE CHILDRENS HOME A	44
Ventilator	WESTCHESTER	DUMONT CENTER FOR REHABIL	15
Ventilator	WESTCHESTER	MICHAEL MALOTZ SKILLED NU	8
Behavioral	YATES	SOLDIERS AND SAILORS MEMO	20

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May 20, 2014

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Governor of New York State
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Fax: (518) 474-1513

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Re: Time for Change in New York's Managed Long-Term Care

Dear Governor Cuomo, Ms. Mann, Dr. Zucker, and Mr. Helgerson:

We write to urge you to address the serious problems with Managed Long-Term Care (MLTC) in New York State. Many of our organizations have been warning government officials about these problems for years. As a matter of sound public policy, these problems can no longer be ignored.

A May 8, 2014 *New York Times* article (attached) highlights the human and financial costs of the key problem—MLTC plans are denying services to people who need them while aggressively recruiting clients who do not. The article juxtaposes the delay, disruption, and denial of community-based long-term care services to vulnerable New Yorkers who desperately need services with the MLTC plans' illegal marketing practices and enrollment of people who do not need those services.

The article illuminates the problematic financial incentives for MLTC plans and the providers associated with those plans: **"the more enrollees, and the less spent on services, the more money the**

companies can keep." These incentives encourage the provision of services to those who do not need them and reward plans that deny services to those who need them most.

The article also highlights the life-and-death consequences of these incentives. For example, cuts in certified home health agency reimbursement led to massive dumping of people like Ena Johnson, whose 24-hour care was immediately dropped and not restored until it was too late. **"By the time lawyers won her return home with 24-hour aides, she had a bone-deep 13-inch bedsore . . ."** Advocates have reported the same types of abuses by MLTC plans. Just last week New York Legal Assistance Group filed a complaint about an 85-year-old Bronx resident who needed 24-hour care due to a stroke, vascular impairments, diabetes, and other complex needs. Her care, previously stable for seven years, was reduced to 7 hours per day after her transition into MLTC from the personal care program. As has been all too common, the MLTC plan gave no written notice, no notice of appeal rights, and as a result, no right to "aid continuing."[1]

Once MLTC fully expands to include nursing homes, another vulnerable population will be at risk. Ignoring these problems will lead to bad public policy that will be harmful to seniors, people with disabilities, and their families for years to come. Policymakers can no longer tout the claimed budgetary successes of this new program without acknowledging the undeniable human costs.

New York State will fail to meet the goals of MLTC—to reduce waste and improve patient outcomes—unless these problems are addressed now. We call for the following changes to the MLTC program immediately:

- **Implement conflict-free assessments and coverage decisions.** The current MLTC program allows financially motivated MLTC plans to conduct the clinical assessments that determine who is eligible to receive services and who is not, thus placing the highest-need and potentially costly beneficiaries at extreme risk. Enrollment should be suspended or greater oversight implemented until conflict-free assessments are fully implemented.

- **Require arms-length contracting.** New York law allows the same organizations to own and operate both the MLTC plans and the long term care facilities and home care agencies funded by those organizations. This blatant conflict of interest is structurally poisonous to the entire system of care.

- **Ensure real due process protections for consumers.** MLTC services should not be reduced or terminated without procedures that meet due process standards of notice, aid continuing, and fair hearing rights. So far, New York State has failed to ensure continued provision of services and MLTC plans have cut services illegally. Standardized notices must be developed with

[1] The attached case example, described on page 3, further illustrates this problem.

consumer input. Providers found to have cut services without providing due process should be fiscally sanctioned and required to submit plans of correction to ensure future compliance.

- **End mandatory exhaustion of the internal appeal process.** The requirement that consumers "exhaust" internal appeals before requesting a fair hearing should be eliminated, because consumers are not notified of their appeal rights at all, let alone the obligation to request an internal appeal. Recourse to a fair hearing is essential. The attached case example shows how a consumer's services were cut from 12 to 8 hours per day for over five months until legal advocacy restored them last week. In the meantime, the 96-year-old man fell three times, requiring two hospitalizations. No notice was given, let alone notice of the requirement to request an internal appeal or the right to "aid continuing." *See* case example, attached.

- **Employ robust and effective surveillance.** Oversight of MLTC plans and providers is woefully inadequate and MLTC complaints, whether made through the MLTC complaint line or via other channels, are not adequately investigated and resolved. The State must invest more resources in surveillance. This could include:
    - expeditious implementation of the managed care ombudsman program with safeguards to ensure its independence from State and industry interference;
    - increased funding of the LTC Ombudsman Program, which will inevitably be a "first responder" on issues, particularly for consumers in residential care settings;
    - requiring an annual Office of Medicaid Inspector General audit of the MLTC program (including assessments of plans and providers);
    - using "secret shoppers" to look out for marketing fraud and monitor responsiveness of plan call centers;
    - training staff to identify fraudulent practices;
    - suspending enrollment for longer periods when plans engage in improper marketing and enrollment practices as well as other illegal practices such as due process violations; and
    - involving consumer advocates to identify best practices.

- **Weed out deficient MLTC plans.** The State should end its policy of letting any willing plan join the MLTC program and engage in an active procurement process. It should remove MLTC plans that violate the law or consistently fail to improve patient outcomes. The plans should be required to prove that complaints represent "one-off" incidents, by demonstrating actual compliance with adequate working systems and procedures. The State should periodically halt MLTC enrollment to assess plan performance with input from consumer advocates.

- **Ensure greater transparency and accountability**. There is no public information currently available on MLTC complaint and appeal rates.

Medicare beneficiaries can access information, through the star ratings system, about plan performance in dealing with complaints and appeals. The State Department of Financial Services' annual report on commercial insurers includes statistics on complaints and appeals. MLTC enrollees deserve at least the same level of transparency and accountability. The formal evaluation of MLTC plans must begin incorporating complaint and appeal information and such data must be made publicly available. Additionally, the State's MLTC reports must include plan-specific data on medical loss ratios, care management ratios, and the extent of provision of community-based services. The recent 2013 report presents only a partial picture of plan performance, much of it not plan-specific.

- **Protect nursing home residents in the enrollment process.** As the State rolls out expansion of MLTC to include nursing home care and residents, these vulnerable individuals must be protected. While existing residents will not be required to enroll in plans, they will be allowed to enroll in plans, and as such, will be vulnerable to marketing pressures. An enforceable informed consent requirement should be established, where plans must provide accurate and complete information about eligibility and choice and be able to document a consumer's consent to enrollment – or the consent of their designated representative for those who lack capacity. This is particularly important as the MLTC program begins taking on nursing home patients who are then passively enrolled into Fully Integrated Duals Advantage Plans. Additionally, DOH oversight of nursing homes must be more rigorous.[2]

- **Delay expansion of mandatory MLTC to new upstate counties and to the nursing home population** until the protections requested above are in place. In many upstate counties there are just one or two MLTC plans with only a handful of enrollees. No recipient of stable community-based services should be required to transition to these plans until their capacity is assured and the protections proposed above are incorporated.

With the deficiencies in the State's MLTC program clearly exposed, we ask you to take action so that the most vulnerable New Yorkers do not continue to suffer. We would welcome the opportunity to meet with you to discuss our proposals. Please contact Jota Borgmann at (212) 417-3717 or jborgmann@mfy.org if you would like to request a meeting with our group.

Sincerely,

Jota Borgmann, Senior Staff Attorney
MFY Legal Services, Inc.

[2] Other concerns regarding expansion of MLTC and mainstream managed care to include nursing home population are stated in a letter to CMS and DOH dated March 14, 2014, posted at http://www.wnylc.com/health/news/58.

On behalf of:

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Valerie Bogart
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Bruce Darling, Executive Director
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cc (via email):

Hon. Richard N. Gottfried, Chair, New York State Assembly Health Committee

Hon. Kemp Hannon, Chair, New York State Senate Health Committee

Hon. Joan Millman, Chair, New York State Assembly Aging Committee

Hon. David I. Weprin, Chair, New York State Assembly Task Force on
People with Disabilities

Suzanne Bosstick, CMS (suzanne.bosstick@cms.hhs.gov)

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MLTC SAAM data

- The Semi-Annual Assessment of Members (SAAM) is performed on all MLTC plan members every six months. The SAAM assesses members' demographics, health status, and certain health outcomes. Plans must report these data to the state.
- The data included here are from the January 2012 SAAM, and were obtained from the state via FOIL request.
- The SAAM has since been replaced with the Uniform Assessment System. Additionally, the data here are from the time period before MLTC became mandatory. Many MLTC plans now exist that did not exist in 2012, and plans have much higher enrollment now. Thus, these data are preliminary and may not be entirely reflective of the current climate.

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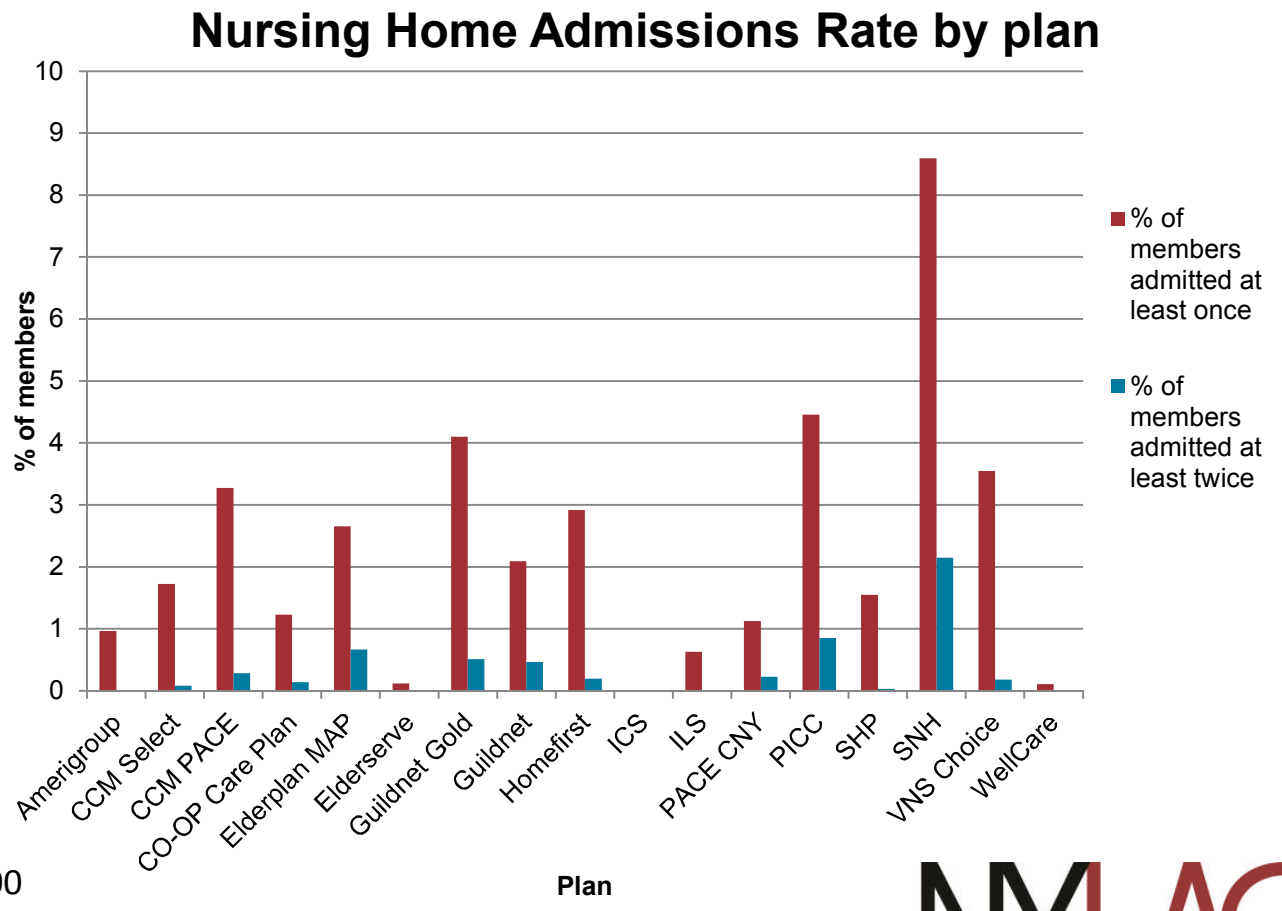
MLTC SAAM data: Nursing Home Admissions

- The SAAM tracks the number of times each plan member was admitted to a nursing home in the past six months.
- The nursing home admission rate ranges from 0% to over 8% across plans.



Only plans with over 300 members are shown.

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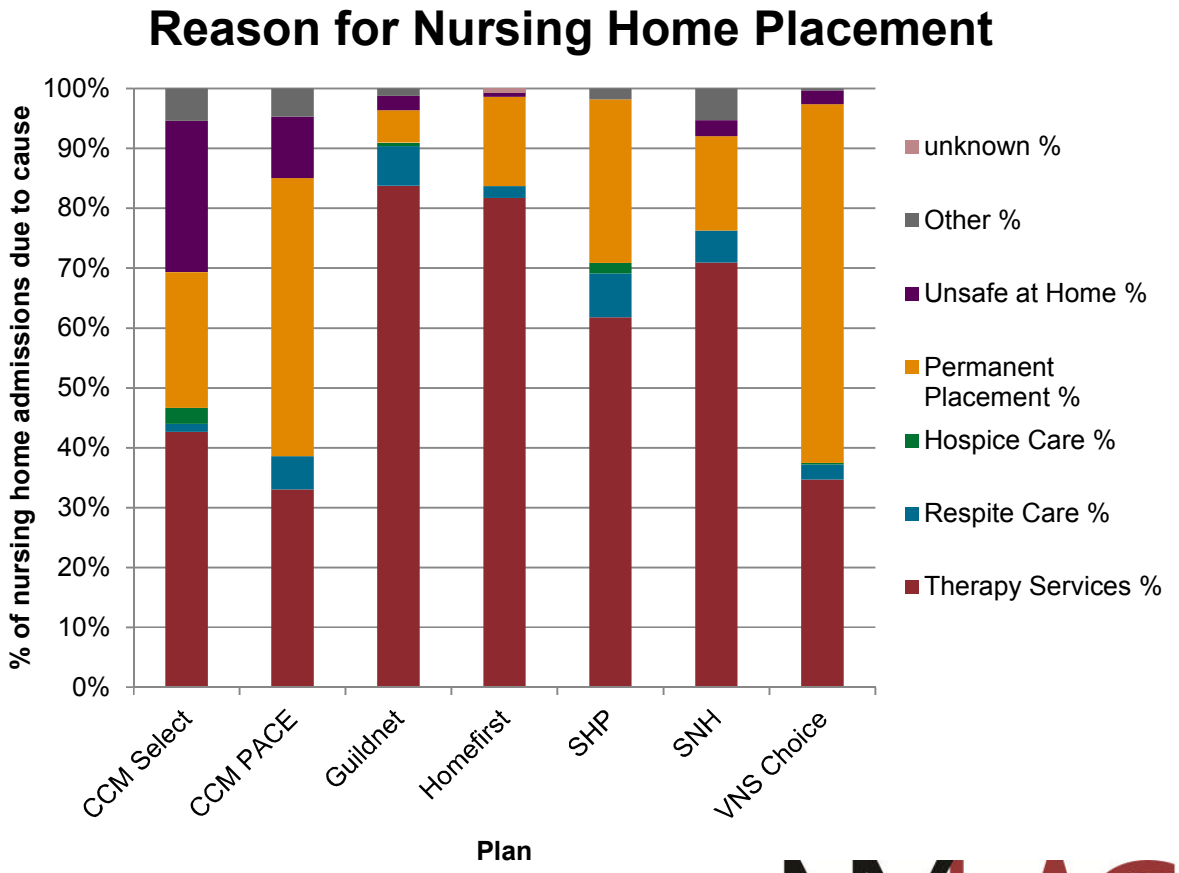
MLTC SAAM data: Nursing Home Admissions

- The SAAM tracks the reason for each nursing home admission.
- Plans vary significantly in whether nursing home placement tends to be for temporary therapy (red), permanent placement (yellow), or the vague "unsafe at home" (purple).

Only plans with at least 30 nursing home admissions are shown here, to avoid small sample size skewing.



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New York State's Duals Demonstration Project: Fully Integrated Dual Advantage (FIDA)

FIDA plans are a new type of managed care plan for certain "dual eligibles" - people who have both Medicare and Medicaid in NYS who need long-term care services.

HOW DUAL ELIGIBLES RECEIVED CARE UNTIL NOW –

Until now, dual eligible have had the choice of using Medicare and Medicaid through either of two models -- Fee for Service or through a Managed Care plan.

For their MEDICARE services, they have always had the **OPTION** of receiving their Medicare services either through a:

- "Medicare Advantage" plan -- a type of HMO or other managed care plan that controls access to and manages all of their MEDICARE services, usually including Part D prescription drugs, or
- "Original Medicare" which is Medicare on a "fee for service basis" (see blue and white Medicare card), and enroll in a separate stand-alone Medicare Part D plan for prescription drugs.

For their care covered by MEDICAID, if they need Medicaid home care or other community-based long term care services, and if they live in NYC, Long Island, Westchester or one of the other counties with MANDATORY Managed Long Term Care, they have been **required** to enroll in an MLTC plan. See MLTC news at http://www.wnylc.com/health/news/41/ . This was true regardless of whether they chose to be in Medicare Advantage or Original Medicare for their Medicare services. MLTC members have the choice of keeping their Original Medicare card or enrolling in a Medicare Advantage plan for their Medicare services. They receive some Medicaid services outside of the MLTC plan – such as covering the Medicare co-insurance for hospital stays and doctor visits.

Plans covering Medicare and Medicaid are not new -- Even up til now, Dual Eligibles have had an option of enrolling in a single plan that combines all of their Medicare and Medicaid services in one managed care plans. These are called *MEDICAID ADVANTAGE* Plans (as opposed to MEDICARE Advantage plans) and PACE plans. The name is misleading because these plans cover MEDICARE as well as MEDICAID services. TO make it more confusing, only some MEDICAID ADVANTAGE plans include Medicaid personal care and other long term care services. These are called MEDICAID ADVANTAGE PLUS Plans. PACE plans also cover Medicaid long term care services as well as all Medicare services

Click here for a chart showing which of these many types of plans are offered by each insurance company in NYS, posted at http://www.wnylc.com/health/download/429.

HOW IS THIS CHANGING? THE NEW FIDA PLANS –

FIDA plans will combine under *one managed care plan*: (1) a Medicare Advantage plan, (2) a Part D prescription drug plan, (3) a Medicaid Managed Long Term Care plan, and (4) all other Medicaid services. FIDA plans will cover not only Medicaid long-term care services, as MLTC plans do, but also cover ALL other medical care covered by Medicare and Medicaid. In other words, a FIDA member will essentially trade in ALL of their insurance cards -- Medicare (Original or Medicare Advantage), Medicaid, MLTC, Medigap, and Medicare Part D -- and only have one health plan -- their FIDA plan.

On August 26, 2013, CMS approved a "Memorandum of Understanding" (MOU) between NYS and DOH to launch this demonstration program. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-08-23_ny_mou_final.

WHERE

As a demonstration program, NYS is targeting a smaller group of dual eligibles, not the whole state. The demonstration area is **NYC, Long Island, and Westchester.**

WHO

Not coincidentally, the target group includes **dual eligibles in NYC, Long Island, and Westchester who**

- Receive or need **MANAGED LONG TERM CARE** services - those adults age 21+ who receive or need community-based long term care services, AND
- ALSO - Dual eligibles living in **nursing homes** or who come to be permanently placed in nursing homes.
- EXCLUDED - People in the OPWDD, TBI, and Nursing Home Transition & DIversion Waiver, who are receiving hospice services or who live in Medicaid Assisted Living Program will be excluded.

WHEN

Notices about the new FIDA plans and "voluntary" enrollment will begin in September 2014, with the first voluntary enrollments effective Oct. 1, 2014. "Passive" (involuntary) enrollment will be effective Jan. 1, 2015.

Passive Enrollment and Opting Out-- Unlike MLTC, enrollment in a FIDA plan is not "mandatory." MLTC members may choose to **OPT OUT** and stay in an MLTC plan and use their Original Medicare or Medicare Advantage cards for their primary medical care. However, if they do not opt out, or select their own plan they will be "passively enrolled" into a FIDA plan selected for them.

- I**n September and October 2014**, MLTC members and nursing home residents will receive notice that they may "voluntarily" enroll in a FIDA plan (and will be heavily marketed by their MLTC plans to join the one sponsored by the same company that sponsors the MLTC plan). If they don't join a plan "voluntarily," and do not affirmatively OPT OUT prior to Jan. 1, 2015, they will be "passively enrolled" into a plan effective Jan. 1, 2015.
- **Oct. 1, 2014** - **Enrollment becomes effective** in FIDA plans for people who voluntarily enrolled in September 2014, with more people enrolled in November and December 2014 if they enrolled in October and November.
- **Oct. 1, 2014 – 60-Day NOTICE OF RIGHT TO OPT OUT OF FIDA -** Those who did not already enroll will receive notice that they may enroll in the next 60 days - or may OPT OUT. They will receive a reminder 30-Day Notice.
    - **IF they don't enroll or OPT OUT, they will be automatically assigned - passively enrolled --** into a plan that is linked to their MLTC plan, or if they are nursing home residents they will be assigned to the plan that contracts with their nursing home.

- They will have the **right to disenroll** after that date at any time, but since enrollment is by the month, there may be a delay in which they will not have access to their preferred doctors and other providers, if they are not in the FIDA plan's network. People in nursing homes will have the same passive enrollment process, but a few months behind those in MLTC plans.

WHICH PLANS?

Most of the downstate MLTC plans are seeking to expand their coverage to become FIDA plans, which means adding all Medicare services and Medicaid services not covered by MLTC. See list showing types of plans offered by each insurance company, with column indicating which will be FIDA plans, posted at http://www.wnylc.com/health/download/429. State's list of FIDA plans posted in Question A6 in this DOH Frequently Asked Questions (FAQs) - September 2013.

CONSUMER RIGHTS – 90-Day TRANSITION PERIOD - CONTINUITY OF PAST SERVICES AND PROVIDERS

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.
- 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.
- 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.

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
- 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 Coun**cil – which will hear Medicaid issues as well as Medicare. Aid continuing applies if timely requested.
4. **Federal district court** appeal. (NO automatic aid continuing)

CONSUMER PROTECTIONS

- **OMBUDSMAN** -Though the state declined federal funding for an Ombudsman program, NYS has committed to including an Ombudsprogram to assist and advocate for consumers navigating FIDA.
- **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.
- **Right to Disenroll** at any time and return to Original Medicare or Medicare Advantage, with Medicaid MLTC for long term care.

FOR MORE INFORMATION

State FIDA website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm - includes NYS DOH FAQ (9/2013), link to the Memorandum of Understanding , CMS Press Release, CMS Fact Sheet, various DOH Presentations such as http://www.health.ny.gov/health_care/medicaid/redesign/docs/fida_stakeholder_mtg_present.pdf

The National Senior Citizens Law Center has created a website with resources for advocates on the Dual-Eligible proposals -- http://dualsdemoadvocacy.org/.

NYS Consumer Advocacy information:

http://www.wnylc.com/health/entry/166/ http://www.wnylc.com/health/entry/196/

Prepared by New York Legal Assistance Group Evelyn Frank Legal Resources Program EFLRP@nylag.org 212.613.7310

FIDA – FULLY INTEGRATED DUAL ADVANTAGE

NYS will begin notifying certain Dual Eligible in NYC, Long Island, and Westchester about enrolling in FIDA in September 2014. Notices will be sent to about 155,000 adults in nursing homes and in managed long term care plans.
In May, State DOH shared drafts of the series of four notices with consumers and asked for input. These four notices are:

1. an "announcement" letter
2. 90-day Notice sent around Sept. 1, 2014
3. 60-day Notice sent around Oct. 1, 2014
4. 30-day Notice around Nov. 1, 2014 – last chance to OPT OUT of FIDA or choose one's own FIDA plan

- Jan. 1, 2015 – PASSIVE ENROLLMENT begins into FIDA plans for those who did not opt out or choose their own plan.

The following DRAFT NOTICE are the proposed edits of the **60-Day NOTICE** submitted by the Coalition to Protect the Rights of New York's Dual Eligibles (CPRNYDE). To see the State's proposed draft, and the other notices – as proposed and as edited by the consumer Coalition – go to http://www.wnylc.com/health/entry/196/. Look in table at May 2014 entries and links.

For more info on FIDA see http://www.wnylc.com/health/entry/166/

New York
Medicaid Choice

60-day

New York State's Medicaid managed care enrollment program

1-855-600-FIDA
Ask ▪ Choose ▪ Enroll

P.O. Box XXXX, New York, NY 10274-XXXX

<Date>

<Barcode><Letter Code>
<Name>
<Address>
<City>, <State>, <Zip>

Dear <Consumer Name>: <CIN>

Second Important Notice

Changes to Your Medicaid and Medicare: The New FIDA Plan

You are getting this letter because you have BOTH Medicare and Medicaid, and because you receive Medicaid long-term care services such as home care or nursing home care. This is the second letter sent to you about the new **Fully Integrated Duals Advantage (FIDA)** Plan. If you did not receive the first letter, call New York Medicaid Choice toll free at 1-855-600-FIDA or 1-855-600-3432 (TTY: 1-888-329-1541). You will receive a third letter on <date>.

Now, you receive your Medicaid home care and other Medicaid services through a Managed Long Term Care (MLTC) plan, and access your Medicare services (physicians, hospital, prescriptions) separately through Original Medicare or a Medicare Advantage plan. A FIDA plan is a new type of plan that combines all of your Medicare and Medicaid services (including MLTC) into a single plan. The FIDA plan provides all of your Medicare and Medicaid services, including all doctors, long-term care and prescription drugs.

Unless you choose a different FIDA Plan or choose not to participate in FIDA at all ("opt out"), the Department of Health will enroll you into <FIDA Plan>with coverage effective on <effective date>.

What are my options?

1. **Choose your own FIDA Plan.**
   If you want to choose your own FIDA Plan, contact New York Medicaid Choice by <*INSERT*:voluntary enrollment cutoff date, 20th day of the month preceding the passive enrollment effective date>. New York Medicaid Choice can be reached toll free at 1-855-600-FIDA or 1-855-600-3432 (TTY: 1-888-329-1541).

2. **"Opt Out" of FIDA.**
   To opt out, you must contact New York Medicaid Choice to opt out by <*INSERT*:voluntary enrollment cutoff date, 20th day of the month preceding the passive enrollment effective date>. New York Medicaid Choice can be reached toll free at 1-855-600-FIDA or 1-855-600-3432 (TTY: 1-888-329-1541). If you opt out, you will stay in your Managed Long Term Care (MLTC) plan and keep your Medicare coverage as it is now.

3. **Do nothing and be Automatically Enrolled into <FIDA Plan>.**
   Unless you choose a different FIDA Plan or choose not to join FIDA at all ("opt out"), the Department of Health will enroll you into <FIDA Plan> with coverage beginning on <effective date>.

How will I get my items, services, and drugs once I join the FIDA Plan?

- You will have a Care Manager who will lead an Interdisciplinary Team (IDT) to coordinate your care. Your IDT will include people who know about your care needs. This includes you or someone that you choose, your primary doctor, other providers that you choose or approve, and a representative from the home care agency or nursing home that knows about your needs.

- The FIDA plan will pay for your covered items and services from the plan's network of providers.

May I see my current Medicare doctors after I enroll in FIDA?

It depends. Generally, you may only see doctors and other medical providers who are in the FIDA plan's network. Therefore it is important that you **ask your preferred doctors and other providers if they are in a FIDA Plan, and which ones**. You must also get your medicines from the FIDA plan's pharmacy or mail order pharmacy. However, you may use providers who are not in the FIDA plan ("out of network") during the first 90 day "transition period" you are in the FIDA plan. You may also use providers who are not in the FIDA plan in emergencies.

What happens to my home care services and medical treatment I have now, after I join FIDA? Will they stop?

- To make sure there is no gap in coverage, the FIDA plan will continue all of your current services for a 90-day **transition period** until at least <date>. During that time:
    - You may use doctors and other providers who aren't in the FIDA plan if you have already been seeing them at the time you join the FIDA Plan.
    - You won't need prior authorization for services you are already receiving at the time you join the FIDA Plan.
    - You may continue to use prescription drugs you are using at the time you join the FIDA plan.
    - Your plan must continue the same home care and other long-term care services you have been receiving

REMEMBER THIS: After the 90-day **transition period**, you will need to get "prior authorization" (permission) from your FIDA plan Interdisciplinary Team (IDT) to see any doctors or other providers that are outside of the FIDA Plan's network. You may only be able to see doctors or other providers that are "out of network" if you need **urgent or emergency** care, or you need out-of-area dialysis, or you need family planning. The FIDA plan may also reduce or change your home care or other services after the 90-day **transition period**, but will give you advance notice and the right to appeal those changes.

May I disenroll from FIDA if I want to return to Original Medicare or Medicare Advantage for my doctors and hospital care?

Yes. You may disenroll from FIDA at any time. You can even disenroll during the 90-day **transition period** or at any time after that. If you disenroll from FIDA, you will go back to Original Medicare or your Medicare Advantage plan for your doctors and hospital care. You will then need to enroll in a Managed Long Term Care plan to receive Medicaid home care and other long term care services, and you may need a Part D plan for prescription drugs.

How much will I have to pay for items, services, or drugs once I am in the FIDA Plan?

You do not have to pay a plan premium, deductible, or copayments when getting covered items, services, or prescription drug and other medication coverage through a FIDA Plan.

If you are not enrolled in a Medicare Savings Program, you will still need to pay your Medicare Part B premium ($104.90/month). The Medicare part B premium is usually withheld from your Social Security check.

If you have a Medicaid Spend-down or "excess income," you will still have a spend-down in FIDA. As with your MLTC plan, the FIDA plan will send you a monthly bill for the amount of your excess income or spend-down.

If I enroll in FIDA, what happens to my Medicare Part D plan?

You may have received a letter from your current Medicare Part D prescription drug plan telling you that beginning <effective date>, your prescription drug plan won't cover your prescription drugs. That is because you are being enrolled in a FIDA plan which now includes your Medicare drug coverage. If you choose a FIDA Plan, you will get all of your prescription drug and other medication coverage through a FIDA plan. You will not be able to use your current Part D plan, and you cannot keep your current Part D plan and be in a FIDA Plan at the same time. If you choose a FIDA plan, you will continue to receive your prescription drug benefits from your current Part D plan until < effective date>. Your new prescription coverage from the FIDA Plan will start on <effective date>. There will be no gap in your prescription drug coverage.

WHAT DO I DO NOW?

Share this letter with your family or the people who know your health care needs – your doctor, senior center, or independent living center. Find out if your

preferred doctors and other providers have joined any FIDA plan and if so, which one.

Your Choices Are:

1. **Call New York Medicaid Choice to choose your FIDA Plan.** To make sure you are enrolled in the plan that you want and to get your plan materials in time for the start of your coverage. call New York Medicaid Choice by **<*INSERT*:** voluntary enrollment cutoff date, 20th day of the month preceding the passive enrollment effective date**>**

OR

2. **Call New York Medicaid Choice to "opt out" of FIDA and keep what you have now.** Tell New York Medicaid Choice that you don't want to be enrolled into FIDA by <Date -day before the effective date>. They can help you keep your current coverage – your Managed Long Term Care plan for home care and other Medicaid services and your Original Medicare or Medicare Advantage coverage. They can also talk to you about other options.

OR

3. **Do Nothing –** and **You will be Automatically Enrolled into <Plan Name>** with enrollment effective <INSERT: passive enrollment effective date>. You will have the right to disenroll from <Plan Name> and switch back to your MLTC and Original Medicare or Medicare Advantage at any time. But the switch will always be delayed until at least the 1st of the following month.

CONTACT
New York Medicaid Choice (NYMC)
1-855-600-FIDA or 1-855-600-3432 TTY: 1-888-329-1541
Monday to Friday 8:30 am to 8:00 pm
Saturday 10:00 am to 6:00 pm
Website www.nymc.com

How To Request Letter in Alternate Format or Language

This letter and the FIDA booklet are available in Braille, large-print, audio edition, or in other languages:

Spanish Russian Chinese Italian
Haitian-Creole Korean

We also have free interpreter services to answer any question you may have. To get an interpreter or request this letter in an

alternate format, just call us at 1-855-600-FIDA or 1-855-600-3432 (TTY: 1-888-329-1541)

CONTACT
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Website www.nymc.com

FOR MORE HELP YOU CAN CONTACT:

1. Refer to FIDA OMBUDS
2. Refer to 1-800-MEDICARE (see comments in Excel)