FIDA: Fully Integrated Dual Advantage & MLTC UPDATE

FIDA Demonstration Program

New York City and Nassau – Currently Enrolling

Suffolk and Westchester Counties – Delayed til 2016

Evelyn Frank Legal Resources Program, NYLAG Nov. 17, 2015

Topics covered

- FIDA update – what is happening?
- MLTC update –
  - Delays in Conflict-Free assessments
  - Aide Overtime Pay requirements
  - MLTC plans trying to reduce hours
  - Nursing home care and how it relates to MLTC
- Delays in MLTC enrollment – Troubleshooting Tips
- Spend-down tips
- MLTC Plans Reducing Hours – Consumer Rights

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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/

FIDA EQUALS

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

		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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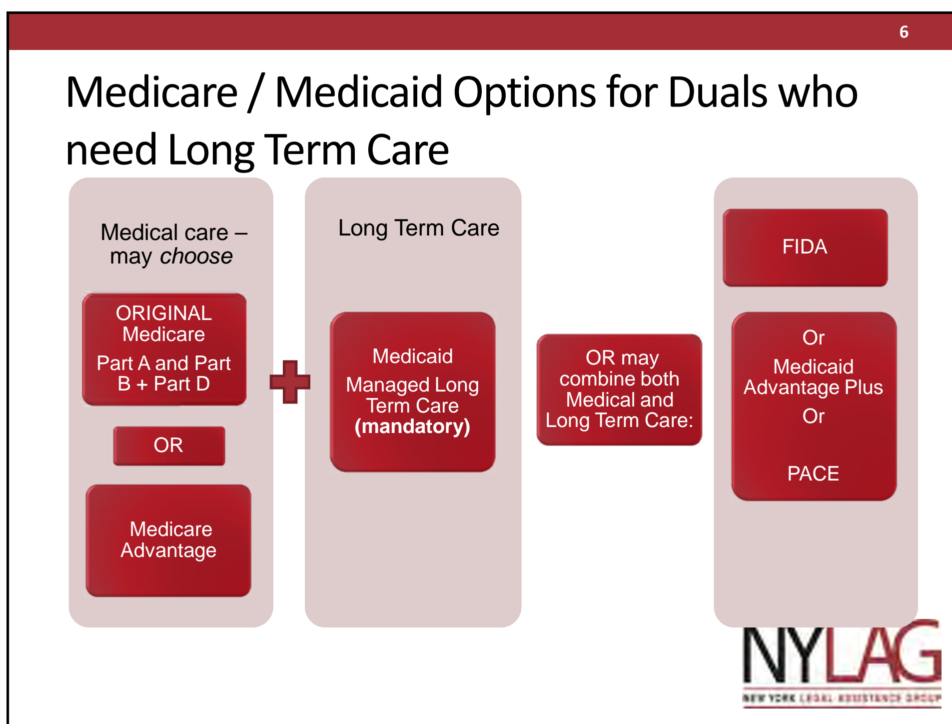
Original Medicare vs. Medicare Advantage

	Original Medicare	Medicare Advantage
Type of Plan	Fee for Service	Managed Care
Administered By	CMS – Federal Government	Private Insurance Plan
Access to Providers	Medicare Providers throughout US	Plan Network (caution – may be local, not good for sunbirds)
Referral to Specialist	NOT required	YES – may be required
Prior Authorization for Services	NOT required with some exceptions	YES
Out-of-Pocket Costs	Part B and D Premiums, Deductibles, Coinsurance	May limit some but not all costs.
Buy Medigap Supplement?	Optional	Can't use Medigap for co-insurance or copays.



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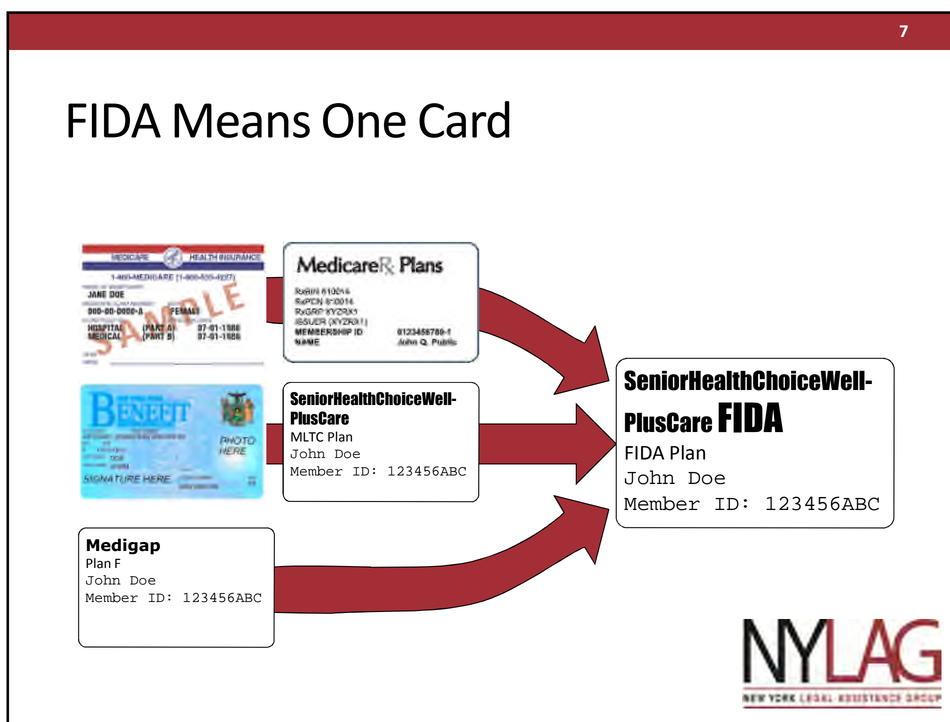

What does FIDA cover?

- 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)

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 indefinitely delayed) and
- **Need Long Term Supports and Services** (LTSS) for more than 120 days, either because:
  1. Newly permanently residing in a nursing home; or
  2. Eligible for the Nursing Home Transition and Diversion Waiver (NHTD); or
  3. **Enrolled in or will be enrolled in an MLTC or MAP plan**.
- **Excludes** people in TBI, OPWDD waivers, hospice, Assisted Living Program.

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

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 2015.
  - **57,735 have OPTED OUT as of 9/1/2015**
  - **9,163** are enrolled in FIDA as of Oct. 2015. OF these, about 4,700 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.

Opt-Out from FIDA

- At any time prior to an individual's passive enrollment date, he/she may choose to opt-out of FIDA
- Opting out ensures that the individual will not be passively enrolled into a FIDA plan for the life of the three-year Demonstration.
  - ***Update***: DOH said 4/20/15 that may STILL be passive enrolled next year even if opted out now. Still being clarified.
- Individuals may opt out by calling N.Y. Medicaid Choice (855-600-3432).
- Within 1-2 weeks of completing the opt-out request, the individual should receive written confirmation by mail

MMP Enrollment Guidance § 30.1.4(E) [pp. 20-21].

Voluntary Enrollment ("opt in")

- FIDA-eligible individuals may voluntarily enroll in FIDA at any time
- WHERE - only in NYC & Nassau, not yet in Westchester & Suffolk because enrollment delayed there – scheduled for 2016)
- There is 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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Which FIDA plan will I be passively enrolled in?

- Most people will be passively enrolled in a FIDA plan offered by the same company that operates their current MLTC plan. Note – only if the FIDA plan serves the borough client lives in.

CAUTION: You are NOT matched to a plan that covers your doctors – just your home care agency.

- There are now 18 FIDA plans in NYC: FIVE BIGGEST (10/2015):

Plan	Enrollment
1. VNSNY CHOICE FIDA Complete	3,014
2. Healthfirst AbsoluteCare FIDA Plan (Senior Health Partners MLTC)	2,840
3. GuildNet Gold Plus FIDA	1,003
4. Fidelis	600
5. Elderplan FIDA Total Care	446

The rest of the FIDA plans – Oct 2015 Enrollment

Plan	Enrollment
6. Empire BlueCross BlueShield HealthPlus FIDA Plan (AmeriGroup)	**393**
7. CenterLight Healthcare FIDA Plan	**346**
8. WellCare Advocate Complete FIDA	**339**
9. ICS Community Care Plus FIDA MMP	**309**
10. MetroPlus FIDA (NYC HHC)	**192**
11. Aetna Better Health FIDA Plan	**98**
12. VillageCareMAX Full Advantage FIDA	**91**
13. SWH Whole Health FIDA Plan	**89**
14. AlphaCare Signature FIDA Plan (Magellan)	**74**
15. RiverSpring FIDA Plan (ElderServ MLTC)	**70**
16. AgeWell New York FIDA Plan (Parker)	**68**
17. Integra FIDA Plan (Personal Touch)	**66**
18. Centers Plan for FIDA Care Complete	**65**

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7 NYC MLTC plans with NO FIDA PLAN

- The following 6 MLTC plans in NYC do not have affiliated FIDA plans. Members will be "intelligently assigned" to a FIDA plan that contracts with the same home care agencies to maintain continuity of care:
    1. **Extended MLTC**
    2. **Montefiore MLTC – DROPPED OUT OF FIDA earlier in 2015**
    3. **UnitedHealth**
    4. **Archcare – JUST DROPPED OUT OF FIDA**
    5. **Emblemhealth – JUST DROPPED OUT OF FIDA**
    6. **North Shore-LIJ**
- As of 10/2015, about 8,000 NYC residents are in these 7 MLTC plans with no FIDA plan.

Disenrollment

- FIDA participants can disenroll for any reason
- FIDA participants can only be involuntarily disenrolled for specific reasons:
    - Loss of eligibility for FIDA
    - Absence from plan service area for more than 6 months
    - Material Misrepresentation Regarding Third-Party Reimbursement
    - Disruptive behavior (but only after serious effort to resolve, multiple notices to member, and approval by CMS)
    - Fraudulent enrollment application or abuse of FIDA card
    - Participant knowingly fails to complete any necessary release form

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

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.

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 <u>any</u> Medicare provider will be paid the Medicare rate—unclear if providers will agree to procedures
- **Drug formularies**
  - Even if pharmacy accepts FIDA, are the <u>drugs</u> needed covered?
- **Prior approval -** Unlike Original Medicare, prior approval may be required for certain procedures and services
- **Supplemental Coverage**
  - Risk of losing **<u>retiree coverage</u>** for self and dependents
    - Requires investigation!
  - **<u>Medigap</u>** 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!

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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

FIDA Updated as of 10/1/2015

Announcement Letters Sent to Region 1 (NYC, Nassau)	Total Enrollment	Total Number of Opt-Outs
100,000+	9,163 (at least half "passive")	About 57,375

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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.
- State may be making some changes in 2016 to encourage more participation. Stay tuned.

MLTC IS BUILDING BLOCK OF FIDA

- **Review and Status of MLTC**
- **Tips on Enrollment Delays**
- **New Overtime Wage Requirements**

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Who is enrolled in MLTC?

1. Since late 2012, MOST adult Dual Eligibles (age 21+) seeking Medicaid home care on a long-term basis in NYC must enroll in an MLTC plan – no more CASA or Lombardi. Includes CDPAP and Private Duty Nursing.
2. As of **Oct 1, 2015 in NYC** - # of recipients
   - 107,805 MLTC - includes over 50,000 transitioned from CASA, Lombardi (136,383 statewide)
   - 9,011 PACE & Medicaid Advantage Plus (MAP) plans
   - 3,467 Home Attendant/Personal Care Level II (down from 40,000+)
   - 1,125 Housekeeping (Personal Care Level I) (down from 5600)
   - 179 Lombardi (Kids + last to send to MLTC)
3. STATEWIDE mandatory MLTC enrollment – the last few counties upstate became mandatory by summer 2015.

Data from http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/ and http://www.nyc.gov/html/hra/html/facts/hra_facts.shtml

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Who is **EXCLUDED** from MLTC?

- **Duals who may not enroll in MLTC even in mandatory county –**
  - In **Traumatic Brain Injury, Nursing Home Transition & Diversion or Office for People with Developmental Disabilities waivers –** But these will be moved into MLTC in 2017)
  - Have **hospice** care at time of enrollment (but may stay in MLTC if enroll in hospice once already in MLTC. MLTC Policy 13.18 (June 25, 2013)* or
  - Live in **Assisted Living Program**
  - Under **age 18**
  - **Needs are not extensive enough to qualify -- If need only --**
    - **Housekeeping** services – apply at HRA HCSP (See MLTC Policy 13.21*) (if have housekeeping and then later need upgrade to home attendant, submit M11q to HCSP – will get thru CASA. Eventually will be required to join MLTC.
    - **Social Adult Day** Care services – not available thru Medicaid

* Policies posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm .

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Managed Long Term Care (MLTC) Benefit Package
(Medicaid services that must come from a managed care plan)

- **Various types of home care (More than 120 days):**
  - **Personal Care (home attendant and housekeeping)**
  - **Consumer-Directed Personal Assistance Program (CDPAP)**
  - **Home Health Aide, PT, OT (CHHA Personal Care)**
  - **Private Duty Nursing**
- Adult day care – medical & social
  - Social day care alone is not enough for MLTC
- Medical alert button, home-delivered meals, congregate meals
- Medical equipment, supplies, prostheses, orthotics, hearing aids, eyeglasses, respiratory therapy, Home modifications
- **4 doctors—Podiatry, Audiology, Dental, Optometry**
- Non-emergency medical transportation
- **Nursing home**

SeniorHealthChoiceWell-PlusCare
MLTC Plan
John Doe
Member ID: 123456ABC

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

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

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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 – Statewide as of July 1, 2015

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Until now – nursing home was "fee for service" – not through managed care

1. MLTC ***was*** mandatory only for duals who need ***home care***
   - Once an MLTC member needed NH placement, she would typically "voluntarily disenroll," even though NH is in MLTC benefit package
     - Would disenroll if didn't like choice of nursing homes in MLTC plan's network, and receive nursing home FFS.
2. Mainstream Medicaid managed care (MMC) – for those with Medicaid only and not Medicare –
   - Before, members *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 -- will be required to enroll in or stay in a managed care plan** (MLTC for duals, MMC for Medicaid-onlies).

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Current NH Residents Grandfathered in!

- NO ONE WILL BE 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.
  - We thought it was not til they apply for institutional Medicaid and it is approved (with the 5-year lookback), but
  - Now it seems that NH is required to file a "DOH-3559" (NYC MAP-2159i) with local DSS for change of status to long-term care – within 48 hours of decision to make it "permanent placement." That could be within days of admission.
  - Either way, resident would first receive notice from NY Medicaid Choice giving **60 days to select and enroll in a plan**. If doesn't enroll, would be assigned to a plan that contracts with that NH.

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 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 not realize it must be filed! 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

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) – 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!
- "Discharge Alert" forms posted at http://www.wnylc.com/health/entry/117/

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

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NEW OVERTIME REQUIREMENTS FOR AIDES

Started Oct. 13, 2015

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 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.

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
Medicaid application goes to:

HRA HCSP Central Medicaid Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238
T: 929-221-0849

HOUSEKEEPING ONLY (max 8 hrs/wk)
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.
- Then go through Conflict Free Assessment
- Then have to enroll in a plan

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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

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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
  - Even though CFEEC does not determine hours, the assessment is saved in computer and MLTC plan may rely on it.
- No new assessment needed if transferring from plan to plan, or from a previous Medicaid LTC service
- BUT - DOH is requiring CFEEC if receiving nursing home care.
- 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.

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 (2015)

Region	Counties	Deduction
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$382
Long Island	Nassau, Suffolk	$1,147
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1,001
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	$791
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$388
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$376

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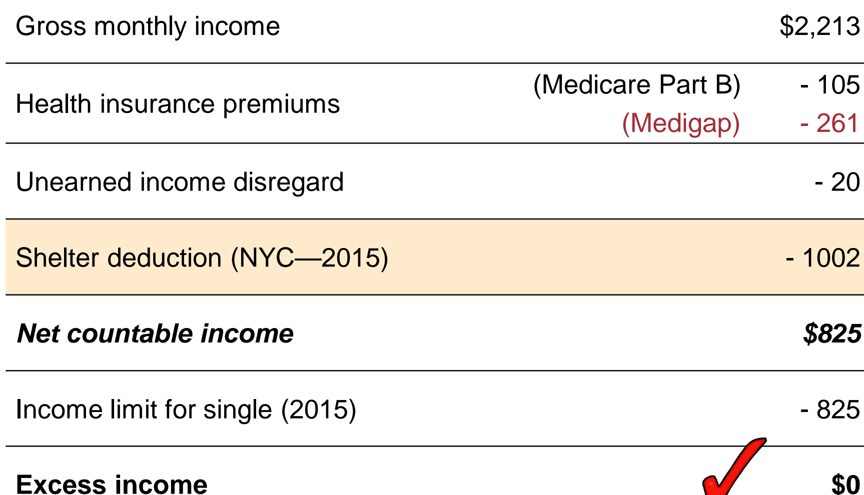
Example budget with NH transition shelter allowance



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.

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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…

NAVIGATING MLTC

- Service Authorizations, Concurrent Review
- Grievances and Appeals

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

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.

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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.

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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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24-Hour Care – Who qualifies?

- Plans sometimes apply arbitrary illegal limits, such as giving 24/hour care only if the member is bedbound.
- New state regulation redefines 24-hour care:
  - **Live-in** care if need for help during the night is **infrequent** or **can be predicted**. A live-in aide should get eight hours of sleep, including 5 consecutive hours of uninterrupted sleep. Aide must have private space – screen is OK.
  - **Continuous "split shift"** care must be given if needs "interrupted care for more than 16 hours per day and… requires total assistance with toileting, walking, transferring or feeding **at times that cannot be predicted**."

See GIS 12 MA/026 and 18 NYCRR 505.14(a). http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/12ma026.pdf

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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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PLAN NOTICES & REDUCTIONS IN SERVICES

Best Practices for Advocacy

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 reduction.
     - Ask client/family did you receive a notice?
     - If the client denies having received any notices, explore whether there are any problems with their mail
     - **You can still request a Hearing even if no notice**. One of your claims is lack of proper notice.
     - **Get the postmarked envelope**. If not MAILED at least 10 days before effective date, notice is DEFECTIVE and will be overturned.

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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.

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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
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)

(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]
  - Whenever a plan wants to make changes in a previously authorized service, it must state the reason for the change on the notice.

MANAGED LONG TERM CARE ACTION TAKEN
DENIAL, REDUCTION OR TERMINATION OF BENEFITS (211)

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

VNSNY CHOICE MLTC is taking this Action because:

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(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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How to read a notice (cont'd)

- There are other things that are required to be included in a notice for it to be considered adequate.[1] For example:
  - Law and/or regulations upon which the action is based
  - Right to request a fair hearing
  - Procedure for requesting a fair hearing
  - Circumstances under which aid continuing is available
  - Right to obtain the evidence packet, and how to obtain it
  - Right to representation
  - Right to question witnesses and present evidence at the hearing
  - Liability for aid continuing
  - Availability of legal services

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(1) 18 NYCRR § 358-2.2(a)(4)–(13).

Defective Notice

- If the notice is defective, you may be able to get the plan to withdraw it. If the plan refuses to withdraw a defective notice, then there will be strong grounds for reversal at a Fair Hearing.
  - Notice Date
    - If the notice date is less than 10 days before the effective date, then the notice is defective because not timely.[1]
  - Postmark Date
    - Reduction and discontinuance notices must be mailed at least 10 days before the effective date.
    - If the postmark date on the envelope is fewer than 10 days before the effective date, the notice is defective because not timely.

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

Defective Notice (cont'd)

- **Reason**
  - For reductions and discontinuances of personal care assistance, both the reason and the language used to describe it must be "appropriate." [1]
  - Plan notices have a section for the reason or rationale, but that section is often populated with conclusory language (e.g., "we have conducted a comprehensive reassessment and concluded that your needs can be adequately met with fewer hours than they were previously").
  - A notice that either gives no reason, or gives an "inappropriate" reason, would be considered a Defective Notice.

[1] 18 NYCRR § 358-2.2(a)(3) & 505.14(b)(5)(v)(c).

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Mayer v. Wing – reasons for reductions

- Mayer v. Wing was a landmark class action whose settlement provided, among other things, that the Medicaid program must provide an appropriate **reason for reducing or discontinuing personal care services.**
- The following slides provide the main reasons given as examples in the Medicaid regulations. 18 NYRR 505.14(b)(5)(c).
- Notice can't just state general ground for reduction – must state FACTS. EX: Not just "we made a mistake before" but what WAS the mistake!

(1) See Fair Hearing # 5230170H (November 10, 2010), available http://otda.ny.gov/fair%20hearing%20images/2010-11/Redacted_5230170H.pdf.

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Mayer Reasons 1-5

1. the client's **medical, mental, economic or social circumstances have changed** and the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
   - NOTICE MUST STATE EXACTLY WHAT CHANGED! Did client get better?
2. a **mistake** occurred in the previous PCS authorization;
3. the client refused to cooperate with the required assessment;
4. a **technological development** renders certain services unnecessary or less time consuming
   - NOTE - may not use PERS emergency alert to reduce hours if needs aide assistance with ADLs
5. the client **can be more appropriately and cost-effectively served** through other Medicaid programs and services;
   - NOTE: MLTC plan must assess for and authorize other services, including private duty nursing, adult day care, CDPAP, etc.

(1) 18 NYCRR § 505.14(b)(5)(v)(c).

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Mayer Reasons 6-10

6. the client's **health and safety** cannot be assured with the provision of personal care services;
   - NOTE health and safety need not be GUARANTEED – just reasonably expected to be maintained
7. the client's medical condition is not **stable**;
   - NOTE: Client may not be eligible for PCS if condition not stable, but MLTC plan must determine if eligible for private duty nursing or CHHA services
8. the client is **not self-directing** and has no one to assume those responsibilities;
9. the services the client needs exceed the **personal care aide's scope of practice;**
   - NOTE – again, plan should assess for private duty nursing or CHHA
10. the client resides in a facility or services which are responsible for the provision of needed personal care services.
    - NOTE – with MLTC now responsible for Nursing Home Care & other LTC services, this is no longer a basis for termination

(1) 18 NYCRR § 505.14(b)(5)(v)(c).

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Defective Notice (cont'd)

- Appeal Rights, Aid Continuing, Right to Representation, etc.
  - These notices are required to include a great deal of information about appeal rights, which are usually handled through several pages of boilerplate.
  - Because plans are now required to use DOH-issued model notices, it is unlikely that a notice will lack these things. But if it does, that renders the notice defective.
- **Giving NO WRITTEN NOTICE is DEFECTIVE NOTICE!**
  - You may request a hearing if you did not receive any written notice, just verbal. You should win based on lack of written notice.

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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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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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GET AID CONTINUING

The Right to Continue the Previous Amount of Services Unchanged until the Hearing is Held and Decided

Reduction CANNOT go into Effect

Time is of the essence!

- The effect**ive date** of a reduction or discontinuance is the most important date.
- This is the deadline by which the member must request a fair hearing in order to get **aid continuing**.
- The **notice must be mailed 10 days before the "effective date" of the reduction**. But this includes mailing time and weekends! So in practice, there may be just a few weekdays to request a hearing.
- If the effective date has already passed, see if member has **postmarked envelope** the notice was mailed in. If postmark is later than the date of the notice, then it is not too late to request a hearing and get Aid Continuing.

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Warning about internal appeals

- 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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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]

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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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Requesting a fair hearing

- Website shows 3 ways to request – phone 1-800-342-3334, fax, or online http://otda.ny.gov/hearings/request/ . That link has a form you can fax. Attach copy of notice if you have it.

Services News Government Local

FAIR HEARING REQUEST FORM
Office of Administrative Hearings
P.O. BOX 1930
Albany, NY 12201-1930
Fax (518) 473-6735

Note: For security purposes, you have 15 minutes to complete this form, otherwise your request will not be received and you will need to start over.

* Indicates Required Information. Correct and complete information will permit us to promptly process your request.

Case Information
(If fair hearing is for someone other than the case name, describe who it is for in the comments box below.)

* Last Name:
* First Name:
Middle Initial:

* Street Address:
Suite/Floor/Apt#:
* City:
* State: NY
Zip Code:
Email Address:

- No punctuation allowed
- No hyphens in phone or SSN
- Reason limited to 255 characters.
- Give name of MLTC plan.

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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
- **Consumer FIDA Ombudsprogram – ICAN – 1-844-614-8800 http://icannys.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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What Is ICAN?

- 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**

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