FIDA: Fully Integrated Dual Advantage & MLTC UPDATE January 2016

FIDA Demonstration Program - 2016 Changes
MLTC Update

Evelyn Frank Legal Resources Program, NYLAG Jan. 13, 2016

Topics covered

- FIDA update – 2016 Changes
- MLTC update –
  - Nursing home care and how it relates to MLTC
  - Aide Overtime Pay requirements & 24-Hour Care Changes
- Delays in MLTC enrollment – Troubleshooting Tips
  - Spend-down tips – Spousal Impoverishment protections, Special Housing Allowance
- NAVIGATING MLTC –
  - MLTC Plans Reducing Hours – Consumer Rights
  - Requesting Increases

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What is FIDA?

WHAT? FIDA plans are managed care plans similar to **Medicaid Advantage Plus**. They are FULLY CAPITATED.

They combine a **Medicare Advantage** plan with an **MLTC** plan and add all other Medicaid services-- all:

- **Medicaid** services including LTC now covered by MLTC plans PLUS other Medicaid services NOT covered by MLTC (hospital, lab/xray)
- **Medicare** services – ALL primary, acute, emergency, behavioral health, long-term care, prescription drugs
  - But not: Methadone maintenance, out of network family planning services, direct observation therapy for tuberculosis, and **hospice care**
    - These are still offered through regular Medicare/Medicaid (i.e., government pays, not the plan

- NEW state website - http://www.health.ny.gov/health_care/medicaid/redesign/fida/

Medicare (seniors and people with disabilities) + **Medicaid (people with limited finances)**

FIDA EQUALS

		Inpatient	Outpatient	Drugs	Long Term Care, dental, glasses, hearing aids
Original Medicare	Part A	✓			
	Part B		✓		
	Part D			✓	
Medicare Advantage ("Part C")		✓	✓	✓	
Medicaid FFS		✓	✓	✓	
MLTC					✓
FIDA, PACE or Medicaid Advantage PLUS		✓	✓	✓	✓

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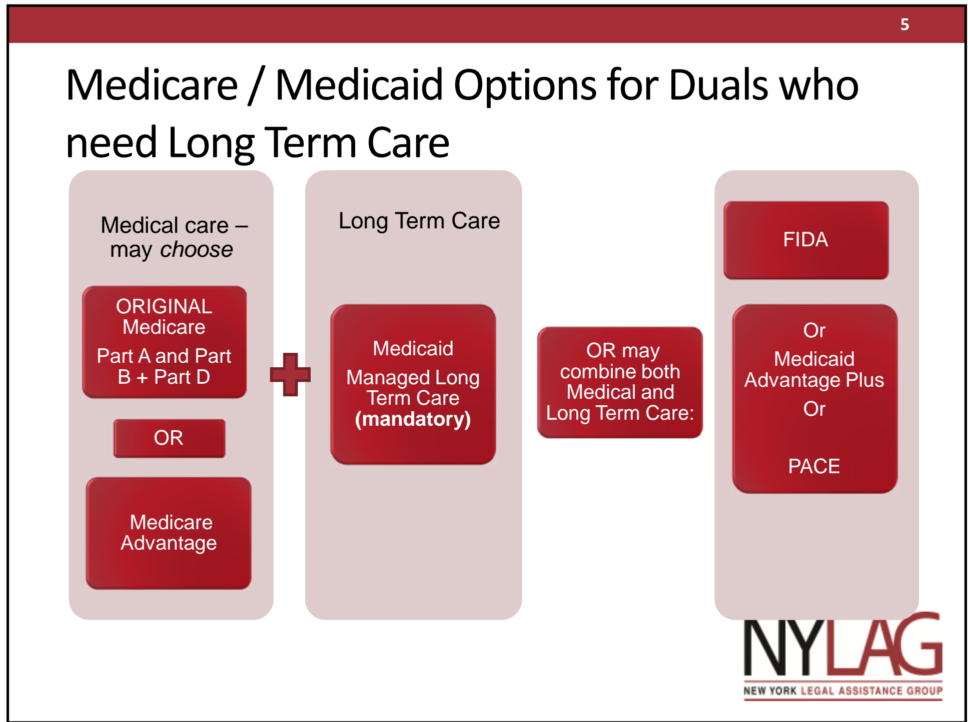

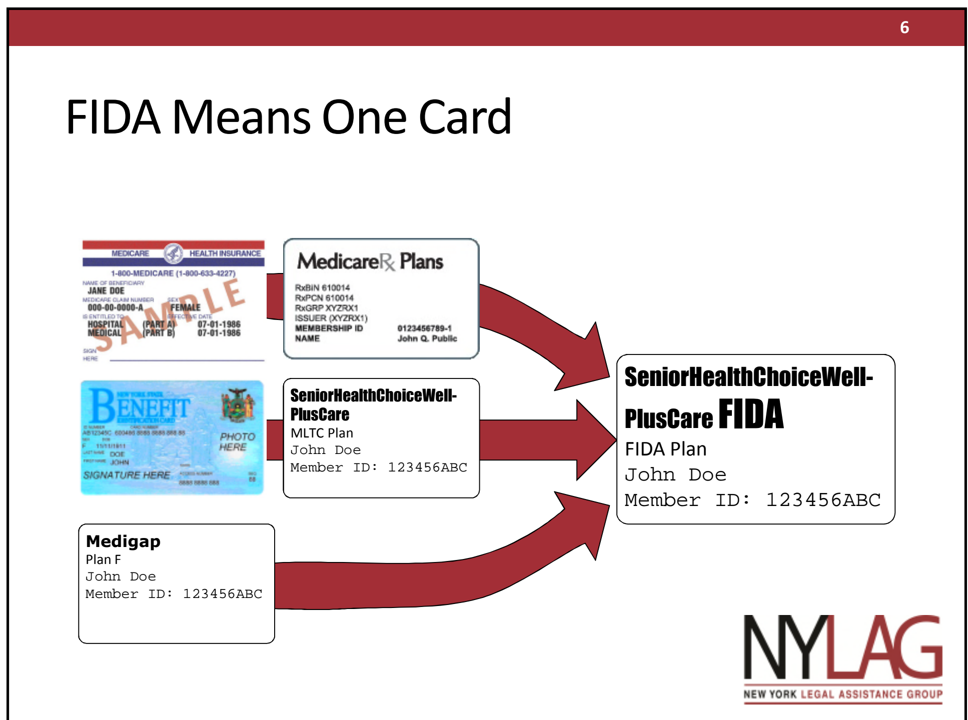

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What does FIDA cover?

- Short Answer: EVERYTHING
  – Medicare + Medicaid
- Long Answer:
  – Doctors
  – Hospitals
  – Lab Tests/ MRI
  – Preventive care
  – Prescription drugs
  – Over-the-Counter drugs
  – Behavioral Health
- Rehabilitation Therapy (PT, OT, ST)
- Home Care (PCA, HHA, CDPAP)
- Nursing Home (short-term and long-term)
- HCBS Waiver Services (such as NHTD and TBI Waivers)

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FIDA 3-Way Contract, Appendix A-1 [p. 253]

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Who is eligible for FIDA?

To enroll in FIDA, either voluntarily or passively, you must be:

- **WHO: DUAL ELIGIBLES Age 21 or older** – must be entitled to Medicare Part A and enrolled in Parts B and D; and
- **WHERE**: Reside in Demonstration Area: **NYC and Nassau County** (**Suffolk and Westchester** slated for **mid-2016)** and
- **Need Long Term Supports and Services** (LTSS) for more than 120 days, either because:
  1. **Enrolled in or will be enrolled in an MLTC or MAP plan;**
  2. Newly permanently residing in a nursing home; or
  3. Eligible for the Nursing Home Transition and Diversion Waiver (NHTD); or
- **Excludes** people in TBI, OPWDD waivers, hospice, Assisted Living Program.

FIDA 3-Way Contract § 3.2.1 [p. 186], MOU § C.1.

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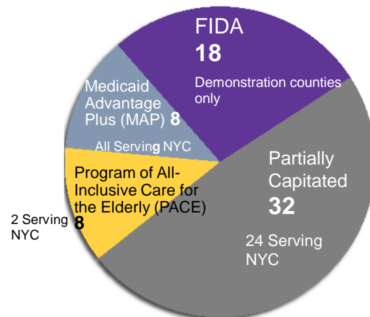
Passive Enrollment if Don't "Opt Out"

- **FIDA is not mandatory**. You have the right to opt out. BUT if you don't opt out you will be "passively enrolled" into a FIDA plan.
- **100,000 MLTC members in NYC & Nassau** received notice of FIDA in early 2015, with first enrollment April 1, 2015. These notices continued all the way through late 2015.
  - **57,735 have OPTED OUT as of 9/1/2015 – by calling New York Medicaid Choice (enrollment broker)(1-855-600-FIDA (1-855-600-3432)**
  - **7,540** are enrolled in FIDA as of Nov. 2015. Many of these were passively enrolled for Sept. 1st and Oct. 1st. In the past, many of those who passively enrolled later disenrolled from FIDA once they realized they were in FIDA. This is likely to happen with this group and enrollment will go down.

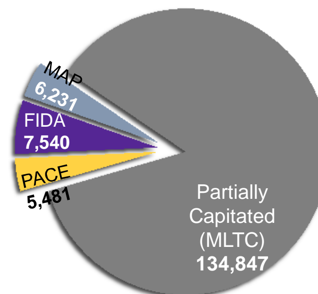
MLTC Statewide Enrollment – November 2015*

*Based on the November 1, 2015 managed care enrollment report

Number of Plans Statewide Actively Enrolling **66**



Total Enrollees Statewide **154,099**



State concerned about Low Enrollment

- Why is FIDA enrollment so low?
- Doctors and other providers do not want to participate in FIDA
  - The "Inter-Disciplinary Care Team" (IDT) has potential to give consumer more say in care plan, but requires time commitment from doctor to attend meetings
  - Not enough education of doctors and other providers about FIDA – they don't understand it and tell patients not to enroll
- Consumers don't want to lose access to doctors – if doctor doesn't accept the FIDA plan, Medicare won't cover MD's care. Same for hospital, labs, all providers.
- State announced changes in 2016 to encourage more participation.

Passive Enrollment Suspended -2016

- MLTC members will no longer receive notices telling them that they must opt out, or they will be auto-enrolled in FIDA.
- FIDA-eligible individuals may **voluntarily** enroll in FIDA at any time
- WHERE - only in NYC & Nassau, not yet in Westchester & Suffolk (mid-2016?)
  - No lock-in or open enrollment period; individuals can disenroll or switch FIDA plans at any time, effective the first of the next month
  - Individuals can voluntarily enroll in FIDA even after opting out of passive enrollment

MMP Enrollment Guidance §§ 40.2, 40.3 [pp. 41, 49]; Appendix 5: State-Specific FIDA Enrollment Guidance for NY §§ 18-24 [pp. 9-12].

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FIDA Reforms

IDT Reforms:

- The Participant has right to choose the make-up of Interdisciplinary Team (IDT) and its members:
  - The IDT can consist of just a Care Manager and Participant, or broader, with a variety of members (from the original IDT list).
- IDT members may meet at different times. The Care Manager may separately meet with different IDT members in developing the Person Centered Service Plan (PCSP).
- Provider participation in an IDT is adjustable, depending on member availability, items being discussed in a given meeting, or the needs, wishes, and goals of the Participant.

NEW YORK STATE Department of Health Office of Health Insurance Programs

FIDA Reforms

IDT Reforms:

- Primary Care Providers may sign off on a completed PCSP without attending IDT meetings.
- Plans have authorization over any medically necessary services included in the PCSP that are outside of the scope of practice of IDT members.
- IDT training will be encouraged, but not mandatory.
- Plans develop their own procedures for communication among IDT members.
- Plans retain responsibility for effective and efficient information sharing among providers (including non-IDT participants), including any PCSP revisions.

NEW YORK STATE Department of Health Office of Health Insurance Programs

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FIDA Reforms

Marketing:

- Plans now have authorization to do the following:
  - Market multiple lines of business under the Medicare Marketing Guidelines.
  - Provide a written or verbal comparison (either DOH/CMS prepared or plan-prepared) among their MLTC (Partial, PACE, MAP) and FIDA programs.
  - Conduct outbound FIDA marketing calls to individuals enrolled in any other Medicaid or Medicare product line with the Plan or company.
  - Organize in-person appointments if they are solicited by the individual.
  - Conduct promotional activities and make nominal gifts at the Medicare Marketing Guidelines levels ($15).
  - Send, with a prior approval from DOH/CMS, FIDA educational materials (e.g., letters, newsletters, etc.) to participants who have opted out.

NEW YORK STATE Department of Health

FIDA Reforms

Marketing:

- Plans may submit enrollment requests to Maximus (consistent with MLTC procedure). Maximus will process the enrollment and send letters, which include ICAN contact information, to the individuals that:
  - confirms the Participant's enrollment in FIDA;
  - informs the Participant that choice counseling is available through Maximus; and
  - informs the participant of the option to switch or disenroll from a FIDA Plan at any time.
- Plans may remain on the phone when prospective Participants call Maximus.
- Plans do not have to include both the plan phone number and enrollment broker number in their marketing materials.

NEW YORK STATE Department of Health

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FIDA Reforms

2016 Enrollment:

- Suspend passive enrollment until further notice, except in limited circumstances.
- Enrollment in Region 2 (Suffolk and Westchester) will not start until after mid-2016.

Continuity-of-Care Period:

- The coverage continuity period for out-of-network providers remains 90 days or until a PCSP is developed and implemented, whichever is later.

NEW YORK STATE Department of Health

FIDA Reforms

ADA Attestation Form:

- No provider should be terminated from a FIDA Plan network for not answering in the affirmative to elements on the form.
- The form is to help FIDA participants identify which providers offer specified accessibility features.
- Completion or non-completion of the form, or responding in the affirmative to elements included therein does not alter existing obligations to comply with the ADA.
- FIDA Plans must maintain a complete and accurate provider directory, including information collected by the form. FIDA Plans have discretion on how to address provider refusals to complete the form.

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Advocacy Concerns about 2016 Changes – Marketing & Enrollment

- Plans will now market members of their MLTC, MAP, & Medicare Advantage plans & enroll them directly in FIDA Plan.
  - Includes those who already OPTED OUT.
  - Now, MLTC plans can have members sign FIDA enrollment forms and plan can submit directly to NY Medicaid Choice. Phone interview no longer required with NY Medicaid Choice to ensure consumer understands what enrollment means – network of providers, access to MD, etc.
  - Marketing inducements allowed up to $15
  - Marketing phone calls to members of plan owned by same company allowed (if in their Medicare Advantage or MLTC plan)
  - Marketing home visits allowed if "solicited by individual" – what does that mean?
- Next slide shows number of MLTC members who may get marketing calls or visits to join FIDA plan. Talk to your clients!

Organization	FIDA	MLTC
1 GuildNet	849	12,436
2 Healthfirst / Senior Health Partners	1455	12,426
3 VNS CHOICE	2593	12,336
4 RiverSpring (ElderServe)	??	10,253
5 Elderplan	324	9,731
6 Fidelis Care	329	6,372
7 WellCare	232	6,225
8 ICS	221	5,729
9 CenterLight	231	5,142
10 VillageCareMAX	33	4,974
11 AgeWell New York	50	4,943
12 Centers Plan	42	4,032
13 SWH Whole Health	67	3,651
14 Aetna	67	3,012
15 North Shore-LIJ Health Plan, Inc.	28	3,012
16. Alphacare	54	2,386
17 Metroplus	180	939
__ EmpireBlue/Healthplus/AmeriGP	Closing 271	2,790
__ EmblemHealth	CLOSED	CLOSING 1,137
6 other MLTC plans with no FIDA*	0	9,756
TOTAL	7,026	111,526

FIDA/MLTC Enrollment

NYC + Nassau

12/2015

Emblem MLTC merging into Guildnet

***3 MLTCs with FIDA plans that closed** – Montefiore, Archcare, Integra,
3 MLTC plans with no FIDA: Extended, Montefiore, UnitedHealth

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Advocacy Concerns about 2016 Changes – IDT

- The Inter-Disciplinary Team was a unique feature of FIDA.
- Conceived as person-centered care planning with participation of consumer, family members, treating physician, home care aides, others. Plan NOT have the final say about plan of care.
- Now, participation of treating physician is optional – instead of attending IDT meeting can be given plan of care for sign off – just as always done for CHHA, etc.
  - Or physician can "meet" separately by phone with care manager, not at same time as with consumer or other members – flexible is good but information not shared with all team members – can it be skewed?
- "Plans have authorization over any medically necessary services included in the PCSP that are outside of the scope of practice of IDT members." What does this mean for home care?

If CLIENT didn't OPT OUT and wants to DISENROLL from FIDA – BE SURE TO:

- Take steps to ensure MLTC and Part D coverage reinstated!
- **May choose a stand-alone Part D drug plan and enroll directly with that plan,** which automatically disenrolls client from FIDA. But – that doesn't ensure that client is back with MLTC!
- **MLTC** -Must call New York Medicaid Choice and ensure that they enroll client back into MLTC plan. 1-855-600-3432
- **MEDIGAP** – If they did not drop their Medigap policy, it should just continue. However, if they dropped it, they cannot get it back if they are on full Medicaid with no spend-down.

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FIDA Considerations: Risks (compare plans)

- **Provider networks**
  - Doctor, clinic, pharmacy, hospital, nursing home, home care agency
    - Plans have restricted networks, and those networks vary
    - Guildnet has a "point of service" network which promises any Medicare provider will be paid the Medicare rate—unclear if providers will agree to procedures
- **Drug formularies**
  - Even if pharmacy accepts FIDA, are the drugs needed covered?
- **Prior approval -** Unlike Original Medicare, prior approval may be required for certain procedures and services
- **Supplemental Coverage**
  - Risk of losing **retiree coverage** for self and dependents
    - Requires investigation!
  - **Medigap** coverage: do not need under FIDA, but cannot get it back if you drop it because of Medicaid rules
    - Consider keeping Medigap while test-driving FIDA!

FIDA Considerations: Benefits

- **One insurance card**
- **Ombuds** program "**ICAN**" (also available for MLTC) TEL 1-844-614-8800 http://icannys.org
- **No Medicare cost sharing** (must still pay Medicaid spend-down)
  - No deductibles or premiums, but must pay Medicare Part B unless eligible for MSP – Medicare Savings Program
  - No copays for prescription drugs or doctors
- **Inter-Disciplinary Team (IDT) makes care planning decisions**
  - Consumer, family, and doctors all participate
- **Integrated/unified appeals process** (except for Part D)
  - Internal appeal to the plan→State's integrated hearing officer→Medicare Appeals Council→Federal Court
  - ONE notice – not separate Medicare and Medicaid notices.
  - Aid continuing in ALL appeals, if requested within 10 days of the notice

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NURSING HOME CARE "CARVED IN" TO MLTC AND MAINSTREAM MANAGED CARE - 2015

Permanent nursing home residents are required to enroll in an MLTC or Mainstream MMC plan

Another "Medicaid Redesign Team" initiative

- Another step in NYS' move to expand Managed Care for all Medicaid services and populations.
- MRT 1458 – State policies posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm - scroll down to near last section:

February 1, 2015 (*) Population Transition – Nursing Home ("New" Duals and Non-Duals) (FIDA Region Adults) (NYC, Nassau, Suffolk & Westchester)

- **Links to State powerpoints and FAQs**

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Nursing Homes and Managed Care

- Big Changes Started **STATEWIDE** in 2015 for NEW permanent residents in nursing homes --
  - Dual Eligibles – are required to stay enrolled in – or stay in -- an MLTC plan when they need permanent nursing home care; and
  - People with Medicaid only – not Medicare- are required to enroll in or stay in a "mainstream" Medicaid managed care plan if they need long-term nursing home care
- WHEN – NYC started Feb. 2015
  - Statewide as of July 1, 2015

Until now – MLTC *was* mandatory only for duals who need ***home care – not nursing home care***

- Before - An **MLTC** member who needed NH placement would typically "voluntarily disenroll," even though NH was in MLTC benefit package – and receive NH care Fee for Service
- Before - **Mainstream** Medicaid managed care (MMC) – for those with no Medicare *were disenrolled* from the plans if they were in a nursing home for more than 60 days. NH was paid "fee for service."
- **Now, all adult Medicaid recipients – when they become *permanent* nursing home residents – are required to enroll in or stay in a managed care/ MLTC plan** (MLTC for duals, MMC for Medicaid-onlies). Plan pays for the nursing home care directly.

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Current NH Residents Grandfathered in!

- NO ONE FORCED TO MOVE - **Permanent NH residents** are grandfathered in – **No one is required to enroll in a plan if they were in a nursing home and approved for institutional Medicaid BEFORE**:
  - Feb. 1, 2015, and in NYC
  - April 1, 2015 - Long Island, Westchester
  - July 1 , 2015 (rest of state)
  - But – in Oct. 2015 "voluntary enrollment" began for NYC NH residents, when they MAY enroll in MLTC plans.
  - In NYC/L.I./Westchester, most companies with MLTC plans also have a FIDA plans and want to increase market share.

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When must new NH residents enroll in a managed care plan?

- Depends WHEN they became a PERMANENT NH resident -
  - If before Feb. 1, 2015 (NYC) -- NOT required to enroll in any plan. They are "grandfathered in."
  - If after Feb. 1, 2015 – then it depends on if they were already in an MLTC or mainstream MMC plan at the time of NH placement
- **Merely going into NH for short-term rehab does not require enrollment in any plan.** When they must enroll is still a bit unclear.
  - Must enroll when placement is "permanent." We believe this is AFTER institutional Medicaid is applied for and approved (with the 5-year lookback).
  - **NO ONE MUST ENROLL IN MLTC PLAN IN ORDER TO ENTER A NURSING HOME, whether for permanent or short-term care.**

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Process for new nursing home admissions

1. **Consumers NOT already enrolled in MLTC/MMC**
   - Select and enter any **nursing home of their choice**
   - When Medicare coverage ends, must apply for **Institutional Medicaid** (Includes 5-year look-back and transfer penalties)(can be retroactive 3 months)
   - They will receive **notice from NY Medicaid Choice giving 60 days to pick a plan** (pick one that includes their nursing home in the network)
   - If don't pick a plan, will be **auto-assigned** to a plan that has that NH in network (MLTC for duals, MMC for non-duals)
   - Do not have to enroll until receive 60 day notice from NY Medicaid Choice

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Process for new nursing home admissions (cont'd)

2. Consumers already enrolled in mainstream Medicaid Managed Care (MMC) plan (do not have Medicare)

- **Must enter a NH in that plan's NETWORK** or Medicaid will not pay for it
- MMC plan no longer will disenroll someone because they need long term nursing home placement. Plan must pay for NH.
- If NH stay > 30 days, must do 5-year lookback, even though no asset test (MAGI)
- Plans should assess members who are NH residents for possible discharge home and provide home care services on discharge.

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Process for new NH Admissions (3)

3. Where Already Enrolled in MLTC plan – If entering from hospital --

- Where Medicare pays primary – choice of NH is *not* limited to MLTC plan's network. MLTC plan must pay Medicare coinsurance out-of-network too. **DOH Q&A Aug. 16, 2012*** - Question 42 on page 7. (also see Mar. 2015 Q&A #26).
- **Once Medicare ends, if NH is not in the plan's network, i**ndividual may change to MLTC plan that has NH in network, but not effective until 1st of the next month. Old MLTC plan should pay for reasonable time to transfer plans, but DOH has not made this clear.
- Must submit **5-year lookback application – since NH is getting paid by MLTC plan, they may wrongly think it is not needed**! If transfer penalty found, will be disenrolled from MLTC plan and could be liable to repay

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm - FAQs posted at bottom of this page with other info re adding NHs to MLTC

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Remember to ask for Community Budgeting!

- Nursing home residents are presumed to be permanently placed, with no living expenses outside of the NH. They may keep only $50/month as a Personal Needs Allowance.
- BUT – if they have a reasonable expectation to return home, they qualify for "Community Budgeting" which allows them to keep the full Medicaid income allowance used in the community - $845/month (2015-16) – with the excess income (spend-down) going to the NH.
  - Can be for 6 months with another 6-month extension
  - If they have a pooled trust, they may continue to use it to eliminate the spend-down.
- You must insist that the NH and MLTC plan request this budgeting with the 5-year lookback application!
- New "Discharge Alert" forms posted at http://www.wnylc.com/health/entry/117/

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Minimum Network Size = # NHs required

	# of NHs	Network minimum
Manhattan	16	5
Brooklyn	42	8
Queens	55	8
Bronx	43	8
Staten Island	10	5
Nassau	35	8
Suffolk	43	8
Westchester	38	8
Monroe, Erie		5
Oneida, Dutchess, Onondaga, Albany		4
Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster		3
All other counties		2 unless only 1 exists
Specialty NHs (AIDS/ vent/ behavior)		2 unless fewer exist

NH Residents who Want to Return Home

- If not yet in an MLTC plan, but already have Medicaid, will need to enroll in MLTC in order to obtain home care in the community.
  - Must request Conflict-Free (CFEEC) assessment from NY Medicaid Choice whether in short-term rehab OR if permanently placed pre-February 2015. DOH MLTC Policy 15.06 11/2015*
  - Same directive says CFEEC NOT required if NH resident is enrolling in MLTC plan without seeking to return to community. Seems inconsistent!
  - IF institutional Medicaid was already approved, will need to "convert" Medicaid to community Medicaid. See this Fact Sheet for tips. http://www.wnylc.com/health/download/534/

https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_15.06_nursing_home_trans.pdf

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NEW OVERTIME REQUIREMENTS FOR AIDES & 24-HOUR CARE CHANGES

Started Oct. 13, 2015

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Aides entitled to Overtime

- Federal labor regulations used to exempt home care aides from the Fair Labor Standards Act overtime requirements.
- Eff. Oct. 13, 2015 this has changed. Aides must be paid overtime if work over 40 hours/week or Live-In aides working over 4 days in a work week.
- **Travel time** between different clients of the same employer/ home care agency must be paid. Travel to and from aide's home is not paid.
- **Live-in** – may only be reduced for 8 hours of sleep and meal time. Essentially must be paid for 15- 16 hours/day. If actually works more than 16 hours/day must be paid.
- See http://www.nelp.org/campaign/implementing-home-care-reforms/

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Who will pay for the overtime??

- MLTC plans must ensure that home care agencies pay overtime.
- DOH has estimated that overtime costs will increase average hourly rate by 34 cents/hour and is increasing monthly capitation paid to plan to allow for that increase.
- Consumer-Directed Personal Assistance Programs (CDPAP) are protesting using that average, saying many of the 17,000 CDPAP users want to keep reliable longtime aides and pay them overtime – more often than traditional home care agencies, but 34 cents isn't enough and CDPAP agencies may go out of business. See http://cdpaanys.org/
- New requirements may disrupt stable care plans, with more aides needed to cover shifts. But – living wage is crucial.

New Definitions 24-hour Care - 12/2015

- **Split Shift** – "uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning or positioning, & needs assistance with such frequency that a live-in 24-hour PCA would be unlikely to obtain, on a regular basis**, 5 hours daily of uninterrupted sleep** during the aide's eight hour period of sleep."
- **Live-in** -- "care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep."

GIS 15 MA/024, 18 NYCRR 505.14(a), at https://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm

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More about 24-hour care

- Changes binding on MLTC and Mainstream managed care plans.
- “Turning and positioning” was not explicitly listed in the past as a task that justified 24-hour care .
- Before, only need for TOTAL assistance with ADLS, not SOME assistance, merited split-shift care. Now, Total/Some distinction is eliminated. If one needs ANY assistance, FREQUENCY is the key factor.
- NOT NEW: If client has 24-hour needs, even if family covers one shift, the plan my NOT use “task based assessment” to calculate the number of hours. They must cover the full span of time family is not available. “Mayer-3” rule.

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MEDICAID HOME CARE APPLICATIONS

- New applications
- Tips for filing
- Special budgeting rules available for MLTC

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New Applicants for Medicaid Home Care in NYC

Front Door Closed to apply through CASA/DSS *unless* in home hospice or need *only* housekeeping (limited to 8 hours/week).

MLTC/HOME CARE	HOUSEKEEPING ONLY (max 8 hrs/wk)
Medicaid application goes to: **HRA HCSP Central Medicaid Unit** 785 Atlantic Avenue, 7th Floor Brooklyn, NY 11238 T: 929-221-0849	Medicaid application **and M11q** go to: **NYC HCSP Central Intake** 109 East 16th Street, 5th Floor New York, NY 10003 T: 212-824-0706 FAX 212-896-8814

NOTE: MLTC plans can't give services Medicaid-pending. Some will help apply for Medicaid and w/pooled trust.

Tips for filing Medicaid applications

- Must complete **Supplement A** and provide current **asset documentation** (+ last 3 months if want retro)
- Indicate on top of Application and Cover Letter that seeking MLTC (see sample Cover Sheet)
- If client will have a spend-down – special steps:
  - May be worth having MLTC plan file app, avoids "coding" problems
  - Wait to enroll in pooled trust until AFTER Medicaid approved and enrolled in MLTC. Faster.
  - Submit any medical bills client has paid in last 3 months, and any unpaid bills from before that.
  - MARRIED APPLICANTS may only have a spend-down – or have to use Spousal Refusal -- initially. Once one spouse enrolls in MLTC, can request Spousal Impoverishment protections. More later. See form.

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Conflict-Free Eligibility & Enrollment Centers (CFEEC) for new applicants

- Since 10-2014, after Medicaid is approved by local DSS, must request "CFEEC" assessment by Maximus/NY Medicaid Choice. CFEEC determines eligibility for MLTC – NOT hours of care.
  - State aims to end "cherry picking" – plans recruiting people who don't even need any home care and turning away high-need people.
  - **Concern about delays. Maximus must SCHEDULE appointment in 7 days but not actually CONDUCT assessment in any time limit.**
    - **If more than 2 weeks until CFEEC scheduled, call NYS DOH to complain. 1-866-712-7197 or e-mail mltctac@health.ny.gov**
- To schedule CFEEC call NY Medicaid Choice 1-855-222-8350.
- **New CFEEC FAQ issued 3/27/2015 –** posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm http://www.health.ny.gov/health_care/medicaid/redesign/2015-03-27_cfeec_faq.htm

Conflict-Free Assessment *con'd.*

- All counties in state now require CFEEC.
- Nurse conducts assessment using same Uniform Assessment Tool as MLTC plans. Conducted in-home, hospital or nursing home.
  - **TIP: MAKE SURE FAMILY OR SOCIAL WORKER ARE AT ASSESSMENT!**
  - TIP: Have MD letter/M11q with diagnoses, meds, functional impairments at assessment
- No new assessment needed if transferring from plan to plan, or from a previous Medicaid LTC service
- BUT - DOH is requiring CFEEC even if permanently placed in nursing home if seek MLTC enrollment to return home. MLTC Policy 15.06 (Nov. 2015)
- https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
- http://nymedicaidchoice.com -On home page click on Do I Qualify for Long Term Care? Direct link http://nymedicaidchoice.com/ask/conflict-free-evaluation-and-enrollment-center

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"Immediate Need" Medicaid Request to HRA

- Though "Front door" closed for requesting Personal Care/ Home Attendant from CASA, new strategy available in urgent cases where delay in MLTC enrollment will harm client.
- Submit an **M11q** with the Medicaid application to HRA HCSP, or while it is being processed.
- See sample cover letter attached – adapt to case. Letter cites 2015 law requiring expedited Medicaid approvals in 7 days, but state hasn't implemented that yet. Even without that --
- Attach NYS DOH GIS GIS 15 MA/011 - Reminder of Expedited Authorization Process for Medicaid Recipients with Immediate Need for Personal Care Services, (July 2015) copy available at http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm - HRA may authorize personal care until client enrolled in MLTC plan.

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TIPS for dealing with spend-down

1. REDUCE or ELIMINATE SPEND-DOWN
   a. Nursing Home Transition Shelter Allowance
   b. Spousal Impoverishment Budgeting
   c. Enroll in a pooled income trust

      (but wait to submit trust and other forms AFTER Medicaid approved with spend-down)

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1a) Nursing Home/ Adult Home Transition Shelter Allowance

If Medicaid made a payment for a nursing home or adult home stay, Medicaid will deduct a regionally-standardized shelter cost from income upon discharge where the individual has a housing expense AND:

- Has been in a NH for at least 30 days (not counting the day of discharge);
- Is eligible for/enrolled in an MLTC plan upon discharge; and
- Is not receiving spousal impoverishment budgeting
  - Married individuals participating in PACE cannot get this

N.Y. Dep't of Health, Administrative Directive: Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program, 12 OHIP/ADM-5 at 2-4 (Oct. 1, 2012); GIS 14 MA/17 (Aug. 5, 2014).**Medicaid Alert (Feb. 14, 2013)—Form MAP 3057(E) in NYC**

MLTC Housing Allowance (2016)

Region	Counties	Deduction
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$384
Long Island	Nassau, Suffolk	$1,060
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1,094
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$440
Northern Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$837
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$400
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$341

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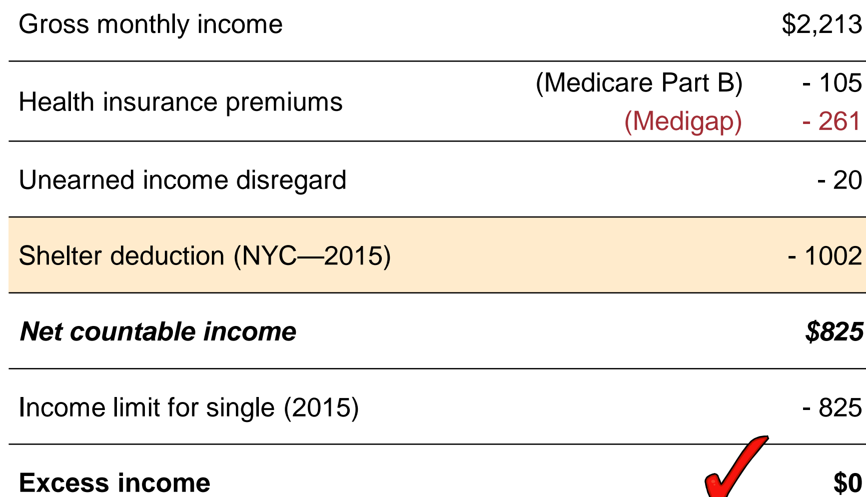
Example budget with NH transition shelter allowance



Gross monthly income		$2,213
Health insurance premiums	(Medicare Part B)	- 105
	(Medigap)	- 261
Unearned income disregard		- 20
Shelter deduction (NYC—2015)		- 1002
Net countable income		***$825***
Income limit for single (2015)		- 825
Excess income	✓	**$0**

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1b) Spousal Impoverishment Budgeting

- Spousal impoverishment budgeting, previously only for nursing home and waiver programs, is now available to married couples where one spouse is in MLTC.
- If applicant has a **community spouse**, he/she may shelter up to $2,980/mo. (2015) of joint income (and up to $74,820 of assets).
- It works almost the same as for nursing home, but with some minor variations.
- See example of budget on next page.

Use **Request for Assessment Form** – at p. 9 of this update http://www.health.ny.gov/health_care/medicaid/program/update/2014/mar14_mu.pdf . **Send to HCSP Centralized Medicaid Eligibility Unit 785 Atlantic Avenue, Brooklyn, NY 11238**

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Example budget with spousal impoverishment
* Applicant Spouse - $2,130/mo. Income
* "Community Spouse" - $1,500/mo. income

Gross monthly income – Applicant		$2,130
Personal Needs Allowance (2015)		- 384
Community Spouse Monthly Income Allowance (CSMIA)	MMMNA ($2,980) - Otherwise Available Income of spouse ($1,500) =	- 1,480
Health insurance premiums	(Medicare Part B)	- 105
	(Medigap)	- 161
Excess income		**$0**

N.Y. Dep't of Health, Medicaid Update Vol. 30, No. 3 at 5-9 (March 2014); N.Y. Dep't of Health, GENERAL INFORMATION SYSTEM MESSAGE: SPOUSAL IMPOVERISHMENT BUDGETING WITH POST-ELIGIBILITY RULES FOR INDIVIDUALS PARTICIPATING IN A HOME AND COMMUNITY-BASED WAIVER PROGRAM, GIS 12 MA/013 (April 16, 2012); N.Y. Dep't of Health, MEDICAID REFERENCE GUIDE: INCOME at 278-282 (June 2010).

Problem: Spousal Impoverishment only available AFTER on Medicaid

- Spousal Impoverishment is a "post-eligibility" methodology.
- Married person must APPLY for Medicaid using regular community Medicaid rules.
  - This would require use of **SPOUSAL REFUSAL** if spouse's income would create a large spenddown, or if spouse's assets disqualify the applicant spouse from Medicaid.
  - The applicant may have a high spend-down using regular community Medicaid rules. In the example on the previous slide, even if the "community spouse" did a spousal refusal, so that $1,500/month income isn't counted, the Applicant's Spouse's income of $2,130 would create a high spenddown. But just for one month, because right after she enrolls in an MLTC plan, she can request Spousal Impoverishment budgeting and will have NO spenddown.
  - A pooled trust wouldn't be worth the trouble.

May a married MLTC enrollee use a pooled trust?

- YES, as of 11/3/2014 – DOH changed previous policy and allows a married MLTC enrollee to choose either spousal impoverishment rules *or* use community budgeting– with a pooled trust -- as a household of one – whichever is more favorable.
- This allowed enrollees to choose community budgeting with pooled trust if better; i.e. if community spouse had her own income over $2980, applicant couldn't give her part of his own income as a spousal allowance – has a spend-down.
- 11/3/14 – GIS 14 MA/025 **– but stay tuned! May change again.** Pending CMS clarification**.** See more at http://www.wnylc.com/health/entry/165/

N.Y. Dep't of Health, General Information System Message: Spousal Impoverishment Budgeting with Post Eligibility Rules Under the Affordable Care Act- GIS 14 MA/25 (Nov. 3, 2014).

Dealing with Spend-down – Enrollment Delays

- See handout on Spend-down Tips. Since we advise NOT to submit pooled trust with application, because of delays, and you can't get Spousal Impoverishment protections initially, client will have a spend-down at first and may need to use Spousal Refusal. If plan refuses to assess and/or enroll client because code says Not Eligible:
  - Give the plan a copy of the **notice** approving Medicaid.
  - Give the plan the **HRA HCSP FAQ** dated Nov. 13, 2013 (copy in handout and posted at http://www.wnylc.com/health/download/449/)
  - Tell the plan it must submit a **MAP Medicaid Cover Sheet Form HCSP-3047a** (MLTC/PRU Cover Sheet a/k/a "**CONVERSION FORM")(updated 1/26/2015)** to the **HRA HCSP MLTC Provider Relations Unit**, requesting that the eligibility code be changed.
- TEL: (929) 221-2427 Fax: (718) 636-7848 - copy posted at http://www.wnylc.com/health/download/450/.
- DO NOT use "pay-in." Causes problems.
- Gets complicated if you want to access CHHA pending MLTC enrollment. You will need to get codes changed…

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NAVIGATING MLTC

- Reduction in Hours – what to do
- Service Authorizations, Concurrent Review
- Grievances and Appeals

Model MLTC Contract – download at
http://is.gd/NY_MLTC_contract

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Some MLTC plans trying to reduce hours

Plans must follow strict requirements if trying to reduce services. These are:

1. **WRITTEN NOTICE IN ADVANCE** – must be sent 10 days in advance of Effective Date of reduction. Even if DATED 10 days in advance of reduction, must also be MAILED 10 days in advance.
2. **IF request a Fair Hearing before the Effective Date, you get Aid Continuing** – reduction does NOT go into effect until hearing held and decision made.
3. **What if you miss the deadline? Get the postmarked envelope**. If not MAILED at least 10 days before effective date, notice is DEFECTIVE and will be overturned even if
4. **You can still request a Hearing even if no notice**. One of your claims is lack of proper notice. If no notice, no deadline to request hearing. Automatically entitled to AID CONTINUING.
5. Plan must give **REASON** for reduction – must be a CHANGE from the past- change in medical condition, family availability to help. They often say made a "mistake" or that proposed hours are enough. THESE CAN BE WON AT HEARINGS!

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There are two Model Notices

posted at http://www.wnylc.com/health/download/579/

- Initial Adverse Determination

ZZZ Health Plan
564 First Street
New York, New York 00000

**This notice can be read to you in another language. This notice is available in other formats for special needs.
Call 1-800-555-5555 for help.**

April 1, 2014

Jane Smith
123 Main Street
New York, NY 00000

Enrollee ID: XX88888X
Health care service: request for 2 hours/day level 1 personal care, 4 days/week
Provider: Sweet Care at Home

Dear Ms. Smith:

You are getting this notice because your managed long term care plan did not approve your health care service or is changing the health care service you are getting now. This is an **initial adverse determination. You are not responsible for payment of covered services and this is not a bill.**

You or your provider asked ZZZ Health Plan to approve the health care service described above. ZZZ Health Plan has determined that coverage for this service will be reduced. This action will take effect on 04/15/15. The plan is taking this action because the health care service is not medically necessary.

You were receiving level 1 personal care services two (2) hours per day/four (4) days per week for help with grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed on March 25, 2015. The assessment showed that your sister started living with you in March and will prepare breakfast and dinner for you. Therefore it is not medically necessary to have your aide prepare these meals for you. One (1) hour per day is enough time to complete the light housekeeping, grocery shopping and meal preparation that you need because of your arthritis condition.

- **Action Taken Notice**

LDSS-4687 (02/15) Page 1 of 3 **MANAGED LONG TERM CARE ACTION TAKEN**
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)

Notice Date: 04/01/2015	**This Action will take effect on 04/15/15**	**Call 1-800-555-5555 for help**

Case Name (c/o, if present) and Address:

Jane Smith 123 Main Street New York, NY 00000	ZZZ Health Plan 564 First Street New York, NY 00000
CIN: XX88888X	Reference No.: AA999999XXX

ZZZ Health Plan has made a decision about your health care service.
On 04/15/2015 this health care service: Personal Care Level 1

- [ ] is not approved
- [ ] is partially approved
- [ ] will not be increased
- [ ] claim will not be paid. THIS IS NOT A BILL
- [XX] will be reduced
- [ ] will stop
- [ ] access will be restricted

This Action affects the health care you are getting now:
- Before this Action, from 10/15/14 to 04/14/15, the plan approved:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week = Total 208 hours
- You requested approval for:
  2 hours/day level 1 personal care, 4 days/week, 8 hours/week
- Starting 04/15/15, the plan approval changes to:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week, for 6 months
- This means from 04/15/15 to 10/14/15, your health care service is approved for:
  1 hours/day level 1 personal care, 4 days/week, 4 hours/week = Total 104 hours
- We will review your care again September 2015.

ZZZ Health Plan is taking this Action because:

You were receiving level 1 personal care services two (2) hours per day/four (4) days per week for help with grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed on March 25, 2015. The assessment showed that your sister started living with you in March and will prepare breakfast and dinner for you. Therefore it is not medically necessary to have your aide prepare these meals for you. One (1) hour per day is enough time to complete the light housekeeping, grocery shopping and meal preparation that you need because of your arthritis condition.

How to read a notice – TWO KEY DATES

- Here are the most important facts to look for in a notice:
  - Notice Date
    - This is the date the plan printed the notice and, hopefully, mailed it to the member (see below)
  - Effective Date[1]
    - If the Notice Date or Postmark Date are fewer than 10 calendar days before the Effective Date, then this is a Defective Notice.

MANAGED LONG TERM CARE ACTION TAKEN

VNSNY CHOICE MLTC has made a decision about your health care service.

VNSNY CHOICE MLTC is taking this Action because:

(1) 42 CFR § § 438.404(c)(1) & 431.211; 18 NYCRR § 358-2.2(a)(2).

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How to read a notice (cont'd)

- Action[1]
  - What is the action the plan is proposing to take?
  - If the action cannot clearly be determined by a reasonable layperson, then it is a Defective Notice.
- Reason[2]
  - must state the reason for the change on the notice – not just that "medically necessary" or current assessment allows x hours.

(1) 42 CFR § 438.404(b)(1); 18 NYCRR § 358-2.2(a)(1).
(2) 42 CFR § 438.404(b)(2); 18 NYCRR § 358-2.2(a)(3).

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Requesting a fair hearing

- Website shows 3 ways to request –

1. **BEST WAY -- Fax 518-473-6735 -download fax form here http://otda.ny.gov/hearings/request/**
   - Be sure to include NAME OF MLTC PLAN
   - Attach copy of notice if you have it.
2. Online – same link as above (Not the best way – very fussy website, can't attach notice form)
3. Phone 1-800-342-3334

Request hearing right away even if you can't represent client. Can refer client for representation later – but must lock in AID CONTINUING.

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Should you request an internal appeal first before requesting a fair hearing?

NO – Not if plan is proposing to REDUCE hours.

- After July 1, 2015, you may request a Fair Hearing right away, without first requesting an Internal Appeal.
- However, the Notices will still tell member they have the **right** to request an Internal Appeal.
- **If plan is REDUCING care** - member will only get AID CONTINUING if she requests a FAIR HEARING before the EFFECTIVE DATE of the notice. She will NOT get Aid Continuing if first requesting an Internal Appeal.
- Once she requests the hearing, she can request an internal appeal and see if she wins that while hearing is pending. If she does, she can withdraw the hearing request.

- **If plan is DENYING an increase** – then there is no aid continuing anyway. No harm in requesting internal appeal except some delay. Can't hurt to get 2 bites of the apple.

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Let's Make a Deal – If Member "agrees" to less services – plan must still give notice!

- When a member requests INCREASED hours of home care, or appeals the plan's proposed REDUCED hours of home care, the MLTC plan will sometimes offer a compromise to the member or her family.
- Plan must still give **written advance notice** of the change unless it has a clear written statement signed by the member that:
  - s/he no longer wants services or
  - gives information that **requires** termination or reduction of services and
  - indicates that s/he understands that this must be the result of supplying that information. 42 CFR § 431.213
- This protects client if felt pressured to agree. But plans don't comply with this!

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Expedited Internal Appeals / Grievances

- If you are requesting an increase in hours or new services, so you are not entitled to Aid Continuing, you might try requesting an Expedited Internal Appeal. The plan must decide an expedited appeal within **3 days** instead of **30 days**. Plan must agree that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function; or
- The plan may deny a request for an expedited review – best practice is to have doctor explain in writing jeopardy to health or ability to function without services.

42 CFR § 438.410;
Model Contract, Appendix K, ¶¶ (1)(A) & (B)
[pp.103, 106 of PDF]

Aid Continuing Required Even if "Authorization Period" Expired

- MLTC plans authorize services for periods of up to six months. They must do a reassessment at least every six months. What if the MLTC plan decides, at the reassessment, to reduce the number of hours below the number previously authorized?
- Before April 1, 2014, the plan had to give notice of the reduction, and the right to appeal. But Aid Continuing was required only if the original "authorization period" for the service had not expired.
- After April 1, 2014, under a change in state law enacted in the 2014-15 budget, Aid Continuing must be provided while the hearing is pending even if the authorization period expired.

42 CFR 438.420; NY Soc. Serv. L. 365-a(8); N.Y. Dep't of Health, MLTC Policy 14.05 (August 6, 2014) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_authorization.pdf

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Example of Authorization Period Issue

- Jan. 1 – June 30th - Tracy was authorized to receive 12 hours x 7 days PCS.
- June 20th -- the plan did a reassessment and sent Tracy a Notice of Reduction that would reduce services to 6 hours x 5 days **effective July 1st.**
- June 25th - Tracy requests a Fair Hearing before the effective Date of July 1st, so entitled to Aid Continuing.
- Under the OLD RULE, Tracy would get Aid Continuing initially, keeping 12x7 but **it would be reduced on July 1st,** after the old authorization lapsed, even though the hearing was still pending.
- Under the NEW RULE, Tracy gets Aid Continuing that continues until the hearing is held and decided.

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Notice & Aid Continuing Required if Plan Won't Reinstate PCS after Hospital or Rehab stay

- If plan delays or denies request to reinstate the prior plan of care when ready for discharge home, ask plan in writing for:
  - Expedited Concurrent Review/Prior Authorization for reinstatement of personal care services.
  - Advocacy tip: Include a letter from the doctor indicating the need for services.
  - Plan should provide a written notice denying or granting services. You have right to appeal.
- Federal court held that Medicaid recipients are entitled to immediate reinstatement of their previously authorized PCS services upon discharge from a hospital stay. *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996); NYS DSS 99 OCC-LCM-2 (1999), http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/96ma023.pdf.

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ICAN Can Help with Appeals

- ICAN is the Independent Consumer Advocacy Network
- Network includes a toll free helpline **1-844-614-8800** ican@cssny.org
- Educates and advocates for people who want or get Medicaid long-term care through managed care plans - MLTC & "mainstream" managed care
- Funded by a NYS Department of Health grant

- **ICAN services are free, confidential and independent from all health insurance companies**
- **NYLAG EFLRP is part of ICAN 212-613-7310**

ASKING PLAN FOR NEW OR INCREASE IN SERVICES

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Requesting Services: Terminology

- **"Prior Authorization"**
  - Asking the plan for a **new service**,
  - Asking the plan to change a service in the plan of care for a new authorization period
  - **Consumer or Provider** can make the request
- **"Concurrent Review" –**
  - Asking the plan for additional services (i.e., more of the same service) that are currently authorized in the plan of care (more hours of home care); or
  - Medicaid covered home health care services following an inpatient admission.

Model Contract, Appendix K, at p. 135 of PDF

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When must plan decide request for Increase or New Service?

Type of Request	Maximum time for Plan to Decide
Expedited	**3 business days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Medicaid covered home health care services following an inpatient admission	(1) business day after receipt of necessary info; except when request made the day before a weekend or holiday, **no more than three (3) business days** after receipt of the request for services.

Model Contract, Appendix K, p. 135 of PDF – same time for Concurrent Review & Prior Authorizations , 42 C.F.R. 438.210(d)

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When must plan Expedite Request for Increase?

- If the plan determines or the provider indicates that a delay would **seriously jeopard**ize the enrollee's **life or health or ability to attain, maintain, or regain maximum function.**
- **Must specifically ASK that request be expedited** and explain why criteria apply in this case.

How/ when to ask for Increased or New Services?

- WHEN –
  - May ask at in-home reassessment conducted every 6 months
  - OR any time – by calling Member Services or care manager or by FAX or certified mail.
- HOW: Make request in writing – or confirm an oral request with WRITTEN request. This way you have proof that you requested it and when – starting clock for plan to respond.
  - Letter from your doctor helpful. Use detail.
  - Include request to EXPEDITE if urgent.

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What if Plan Doesn't Make Decision by Deadline?

- If the plan does not issue a decision on a request for services within the deadlines stated above –
- this constitutes a **denial** and is thus an adverse action, which can be appealed just as a written decision can be appealed. 42 CF.R. 438.404(c)(5).
- This is why it is important to make request for increase/new service in writing.. And keep proof that you made it.   Otherwise you cannot appeal if plan fails to decide on your request.

Advocating for more Hours – with Plan or at Fair Hearing

- All managed care plans must make services available to the same extent they are available to recipients of fee-for- service Medicaid. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a)(4)(i). The Model Contract also states: "Managed care organizations may not define covered services more restrictively than the Medicaid Program."
- In other words, there has been **NO CHANGE** in the amount or type of services available under MLTC versus under PCA/CHHA as it was administered before by DSS/CASA offices.
- If medically appropriate for 24-hour care (even split-shift) under the PCA regulations, then should receive 24-hour care under MLTC.

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More on standards for authorizing PCS

Can't use "**task-based-assessment**" – a tasking tool that adds up minutes allotted for each task - when client has 24-hour needs, even if some of the care is provided by informal caregivers ("Mayer-III") 18 NYCRR 505.14(b)(5)(v)(d);

- Plans say PCS doesn't include "**safety monitoring**," but DOH policy says that time for aides to provide assistance to ensure safe performance of ADLs is part of PCS (GIS 03 MA/003)
  - Assistance may be verbal cueing, not only hands-on,
- Person who **cannot "direct" her own care**, such as someone with dementia, is eligible if family member or other can direct care; such person need not live with the consumer (92-ADM-49)
- Plans must **reinstate services after hospitalized** or in rehab – must give same amount as had before hospital/rehab (*Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996); GIS 96 MA-023

GIS messages and "ADM" directives posted at http://www.health.ny.gov/health_care/medicaid/publications/index.htm . See http://wnylc.com/health/entry/114/ & http://wnylc.com/health/entry/7/

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Contact numbers & Other Info

- **New York Medicaid Choice** (Enrollment Broker)
  - **To request a Conflict-Free Assessment** (after Medicaid approval) **1-855-222-8350**
  - **For information about MLTC** **1-888-401-6582**
  - **FIDA** – for information or to OPT OUT **1-855-600-3432**
  - Maximus Project Directors 1-917-228-5607, -5610, -5627
  - Website http://nymedicaidchoice.com/
    - http://www.nymedicaidchoice.com/program-materials - Scroll down to *Long Term Care plans* –
    - http://tinyurl.com/MLTCGuide - Official guide to MLTC
- **NYS Dept. of Health MLTC/FIDA Complaint Hotline 1-866-712-7197** mltctac@health.ny.gov
- **NYS DOH Mainstream managed care complaint hotline 1-800-206-8125** managedcarecomplaint@health.state.ny.us
- **ICAN Consumer FIDA Ombudsprogram – 1-844-614-8800 http://icannys.org**
- **NYLAG EFLRP 1-212-613-7310 eflrp@nylag.org**
- **Related online articles on** http://nyhealthaccess.org**:**
  - **All About MLTC** - http://www.wnylc.com/health/entry/114/
  - **Tools for Choosing a MLTC Plan** http://wnylc.com/health/entry/169/
  - Appeals & Grievances - http://www.wnylc.com/health/entry/184/
  - MLTC News updates: http://www.wnylc.com/health/news/41/
  - FIDA news updates http://www.wnylc.com/health/news/33/

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