A New World: Medicaid Managed Care

The Evelyn Frank Legal Resources Program (EFLRP), based in New York City, is known for its advocacy on behalf of the elderly and for keeping elder law attorneys throughout New York State informed and educated about key issues in the field, particularly Medicaid. The changing landscape of Medicaid and the new requirement of mandatory enrollment in a Medicaid Managed Long-Term Care plan is no exception. The EFLRP, working with the Legal Aid Society and the Empire Justice Center, maintains the Website NYHealthAccess.org. This Website contains a vast array of comprehensive articles covering Medicare and Medicaid, including several articles detailing the facts and issues involving new mandatory enrollment. This article summarizes information contained on the NYHealthAccess.org Website pertaining to this important change. (The EFLRP, formerly associated with Selfhelp, is now part of the New York Legal Assistance Group.)

By Peter Aronson

If you service clients seeking or receiving Medicaid, particularly in the New York City metropolitan area, you are well aware that there has been a drastic change in the community Medicaid program. On September 4, 2012, the federal Centers for Medicare and Medicaid Services approved a request from New York State that all so-called dual eligible adults (those receiving Medicare and Medicaid and age 21 or over who are applying for home care through Medicaid) must enroll in a managed long-term care plan. For many elder care attorneys, this includes all or most of our senior clients who are or will receive home care through Medicaid.

What this means is that these clients no longer apply to a CASA in New York City or the Department of Social Services in another part of the state. Instead, what had been optional for many years is now mandatory: These clients, with a few exceptions, must join a Medicaid managed care plan and enroll in Medicaid through this plan. (This change includes individuals seeking to receive home care through an agency aide or through a consumer directed personal assistance program (CDPAP), as well as those seeking certified home health agency (CHHA) services, private duty nursing or medical adult day care.)

For greater detail about the information covered in this article, please see the NYHealthAccess.org Website: “Managed Long Term Care,” http://www.wnylc.com/health/entry/114/ and other related articles found at NYHealthAccess.org.
For many attorneys and clients, this may be a relief that they no longer have to deal directly with Medicaid and, in particular, with CASAs in New York City.

Under the shift to mandatory managed care, new Medicaid clients must enroll in a managed care plan and existing Medicaid clients must select a plan within 60 days of receiving notice, otherwise they automatically will be enrolled. The shift to mandatory managed care is happening gradually around the state:

Phase I: New York City, September 2012 through January 2013, date depends on community service received

Phase II: Nassau, Suffolk and Westchester counties, January 2013

Phase III: Rockland and Orange counties, June 2013 (tentative)

Phase IV: Albany, Erie, Onondaga and Monroe counties, December 2013 (tentative)

Phase V: Other counties, June 2014

Final Phase: People living in assisted living programs and nursing homes, no date set

Partial Capitation

The Medicaid Managed Care Plan becoming mandatory for most of our senior clients in need of or already receiving home care through Medicaid is called a “partially capitated” plan. The state pays the managed care plan the same amount for each enrolled member per month, not an amount based on the care provided to each member. The plan pools the amount received monthly from the state and this “capitated” rate is designed to allow the plan to save money on enrollees who need less service so that the plan has the resources to provide greater services to the enrollees who need it. This option is called “partial capitation” because the managed care company would provide care for only community-based long-term care services, such as home care and adult day care. This capitation concerns advocates and attorneys because plans have a financial incentive to provide fewer hours of home care so the plans make a larger profit. (A “full capitation” program provides coverage for all medical care, including doctors, hospitals and home care; the enrollee must use all providers in the managed care plan; and the enrollee’s need for daily care must be such that the individual would be eligible for admission to a nursing home. For more details, see “Managed Long Term Care,” http://www.wnyc.com/health/entry/114/ and “Tools for Choosing a Medicaid Managed Long Term Care Plan, http://www.wnyc.com/health/entry/169/.

Enrollment

For clients already receiving home care through Medicaid, they will receive a series of letters from New York Medicaid Choice regarding enrollment. Within the time frames
outlined above for counties in the state, the first letter should arrive approximately 120 days before the client’s current community-Medicaid service needs re-authorization. It will inform the client of this coming change. Approximately 30 days later, the client should receive a second letter stating that the client has 60 days to select a MLTC plan or they will be assigned to a plan. The lists of the plans offered throughout the state can be found at the New York State Department of Health Website at http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm. Consumers with questions can call NY Medicaid Choice at 888-401-6582.

If enrolling in a partially capitated plan, the client can enroll directly with the plan or through NY Medicaid Choice. Enrollment is effective the first day of the month enrolled. However, if the client enrolls after the third Friday of the month, then membership is effective the first day of the next month.

**Transition to the MLTC coverage**

If the client is already receiving home care through Medicaid, the MLTC plan must provide the same services and the same hours for at least a 60-day transition period, or until an assessment is done. The MLTC must do an assessment, which includes having a nurse visit the client and assessing the needs. If the MLTC wants to reduce or end the service, the plan must provide a written notice stating the service to be provided on day 61. The written notice must explain the client’s right to appeal. If the client receives a reduction of service or outright denial within the 60-day transition period, the client should request an Internal Appeal with 10 days of the notice and request aid continuing, so that the same level of care continues during the appeal process. For more details on this transition period, see the New York State Department of Health MLTC Policy 13.01, dated Feb. 6, 2013, found at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.01_revised.pdf

(For more details on appeals process, see Appeals section below)

If the client is not yet receiving home care through Medicaid, the nurse will visit the client to assess the need for care. While the guidelines are not clear, at the outside the plan must complete an assessment and authorize service within 30 days of when the client enrolled in or was referred to a MLTC plan.

The nurse assessor uses a standardized assessment tool called SAAM – MLTC Semi-Annual Assessment of Members, which combines information about demographics, diagnosis, living situation and functional abilities. This tool does not determine the number of hours. Most MLTC plans use proprietary forms to determine the number of hours. Consumer advocates are deeply concerned that there is a lack of statewide guidance and that the state has not required plans to provide the personal care, CHHA and other services in the same amount, duration and scope as is provided in the state plan outside the MLTC plans.

The state is testing a uniform assessment tool to replace SAAM, although there is no set implementation date. Some MLTC plans are saying the new form will be in use this summer,
at least in New York City. The Federal Medicaid statute requires that all MLTC plans provide services to the same extent they are available to Medicaid recipients not enrolled in MLTC plans. All decisions by the MLTC plans may be appealed. (See Appeals section below)

In all the counties in Phase I and Phase II now requiring MLTC enrollment (New York City and Nassau, Suffolk and Westchester), clients may keep their current aides from the CASA or DSS program when enrolling in a MLTC plan. That’s because through December 31, 2013, all MLTC plans are required to contract with all home care agencies currently providing service. For CDPAP service, all MLTC plans are required to contract with local CDPAP vendors through October 31, 2013.

If the MLTC plan refuses to allow the client to keep their current aide, call the NY State Department of Health’s MLTC hotline at 1-866-712-7197.

When applying for community-based Medicaid, the individual would submit a Medicaid application to the Managed Care Plan the individual chooses. In the five boroughs of New York City, there were 18 partially capitated plans serving more than 63,000 individuals at the end of 2012. VNS Choice, Guildnet, ElderServe, Elderplan, Center Light MLTC and Senior Health Partners provided coverage for approximately 80 percent of the enrollees.

The MLTCs must provide the following services:

- Home care, including personal care (home attendant or housekeeping); Certified Home Health Agency Services (CHHA); Private duty nursing; and Consumer Directed Personal Assistance Program (CDPAP);
- Adult Day Health Care;
- Personal Emergency Response System;
- Nutrition (home delivered meals or congregate meals);
- Home modifications;
- Medical equipment, such as wheelchairs and other medical supplies;
- Physical, speech and occupational therapies outside the home;
- Hearing aids and eyeglasses;
- The following medical specialties: podiatry, audiology (including hearing aids and batteries), dental and optometry (including eyeglasses);
- Non-emergency medical transportation to doctor’s office; and
- Nursing home care.

Exceptions to Enrollment

The following individuals are not allowed to enroll in a Medicaid Managed Care Plan:

- Individuals in waiver programs;
- Nursing home residents;

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Residents in the Medicaid Assisted Living Program;
- Individuals receiving hospice;
- Residents of the following: Intermediate Care Facilities for the Developmentally Disabled; Alcohol and Substance Abuse Long Term Care Residential programs, adult foster care homes; and psychiatric facilities; and
- Children under age 18.

Other individuals, such as Native Americans and mostly a narrow group of individuals under age 65, have the option of enrolling in a Managed Long-Term Care plan.

**Requesting Services**

Once a service is in place from a MLTC, an enrollee, or a provider on behalf of an enrollee, may request a new service by filing what’s called a Prior Authorization, or request more of the same service (i.e. more hours of home care) by filing what is called a Concurrent Review. In both situations, a request can be made for an expedited (as opposed to a standard) review of the request, if delay would seriously jeopardize the client’s life or health, or their ability to attain, maintain or regain maximum function. The time frames for review must be no longer than:

**Prior Authorization:**
- Expedited, within 3 business days from request for service;
- Standard, within 3 business days of receipt of necessary information, but no more than 14 calendar days from receipt of request for services, subject to a possible extension;

**Concurrent Review:**
- Expedited, within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services, subject to possible extension.
- Standard, within 1 business day of receipt of necessary information, but no more than 14 calendar days of receipt of request for services, subject to possible extension.

An enrollee, or a provider acting on an enrollee’s behalf, may verbally or in writing seek an extension of up to 14 days. The plan also may seek an extension if it can show the need for additional information and that the extension is in the enrollee’s best interest, with written notice to the enrollee, giving the enrollee the right to file a grievance to oppose the extension. The plan must issue its decision as expeditiously as the enrollee’s health requires and no later than the 14-day extension period.

**Changing Plans**

An enrollee, or a provider acting on an enrollee’s behalf, may verbally or in writing seek an extension of up to 14 days. The plan also may seek an extension if it can show the need for additional information and that the extension is in the enrollee’s best interest, with written notice to the enrollee, giving the enrollee the right to file a grievance to oppose the extension. The plan must issue its decision as expeditiously as the enrollee’s health requires and no later than the 14-day extension period.
An enrollee may change plans once a month, with the change taking effect the first of the next month. However, if the change is made after the third Friday of the month, the change will not go into effect until the first of the second month. **Before making a change, however, it is important to plan ahead. Before enrolling in a plan, a client should inquire as to whether what a plan can offer a client will match the client’s needs. The plan will send a nurse to assess the client’s needs and will issue a written determination, if requested, before the client joins the plan.**

If the client is leaving a hospital and needs home care immediately, the client should contact a CHHA and ask for home care and a visiting nurse temporarily until the client enrolls in a MLTC. The CHHA may provide short-term Medicaid home care for up to 120 days. A list of CHHAs can be found at: [http://homecare.nyhealth.gov/](http://homecare.nyhealth.gov/)

**Surplus Income**

For the most part, the same rules apply for excess income that existed before the changes outlined in this article. If a client has surplus income, the client over 65 may eliminate the surplus by establishing a pooled income trust or a supplemental needs trust. For additional information about these trusts, see: [http://wnylc.com/health/entry/6/](http://wnylc.com/health/entry/6/)

Or, the client may just pay the surplus income to the MLTC and receive services. However, there is an important change. If the client does not choose to pay the excess to the MLTC, establishing a trust to eliminate the surplus is more important now than under the old system. Under the previous system, HRA home care vendors were prohibited from stopping home care because of non-payment of surplus income. Now, MLTC plans, under their contracts, are allowed to disenroll an individual for non-payment of a spend-down. A model MLTC contract can be found at: [http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_contract.pdf](http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_contract.pdf)

**IMPORTANT TIP FROM EFLRP:** For those clients wanting to receive home care with a surplus, they need to be aware that there now is a glitch -- **thus a delay** -- when activating the Medicaid services they applied for. For someone with excess income, Medicaid coverage does not start until the client submits medical bills equal to the spend-down. But client often don’t have enough bills to meet the spend-down, creating a catch-22 dilemma for the client. This problem is caused by a glitch in the Medicaid coding system. To address this problem, in July 2012, HRA created a new eligibility code for **“provisional” Medicaid coverage** for people facing this dilemma. The FULL Medicaid alert outlining this “provisional” coverage can be found at: [www.wnylc.com/health/afile/176/329/](http://www.wnylc.com/health/afile/176/329/)

**IMPORTANT CHANGE: Additional Income allowed for Clients moving from a Nursing Home to Community Medicaid**
A new rule will make it more financially feasible for nursing home residents to return home and receive community Medicaid to pay for home care. The new rule, under 12ADM-05, dated October 1, 2012, allows an individual to receive a housing allowance, in addition to their normal income allowance, when leaving a nursing home if they enroll in a MLTC plan for home-based Medicaid services. The following special monthly income allowances are in place for 2013: New York City, $1003; Long Island, $1,045; Northern Metropolitan (Westchester up to Duchess), $805; Central, $368; Northeastern, $408; Western, $338; and the Rochester area, $380.

**Grievance and Appeals Process**

With the start of mandatory MLTC enrollment, the grievance and appeal process has changed. No longer does a client just file for a fair hearing if the client receives an unfavorable result. Under the new system, if the MLTC makes a decision your client is not satisfied with or the quality of the service provided is not satisfactory, the client either files a grievance or an appeal.

**Grievance**

A Grievance may be filed if the client is not satisfied with the quality of care, services or treatment, or is not satisfied with the communication from the plan. (A grievance is not about the scope, amount or type of service that was approved by the plan, but about the quality of care provided.) A member may file a Grievance either in writing, in person, or by calling the MLTC member services telephone number listed in the MLTC handbook, which each client should receive upon enrollment. The client or the person calling on their behalf must be very clear to specify that the call concerns a grievance, not an appeal.

The EFLRC has posted information about and links to many of the MLTC handbooks and the MLTC phone numbers at [http://www.wnylc.com/health/entry/179/](http://www.wnylc.com/health/entry/179/).

The plan must decide the grievance within 45 days after receiving the information and no later than 60 days. The client may file an expedited grievance if the client thinks delay would result in serious harm or impact the ability to function. Expedited grievances must be decided within 48 hours of the plan receiving the information, and within no more than seven calendar days.

If the client is not satisfied with how the grievance is handled, or it is an emergency, the client may call the State Dept. of Health MLTC Complaint hotline, 1-866-712-7197.

If the client does not agree with the grievance decision, they may file a grievance appeal with the MLTC, in writing, in person or over the phone.

**Appeals**
An appeal is different than a grievance in that an appeal requests that a decision by a MLTC plan be reviewed, such as if a plan denies, reduces or ends service. MLTC plans are required to provide a written document when making any decision regarding care – whether it is an acceptance, denial or change.

A client may appeal those written decisions and also may appeal if a plan misses a deadline. Failure by a MLTC plan to make a decision by a deadline constitutes a denial and triggers, under Federal law, a client’s right to appeal.

The appeal process has two stages. First, a client must request an internal appeal by either calling the MLTC phone number or submitting a writing to member services, noting on the envelope and letter that it is an APPEAL REQUEST. If possible, it is preferable for the client to appeal in writing, so the client has a record of the complaint. The client should include all identifying information: member ID number, name, address, Medicaid number, phone number and the reason for the appeal.

To receive AID CONTINUING – i.e.: the continuation of the current service pending the appeal in cases where the MLTC has reduced the service – the appeal must be filed within 10 days of the date of the notice or before the “effective” date on the notice. Be certain to ask for AID CONTINUING within the 10-day period.

As a whole, an appeal must be filed within 45 days of the date of the notice.

The plan has 30 days to decide the internal appeal. If the client requests an expedited appeal, the plan must issue a decision within three days.

During the appeal process, the member has the right to request and receive copies of their case file.

**Fair Hearing or External Appeal**

If the client loses the appeal, the MLTC is required to send the client a written decision, which will explain the client’s right to then request a fair hearing or an external appeal.

The written decision will further explain the right to request a fair hearing, and if requested within 10 days, the client is entitled to the all-important aid continuing, until the hearing is decided.

The client can request a fair hearing:

- In person, for New York City, at 14 Boerum Place, Brooklyn, NY, or outside New York City, at the local Department of Social Services;
- By phone, 800-342-3334;
- By fax, 518-473-6735; to request a fair hearing by fax, you must download and complete a form found at [http://otda.ny.gov/oah/FHReq.asp](http://otda.ny.gov/oah/FHReq.asp);
Online, at [http://otda.ny.gov/oah/FHReq.asp](http://otda.ny.gov/oah/FHReq.asp); or

By mail, to New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
PO Box 1930
Albany, NY 12201-1930

To file a request for a fair hearing by mail, submit the completed form found at [http://otda.ny.gov/oah/FHReq.asp](http://otda.ny.gov/oah/FHReq.asp)

Just like before the new era of mandatory managed care, be sure to request a fair hearing within 10 days of the date on the plan’s notice and be sure to ask for AID CONTINUING, so that the current service remains uninterrupted until after the fair hearing decision.

Also, the client has the right receive and examine copies of the case file before the hearing. Make this request as soon as possible after receiving the notice from the plan.

**External Appeal**

An external appeal may be requested if the plan has denied coverage because it determined that the service is not medically necessary or is experimental or investigational. The client may request both a fair hearing and an external appeal, although the decision from the fair hearing will be binding and, thus, followed by the plan. External appeals are reviewed by a different state agency than a fair hearing.

To file an external appeal, the client must complete the New York State External Appeal Application, to be found at [http://www.dfs.ny.gov/insurance/extapp/extappl.pdf](http://www.dfs.ny.gov/insurance/extapp/extappl.pdf) and send it to the New York State Department of Financial Services.

For more information regarding external appeals, go to: [http://www.dfs.ny.gov/insurance/extapp/extappqa.htm](http://www.dfs.ny.gov/insurance/extapp/extappqa.htm); call the Department of Financial Services at 1-800-400-8882; or e-mail: externalappealquestions@dfs.ny.gov.

For additional information about appeals and grievances, go to: [http://www.wnylc.com/health/entry/184/](http://www.wnylc.com/health/entry/184/)

For grievance and appeal information and contacts at the various MLTC plans, go to: [http://www.wnylc.com/health/entry/179/](http://www.wnylc.com/health/entry/179/)
Footnotes

1. N.Y. Soc. Serv. L. Sec. 364-j (Amended L. 2011 Ch. 59), 18 NYCRR 360-10
2. 42 U.S.C. Sec. 1396b(m)(1)(A)(i); 42 C.F.R. Secs. 438.210 (a)(2) and (a)(4)(i).
5. same as 4
8. 42 CFR 438.404(c)
9. 42 C.F.R 438.404(c)(5)