NEW YORK STATE BAR ASSOCIATION

WORKSHOP A.

Moving Towards Civil Gideon

2014 Legal Assistance Partnership Conference

Hosted by:
The New York State Bar Association
and The Committee on Legal Aid

NYSBA

NEW YORK STATE BAR ASSOCIATION
2014 PARTNERSHIP CONFERENCE

A. MEDICAID IN 2014: IMPACT OF FEDERAL AND STATE REFORM

AGENDA

September 11, 2014
10:00 a.m. – 1:15 p.m.

3.5 Transitional CLE Credits in Professional Practice.
Under New York's MCLE rule, this program has been approved for all attorneys, including newly admitted.

Panelists:
Rebecca Antar Novick, Esq., Supervising Attorney, Health Law Unit, The Legal Aid Society
Christine Chiu, Esq., Staff Attorney, Health Justice Program, New York Lawyers for the Public Interest
Belkys García, Esq., Staff Attorney, Health Law Unit, The Legal Aid Society
Geoffrey A. Hale, Esq., Senior Health Law Attorney, Empire Justice Center
Linda R. Hassberg, Esq., Senior Staff Attorney, Empire Justice Center
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Carol Santangelo, Esq., Staff Attorney, Health Law Unit, The Legal Aid Society
Rebecca Wallach, Esq., Staff Attorney/Skadden Fellow, Evelyn Frank Legal Resources Program, New York Legal Assistance Group

I. New York's Health Plan Marketplace: The Medicaid Expansion and New Federal Subsidies — **10:00 am – 11:05 am**

a. Background: The Affordable Care Act, the Exchange, and Medicaid Expansion
b. Medicaid Expansion
c. Qualified Health Plans
d. Federal Tax Subsidies

II. Medicaid Managed Care Expansion and Impact on Fragile Populations — **11:05 am – 12:05 pm**

a. Overview of Eligibility Criteria and Coverage of Mainstream and Managed Long Term Care
b. Navigating Mainstream and Managed Long Term Care as Legal Advocates
c. Fully Integrated Duals Eligible (FIDA) Demonstration Plan Overview
d. Questions

FIFTEEN MINUTE BREAK

III. Impact of Medicaid Redesign on Persons with Mental Health Disabilities **12:20 pm – 12:45 pm**

a. Medicaid Redesign
b. Health Homes
    i. Behavioral Health Organizations ("BHOs")

IV. Impact of Health Reform on Low-Income Communities of Color **12:45 pm – 1:15 pm**

a. Demographic Overview & Prevalence of Health Disparities
b. ACA's Promise
c. Challenges Ahead

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Substantive Outline

A. MEDICAID IN 2014: IMPACT OF FEDERAL AND STATE REFORM

OUTLINE

Note: Acronyms Glossary on last page of Outline

I. NEW YORK'S HEALTH PLAN MARKETPLACE: THE MEDICAID EXPANSION AND NEW FEDERAL SUBSIDIES

A. ACA General Background

B. New York State of Health: New York's Exchange marketplace

1. April 2012: New York State Exchange established by Governor Cuomo. "One stop shop" for public insurance programs, private insurance through qualified health plans ("QHPs"), and insurance affordability programs. New York Executive Order No. 42 (April 2012)
    a. Individual Exchange
    b. Small Business Health Options Program ("SHOP")
2. Streamlined enrollment process for Medicaid, Child Health Plus ("CHP"), and QHPs
    a. Applications by phone, mail, in person or web
    b. Assistance from Navigators and In-Person Assistors
    c. Real time eligibility determination and enrollment
    d. Data electronically verified
    e. Built-in appeals systems

C. Medicaid Expansion

1. 138% Federal Poverty Level ("FPL")
2. Family Health Plus ("FHP")
3. New Eligibility Categories
    a. Modified adjusted gross income ("MAGI") vs. non-MAGI
4. Eligibility Criteria: What's changed?
    a. Residency - No Change
        i. Must be a NY resident to receive NY Medicaid. Soc. Serv. L. § 366-a
        ii. Must intend to remain in NY "permanently or indefinitely." 42 C.F.R. § 435.403
    b. Immigration Status = No change
        i. Permanent Residence Under Color of Law ("PRUCOL") immigrants still eligible for MA. *Aliessa, et al. v. Novello* (96 N.Y. 2d 418); 8 USCA 1611(b)(1)(A); 1621.
        ii. Deferred Action for Childhood Arrivals ("DACA")
        iii. Undocumented immigrants eligible for emergency Medicaid only. NY Soc. Serv.L.§ 122[1](c). As of January 2014, can apply through the Exchange.
    c. Category

i. Old Rule - categories depend on age, disability status, living with children, etc. Remains unchanged for SSI related beneficiaries.

ii. New rule - Modified Adjusted Gross Income (MAGI)

a) Pregnant women. 42 CFR §435.116

b) Children. 42 CFR §435.118

c) Parents/caretaker relatives. 42 CFR §435.110

d) Childless adults. 42 CFR §435.119

d. Income

i. Income levels

a) Pregnant women - 223% FPL. CFR §435.116 ; N.Y. Soc. Serv. L. §366(1)(b)(2);

b) Infants - 223% FPL. 42 CFR §435.118; N.Y. Soc. Serv. L. §366(1)(b)(2);

c) Children - 154% FPL (with some exceptions). 42 CFR §435.118; N.Y. Soc. Serv. L. §366(1)(b)(3);

d) Parents - 138%; 155% - Wrap. 42 CFR §435.110; N.Y. Soc. Serv. L. §366(1)(b)(4);

e) Childless Adults = 138% FPL. 42 CFR §435.119; N.Y. Soc. Serv. L. §366(1)(b)(1);

ii. Household (42 CFR 435.603(d); 42 CFR 435.603(b); 42 CFR 435.603(f)

a) MAGI household is defined as the IRS filing unit

b) Exceptions for certain children

c) Pregnant women counted as self + number of expected children

d) Married spouses living together are in each other's household, regardless of whether they file jointly or separately.

e) If an individual is claimed as a tax dependent and not the spouse or child of the taxpayer **OR** is not expected to file tax return and not claimed as dependent in that year, the household size would include self, spouse, and children less than 19 years old (or, if full-time student, less than 21 years old)

iii. What counts as income

a) Gross Income - wages, SS income, investment income, unemployment, pensions, IRA distribution, alimony, and income from self-employment,

b) Adjustments - alimony, moving expenses, student loan interest, and self-employed health insurance contributions

iv. What is not income: Sec. 36B(d)(2) of IRC of 1986; 42 C.F.R. § 435.603(d); 42 C.F.R. §435.603(e)

a) Child Support

b) Income from child or tax dependent who is not expected to be required to file a tax return in the taxable year for which MA eligibility is determined.

c) Medicaid rules apply to lump sums, and certain educational scholarships and payments to Native Americans.

d) Scholarships, awards and fellowships grants used for education purposes and not for living expenses are excluded as income.

e) Distribution from Alaska Native Corporation and settlement trusts, from property held in trust subject to Federal restrictions, located within a Federal reservation, from rents, leases, rights of way, royalties, from native land, etc. is exempt income.

v. Income Disregard

a) 5% disregard 42 U.S.C. § 1396a(14)(I)(i); 42 C.F.R. § 435.603(d)(1)

e. Resources - no resource test for MAGI. 42 CFR 435.603(g); unchanged for non-MAGI

5. Medicaid Benchmark Benefits for newly eligible MAGI

a. Medicaid benefit will *not* be uniform; benchmark benefit is not "full" Medicaid

b. Benchmark benefit includes all covered Medicaid benefits *except* long-term care

c. Reporting – Individuals must report changes with respect to eligibility standards through the same modalities they can apply for coverage. 42 CFR 435.916(c)

d. Renewal – State must use available information to facilitate annual re-determination process. 42 CFR 435.916

D. <u>Health Insurance Exchange</u>

1. Qualified Health Plans ("QHPs")

a. QHPs offered are categorized by level of coverage into "metal tiers" based on actuarial value

i. Bronze: 60%;

ii. Silver: 70%;

iii. Gold: 80%;

iv. Platinum: 90%

b. Catastrophic plans offered for young adults under 30 who cannot afford coverage

c. Tiers based on level of cost-sharing for average enrollee OR the percentage of costs plan will cover. "actuarial value" - translates to premium amounts and percentage of costs plan will cover

d. Premiums lowest for low actuarial value, but higher out of pocket cost-sharing

e. Catastrophic plans have very low actuarial value & very high cost-sharing

f. To protect against insurers keeping prices high by only offering high premium plans, each insurer participating in Exchange has to offer 1 silver and 1 gold plan

2. Federal Tax Subsidies
    a. ACA requires that Marketplace provide financial assistance in the form of subsidies (advanced premium tax credits and cost-sharing reductions) for individuals and families with incomes between 100% and 400% of Federal Poverty Level
    b. Advanced Premium Tax Credits ("APTC"): federal government pays a portion of monthly premiums directly to insurer to decrease consumer contribution Pub. L. No. 111-148
        i. ACA establishes 2 major insurance affordability programs. One being the continuation public health insurance programs already in place, such as MA program. The new one is financial assistance for QHP offered through tax credits or subsidies
        ii. 100% FPL is $958/month for single adult, $11,500/year; about $2000/month for family 4, $24,000 annual
        iii. 400% FPL is single: $46,000 annual. Family 4: $110,280 annual
        iv. Monthly premiums are paid to plans for every individual enrolled; for those eligible for PTC, government subsidizes premium costs, paying a portion of the total premium costs *in advance* to decrease amount charged to consumers for premiums OR in form of tax return; consumer will be responsible for portion of premium costs not subsidized by government
        v. PTC handled/administered by IRS, credit amounts will be reconciled by IRS
        vi. Only individuals & families not eligible for coverage thru public programs or coverage thru employer
        vii. Medicare recipients can purchase additional coverage through Exchange, but not eligible for premium assistance
        viii. Premium subsidies & MA expansion (which will be discussed later) will be based on income as % federal poverty level. For 2014, 2013 FPL numbers will be used. In general, these programs will be based on FPL levels at time of open enrollment. For 2014, open enrollment starts Oct 2013 ◊ use 2013 FPL. Chart with FPL.

II. MEDICAID MANAGED CARE EXPANSION AND IMPACT ON FRAGILE POPULATIONS

A. Overview of Eligibility Criteria and Coverage of Mainstream and Managed Long Term Care

1. **Mainstream Medicaid Managed Care (MMC) (N.Y. Soc. Serv. L. § 364-j)**
    a. Administration of Medicaid services through Managed Care Organizations (MCOs)

b. As a result of Medicaid Redesign Team ("MRT") recommendations adopted in 2011, MMC is now mandatory for virtually all Medicaid beneficiaries. (NY Soc. Serv. L. § 364-j(3)(a)

i. The only individuals not required to enroll in MMC are (NY Soc. Serv. L. § 364-j(3)(e)):

a) Dual Eligibles – i.e., those eligible for both Medicaid and Medicare;

b) Medicaid beneficiaries with other comprehensive insurance;

c) Those eligible for Medicaid under the excess income program – i.e., spend-down;

d) Medicaid beneficiaries with limited benefits – e.g., Emergency Medicaid, tuberculosis related services, Medicaid Cancer Treatment Program, etc.;

e) Medicaid beneficiaries in receipt of hospice services; and

f) Medicaid beneficiaries enrolled in waiver programs, including OPWDD Waiver, Nursing Home Transition and Diversion Waiver, Care at Home Waiver for children, and the TBI Waiver;

1) Note: The Lombardi Waiver (Long Term Home Health Care Program) must enroll in MMC as of 4/1/2013. For DOH guidance on carving Lombardi services into MMC, see: http://www.health.ny.gov/health_care/medicaid/redesign/docs/lthhc_transition_policy.pdf.

ii. MMC covered services are described in Appendix K of the Model Contract: http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf.

2. **Medicaid Managed Long-Term Care (MLTC) (N.Y. Pub. Health L. § 3304-f)**

a. Under a waiver authorized in the 2011 New York State Budget implementing MRT proposals and approved by CMS August 31, 2012, MLTC will become mandatory throughout New York State by the end of 2014. (Special Terms and Conditions submitted to CMS April 13, 2011: http://www.health.ny.gov/health_care/managed_care/appextension/docs/special_terms_and_conditions.pdf; Special Terms and Conditions, amends and supersedes August 31, 2012, CMS award: http://www.health.ny.gov/health_care/managed_care/appextension/docs/special_terms_and_conditions_04_2013.pdf; CMS award letter, August 31, 2013: http://www.health.ny.gov/health_care/managed_care/appextension/docs/cms_award_letter.pdf; CMS award letter, March 6, 2014: http://www.health.ny.gov/health_care/managed_care/appextension/docs/cms_letter.pdf.)

b. Schedule for expansion of Mandatory MLTC by County:

i. Phase I: NYC, began September 2012;

ii. Phase II: Westchester, Nassau, and Suffolk Counties: January 2013;

iii. Phase III: Rockland and Orange Counties: September 2013;

iv. Phase IV: Albany, Erie, Monroe, and Onondaga Counties: December 2013;

v. Phase V: Remaining Counties in New York State become mandatory during 2014 according to the following schedule:

a) April 1: Columbia, Putnam, Sullivan, and Ulster

b) May 1: Rensselaer, Cayuga, Herkimer, and Oneida

c) June 1: Greene, Schenectady, Washington, and Saratoga

d) July 1, Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, and Oswego;

e) August 1: Warren, Delaware, Niagara, Otsego, and Chenango;

f) September 1: Essex, Clinton, Franklin and Hamilton;

g) October 1: Jefferson, Lewis, St. Lawrence, Steuben, Chautauqua, Cattaraugus, and Alleghany;

h) November 1: Yates, Seneca, Schuyler, Tioga, Cortland, and Chemung;

i) December 1: Genesee, Ontario, Livingston, Orleans, Tompkins, Wayne, and Wyoming.

vi. *See* schedule at: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2014_mltc_transition_timeline.pdf.

c. Medicaid beneficiaries meeting the following eligibility criteria will be required to enroll in MLTC (or PACE or MAP) when their county of residence becomes mandatory:

i. Dually Eligible (eligible for both Medicaid and Medicare);

ii. Age 21 or older; and

iii. In need of more than 120 days of community-based long-term care services.

d. Community-based long term care services include:

i. personal care;

ii. certified home health aide;

iii. Consumer-Directed Personal Assistance Program ("CDPAP");

iv. adult day care;

v. private-duty nursing; and

vi. Long-Term Home Health Care Program (aka "Lombardi").

3. **There are three different models of managed care for long-term care services in NY**: MLTC; Program of All-Inclusive Care for the Elderly (PACE); and Medicaid Advantage Plus (MAP). All three satisfy the requirement that certain Medicaid beneficiaries enroll in a managed care plan in order to receive long-term care services, but auto-enrollment of those who do not choose a plan themselves will only be used to enroll beneficiaries in MLTC.

a. Managed Long Term Care Generally

i. Enrollment

a) Enrollment is handled by Maximus (a.k.a. New York Medicaid Choice).

b) When MLTC becomes mandatory, Medicaid beneficiaries receiving community-based long-term care services will receive a series of letters:

1) Announcement Letter (available here: http://www.health.ny.gov/health_care/medicaid/redesign/docs/1.1-am_notice-english-unenrolled.pdf).

(a) Sent to those with 120 days or more left on their authorizations for long-term care services.

(b) The letter explains that MLTC is becoming mandatory and that future notices will explain enrollment procedures.

2) 60-day Letter. (available here: http://wnylc.com/health/download/318/)

(a) 30 days after the announcement letter, Maximus will send another letter indicating that the beneficiary must choose a MLTC plan within 60 days or be assigned to a plan automatically.

(b) The letter includes information about enrolling in MLTC and contacting Maximus for assistance.

(c) Along with the letter, beneficiaries receive this official guide to MLTC: http://nymedicaidchoice.com/sites/default/files/content-docs/MLTC%20BROCH%20r5-9-13%20v4.pdf.

c) Maintaining plan enrollment:

1) Spend-down

(a) Unlike MMC, where eligibility for Medicaid based on Excess Income Spend-Down makes beneficiaries *ineligible* for MMC, spend-down does NOT prevent Medicaid beneficiaries from enrolling in MLTC. Because MLTC plans are expected to collect the spend-down, Medicaid beneficiaries with a spend-down MUST enroll in MLTC if they reside in a mandatory county and meet the other eligibility requirements.

(i) Under the terms of the Model Contract, MLTC plans must bill beneficiaries with a spend-down for the amount of the spend-

down. *Managed Long-Term Care Partial Capitation Contract*, Art. V (C)(8).

(b) MLTC plans may disenroll beneficiaries from the plan for failure to pay the spend-down, but must follow notice and appeal procedures. *Managed Long-Term Care Partial Capitation Contract*, Art. V (D)(5)(b).

(i) Disenrollment for non-payment of the spend-down appears to violate federal law, which only requires the medical debt be incurred to meet spend-down, but does not have to be paid. *See* 42 C.F.R. § 435.831(d).

2) MLTC Housing Disregard.

(a) A policy issued January 24, 2013, but effective October 15, 2012, creates a special income standard to help pay for housing expenses for nursing home residents who are Medicaid eligible and can safely transition back to the community through enrollment in an MLTC plan. *See* MLTC Policy 13.02 at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.02.pdf; *see also* 12 ADM 05 at: http://www.health.ny.gov/health_care/medicaid/publications/adm/12adm5.htm.

(b) Eligible recipients must:

(i) Be 18 or over;

(ii) Have been in a nursing home for 30 days or more;

(iii)Have had Medicaid pay toward the nursing home care;

(iv)Newly enroll in MLTC; and

(v) Have a housing expense.

(c) Rates vary by region. *See* GIS 13 MA/04 at http://www.health.ny.gov/health_care/medicaid/publications/gis/13ma004.htm.

3) Spousal Impoverishment Protections.

(a) On September 24, 2013, DOH announced that spousal impoverishment protections that help the community spouses maintain income without necessarily jeopardizing the Medicaid eligibility of

his or her institutionalized spouse would be extended to enrollees in MLTC, including MAP and PACE.

(b) *See* GIS 13 MA/018 at: http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/13ma018.pdf.

ii. MLTC Eligibility:

a) Enrollment in MLTC is mandatory for those who:

1) Are dual eligible (eligible for both Medicaid and Medicare);
2) over 21 years of age;
3) need community based long-term care services for more than 120 days; and
4) live in a mandatory county.

b) Enrollment in MLTC is voluntary for those who:

1) Are dual eligible;
2) 18 through 21 years old;
3) Need 120 days or more of community-based long-term care services; and
4) Have been found eligible for nursing home care.

c) Non-dual eligibles may enroll if they are:

1) Over 18;
2) Eligible for nursing home care.

d) *See*: https://www.health.ny.gov/health_care/managed_care/mltc/

iii. Partially Capitated MLTC

a) Partially Capitated MLTC plans do not cover all services. They primarily cover long-term care services (as listed below). Most other services, including primary care services, are not covered by MLTC plans. These services are instead covered by Medicare, Medicare Advantage, or fee-for-service Medicaid.

1) Partially Capitated Model Contract available here:

b) The following services are covered by MLTC plans: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

1) Care management and medical social services;
2) Home care – nursing, home health aide, personal care, occupational, speech and physical therapies;
3) Optometry/eyeglasses;
4) Dental services;
5) Rehabilitation therapies, respiratory therapy;
6) Audiology and hearing aids,

7) DME, including orthopedic footwear, compression stockings, and enteral nutritional supplements;
8) Nutrition;
9) Podiatry;
10) Non-emergency transportation for medical care;
11) Home-delivered meals and/or meals in a day care center or other group setting;
12) Medical equipment and supplies;
13) Social day care or Adult Day Health Care;
14) Social/environmental supports (chore services, home modifications);
15) Personal Emergency Response System (PERS);
16) Nursing home – covered by MLTC, but institutional budgeting and transfer penalty rules apply;
17) Prescription and non-prescription drugs.

c) Services NOT covered by MLTC plans:
1) Inpatient hospital services;
2) Outpatient hospital services;
3) Physician services;
4) Laboratory services;
5) Radiology and Radioisotope services;
6) Emergency transportation;
7) Rural Health Clinic services;
8) Chronic renal dialysis;
9) Mental health services;
10) Alcohol and substance abuse services;
11) OPWDD services;
12) Family planning services;
13) Prescription and non-prescription drugs, compound prescriptions; and
14) Assisted living program;

d) Covered and Non-Covered Services are listed in Appendix G of the *Managed Long-Term Care Partial Capitation Contract*. *See*: https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

b. Program of All-inclusive Care for the Elderly (PACE) (42 U.S.C. § 1396u-4); *see also* 42 U.S.C. § 1395eee; 42 C.F.R. pt. 460).

i. Description:

a) A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. PACE aims to provide a fully integrated package of care for seniors while

allowing enrollees greater independence by avoiding institutionalization. PACE plans require their members to use PACE physicians and providers. PACE members are not allowed to go "out of plan" to receive services. An interdisciplinary team develops care plans for each member and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services required by a PACE member.

1) *See*: N.Y. Dep't of Health, About Managed Long Term Care (2006), *at* http://www.health.ny.gov/health_care/managed_care/mltc/aboutmltc.htm

b) Both Medicare and Medicaid pay for PACE services on a capitated basis. Medicare recipients who are not eligible for Medicaid may participate in a PACE by paying a monthly premium equal to the Medicaid capitation amount, but members are never required to pay any Medicare or Medicaid cost-sharing.

ii. Eligibility:

a) Age 55 or older

b) Who are otherwise eligible for nursing home admission.

c) Unlike enrollees in MLTC, applicants for a PACE must be certifiable for nursing home level of care. The enrollment broker, Maximus, will review this prerequisite at time of enrollment.

1) *See* Centers for Medicare & Medicaid Services, PACE MANUAL, Pub. 100-11 at § 10.1, available at http://www.cms.gov/PACE/Downloads/R1SO.pdf.

iii. Enrollment:

a) Enrollment in PACE is voluntary. Even after MLTC becomes mandatory, those required to enroll in a plan for long-term care services will not be automatically enrolled in PACE; they must choose to do so.

b) PACE enrollment is handled by New York Medicaid Choice (Maximus).

iv. Services:

a) The PACE plan assumes full financial risk for participants' care, without limits on amount, duration or scope of medically necessary services. The PACE is the sole source of medical and health care and services for its enrollees.

b) Maintaining enrollees' social and environmental health is also a key component of PACE. Some social and environment services not normally reimbursed by Medicaid and Medicare may be included in an enrollee's care plan.

c) Services covered under PACE include:
1) care management and coordination;
2) inpatient and outpatient hospital services;
3) primary and preventive care;
4) adult day care (medical and social);
5) meals;
6) nutrition services;
7) ambulance and non-emergency transportation;
8) audiology;
9) dentistry;
10) home health and personal care;
11) radiology/laboratory;
12) prescription/non-prescription drugs;
13) podiatry;
14) physical, speech and occupational therapies;
15) respiratory therapy;
16) medical equipment and supplies;
17) orthotics/prosthetics;
18) personal emergency response systems (PERS);
19) nursing home services (subject to Institutional Medicaid eligibility); and
20) other social and environmental supports.

d) *See* N.Y. Pub. Health L. § 4403-f(10).

c. Medicaid Advantage Plus (MAP)

i. Description:

a) Combination of a Medicare Advantage plan, a Mainstream Medicaid Managed Care plan, and a partially capitated MLTC plan. Like PACE, a MAP is fully-capitated, including both Medicare and Medicaid payments and including all Medicare- and Medicaid-covered services. As with regular Medicaid Advantage and PACE, MAP is voluntary.

b) See: N.Y. Dep't of Health, MEDICAID ADVANTAGE PLUS MODEL CONTRACT at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_medicaid_adv_plus_model_contract.pdf.

ii. Eligibility:

a) Eligibility requirements for MAP are identical to those for MLTC, EXCEPT that applicants for MAP must be certifiable for nursing home level of care at the time of enrollment and must enroll in the MAP plan's Medicare Advantage product. Complete eligibility requirements include:

1) Must be eligible for full Medicaid;

2) Must be enrolled in Medicare Parts A and B, or Medicare Advantage;
3) Must reside in the plan's service area;
4) Must be 18 or older at time of enrollment;
5) Must enroll in the plan's Medicare Advantage product;
6) Must be eligible for nursing home level of care at time of enrollment;
7) Must be able to remain safely in the community with community long-term care services;
8) Must need 120 days a year or more community long-term care services;

(a) *See*: N.Y. Dep't of Health, MEDICAID ADVANTAGE PLUS MODEL CONTRACT, 5.1(a).

4. **Recent Changes in Long-Term Care Services and MLTC Benefit Packages:**
   a. Personal Care "Carve-In" to Mainstream Managed Care Plan
      i. Personal Care Services became part of the mainstream Medicaid managed care benefit package as of August 1, 2011. GIS 11 MA/009.
   b. Nursing Home "Carve-In"
      i. Pending CMS approval, NY will make institutional care – e.g., nursing home care – part of the managed care benefit package. The transition is currently scheduled to begin in New York City and Nassau, Suffolk, and Westchester Counties on September 1, 2014. The rest of the state will follow on December 1, 2014. (Note: These dates have already been pushed back several times since the initial announcement and proposed start date of April 1, 2014. As of July 31, 2014, CMS had not approved the nursing home carve-in, and it is likely that the start date will be delayed again.)

a) DOH presented its policy initiative via webinar on March 10, 2014, available here: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-03-10_trns_of_nh_services.pdf.

b) Medicaid beneficiaries already residing in institutional settings will not have to enroll into MLTC in order to continue receiving institutional care.

c) When the transition begins, beneficiaries in MLTC or MMC will not be disenrolled from their plans, if they require nursing home care;

d) Beneficiaries new to nursing home care will need to enroll in MMC or MLTC, if not already enrolled, in order to receive care in the nursing home.

B. Enrollment Strategies for New Applicants to Managed Long Term Care

1. **General Enrollment Counseling**
    a. Consumer must first choose MLTC Plan (Tools for Choosing MLTC Plans available at http://www.wnylc.com/health/entry/169/)
        i. Partially capitated MLTC: If client wants to keep all of her current doctors, hospitals, clinics, etc., then choose Partial Capitation – MLTC. Most primary and acute medical care is not in the partially capitated MLTC service package, so client keeps her regular Medicare card (or Medicare Advantage plan) for all Medicare primary/acute care.
        ii. Full Capitation – PACE or Medicaid Advantage Plus (MAP)
            a) Plan controls all Medicare as well as Medicaid services. Must be in-network for all services. Plan may require approval of many Medicare services.
            b) Deciding between PACE vs. Medicaid Advantage Plus (MAP):
                1) PACE provides services through a particular site – a medical clinic or hospital. Because all providers are linked, potentially more opportunity for coordinated care.
                2) MAP is a traditional insurance plan model. MAP plans contract with various providers for all Medicaid and Medicare services including community based long term care.

> ***Caution:*** *Medicaid Advantage Plus (MAP) is not the same as Medicaid Advantage (MA). Both include all Medicare services but Medicaid Advantage does not include home care. If client needs home care must enroll in MLTC or MAP/PACE.*

        iii. MLTC plan lists available online.
            a) New York State Department of Health: http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm
            b) NY Medicaid Choice website - http://nymedicaidchoice.com/program-materials - Look only at Long Term Care plans,
            c) List compiled by advocates: http://www.wnylc.com/health/entry/114/#List%20of%20Plans
    b. Best Practices and Advocacy Tips
        i. Ask Multiple MLTC Plan for Assessment Prior to Enrollment

a) To make an informed choice, call several plans to visit client, do an assessment and propose a plan of care, before client agrees to enroll. Many plans refuse to do this unless client has enrolled, but *see* State DOH Q&A 8/21/12 # 39 available at https://www.health.ny.gov/health_care/managed_care/mltc/

b) Client doesn't have to sign on the spot during the initial assessment, or as a condition of the plan conducting an assessment.

c) Family member, advocate, or geriatric care manager should be present at the assessment

c. What if each plan proposes inadequate hours or denies enrollment?

i. Inform clients of their right to receive adequate services.

a) May 8, 2013, DOH released MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care which bars plans from discouraging prospective members from enrolling.

b) "The MLTC plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party."

1) This policy is available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf.

ii. Shop around to other MLTC plans

iii. Complain to the Department of Health (DOH) MLTC Complaint Line at 1-866-712-7197 or mltcworkgroup@health.state.ny.us.

2. **Logistics of Enrollment & Disenrollment**

a. Partially Capitated MLTC

i. May enroll either through the plan or through NY Medicaid Choice (Maximus – enrollment broker contracting with DOH)

ii. Enrollment has no impact on Medicare – client keeps her Medicare Advantage plan or stays in Original Medicare

b. MAP / PACE

i. Must enroll through the plan, not through NY Medicaid Choice

ii. Enrollment consists of two transactions: enrollment in Medicare Advantage plan and in connected Medicaid plan

iii. By enrolling in a MAP or PACE, client is automatically disenrolled from any/all of the following plans:

a) Medicare Advantage (including some retiree/union plans)

b) Stand-alone Part D Prescription Drug Plan (PDP)

c) Mainstream Medicaid Managed Care

c. Enrollment Timing (*MLTC Model Contract*, Article V(C))

i. Services are effective the 1st of the month ONLY because plans are paid a monthly capitation by the DOH on a monthly basis for each member.

ii. All enrollment paperwork must be completed by the 18th of the month for service to be in place the 1st of the following month. E.g., for enrollment to be effective October 1, 2014 all enrollment paperwork must be completed by September 18, 2014.

d. Disenrollment

i. No lock in. Member can voluntarily disenroll and switch MLTC plans, however, disenrollment may take up to two months.

ii. Maximus/NY Medicaid Choice makes final determination for involuntarily disenrollment. Member is entitled to Fair Hearing to contest the disenrollment with aid continuing.

iii. MLTC plan MUST involuntarily disenroll member for reasons:

a) member no longer resides in the plan's service area;

b) member has been absent from the service area for more than 30 consecutive days;

c) member is hospitalized or enters an OMH, OPWDD or OASAS residential program for 45 consecutive days or longer;

d) member clinically requires nursing home care but is not eligible for such care under the Medicaid Program's institutional rules;

e) member is no longer eligible to receive Medicaid benefits;

f) member is not eligible for MLTC because he/she is no longer requiring community-based long term care services or, for non-dual eligible members, no longer meets the nursing home level of care; or

g) member is incarcerated.

iv. MLTC MAY involuntarily disenroll members if the member:

a) or his/her family member or other person in the home engages in conduct or behavior that seriously impairs the MLTC's ability to furnish services; provided, however, the MLTC must have made and documented reasonable efforts to resolve the problems presented by the individual. Consistent with 42 CFR 438.56(b), the MLTC may not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs.

b) fails to pay the MLTC or make arrangements satisfactory to pay the spend down or NAMI.

c) knowingly fails to complete and submit any necessary consent or release.

d) provides the MLTC with false information, otherwise deceives the MLTC, or engages in fraudulent conduct with respect to any substantive aspect of his/her plan membership.

3. **Strategies to Prevent Enrollment Delays for Recipients with Medicaid Spend Down/**

a. In NYC, new applicants to Medicaid with spend-downs seeking MLTC services often face delays in enrollment due to antiquated "WMS" Medicaid computer systems, which in some instances requires additional processing at the DSS before enrollment in an MLTC plan. These delays generally occur in the two different ways:

i. New applicant with spend down is denied Medicaid. Consumer cannot access MLTC because plan sees Medicaid is inactive or nonexistent in the ePaces system. This means that the local DSS did not approve the consumer's Medicaid application with a spend down.

ii. New applicant properly "coded" with PROVISIONAL Medicaid, but MLTC plans refuse to assess consumer because the ePaces system states "NO COVERAGE-EXCESS INCOME."

b. For applicants in scenario C(1)(ii), i.e., properly coded with PROVISIONAL MEDICAID, the following actions to assure timely enrollment may be necessary:

i. New Medicaid Applicants after May 2014: Consumer's Medicaid case may be coded with provisional Medicaid and client may enroll in MLTC without an additional step by local DSS. *See* GIS 14 MA/010 available at http://www.health.ny.gov/health_care/medicaid/publications/gis/14ma010.htm.

ii. For new Medicaid applicants prior to May 2014 or those in receipt of Medicaid, but not community-based long-term care (CBLTC), enrollment in MLTC requires an extra step. The process in NYC is as follows:

a) Consumer must complete enrollment paperwork with the MLTC plan. The MLTC plan will submit this paperwork to Maximus-NY Medicaid Choice.

b) The MLTC plan must confirm eligibility by submitting a "conversion" to HRA. *See* HRA FAQ available at (ADD Link).

Practice Tips:

1. *Request DSS to use "Code 06" which approves Medicaid PROVISIONALLY with Medicaid application. See HRA Medicaid Alert at* http://www.wnylc.com/health/entry/114/#spend-down
2. *Advise consumer that she SHOULD NOT "Pay In" Spend-down!!*
3. *Advise consumer and plan that the conversion process may be necessary.*
4. *Complain to local DSS and DOH MLTC Complaint Line, 866-712-7197, if consumer encounters delay*

C. <u>Navigating Mainstream and Managed Long Term Care as Legal Advocates</u>

1. Requesting a New or Increased Level of Service from a Managed Long Term Care Plan or a Mainstream Managed Care Plan. *See* 42C.F.R. Part 438.

a. Procedures under Managed Long Term Care (*MLTC Model Contract*, Appendix K, Section (3), *MAP Model Contract*, Appendix F Section (1))

i. To access new or increased services provided in the MLTC benefit package, participants and advocates are best served when they use the following terms of art with their requests.

a) Prior Authorization–new service requested. A request by the member or provider on member's behalf for a new service (e.g., physical therapy) or a request to change a service as determined in the plan of care for a new authorization period (more home care hours).

b) Concurrent Review–increase in services already received. A request by a member or provider on member's behalf for additional services (i.e., more of the same) that are currently authorized in the plan of care; or Medicaid covered home health care services following an inpatient admission.

c) The prior authorization and/or concurrent review may be expedited if a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The member or provider may request expedited review and/or the plan may determine that expedited review is warranted.

ii. Timeframe for a decision from the MLTC plans (*MLTC Model Contract*, Appendix K, Section (3), *MAP Model Contract*, Appendix F Section (3))

a) Concurrent review

1) Expedited – within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of request for services.

2) Standard – within 1 business day of receipt of necessary information, but no more than 14 days of receipt of request for services.

3) In the case of a request for Medicaid covered home health care services following an inpatient admission – 1 business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, 72 hours after receipt of necessary information; but in any event, no more than 3 business days after receipt of the request for services.

b) Prior authorization

1) Expedited – 3 business days from request for service.

2) Standard – within 3 business days of receipt of necessary information, but no more than 14 days of receipt of request for services.

Practice Tips:

1. *Request Prior Authorization & Concurrent review simultaneously. Request an EXPEDITED prior authorization & concurrent review when the facts warrant. The request should be made orally and in writing via fax or email.*
2. *Best Practice: Submit a doctor's letter with the requests.*
3. *Be assertive and file grievances, appeals and Fair Hearings requests when deadlines are missed or requests are not processed: For example, the care manager may fail to pass the request on to the appropriate personnel, or give no notice of appeal rights. File internal appeals/Fair Hearings because a delay beyond these timeframes (without a valid extension) is a de facto denial and appeal rights are triggered. Advocates can also file grievances for delays in processing.*

b. Procedure Under Mainstream Managed Care (*MMC Model Contract*, Appendix F.1)

i. To access long term supports and services members or their providers must make a Service Authorization Request to the Managed Care Plan for the provision of a service. The MMC plans' policies and procedures must comply with 42 CFR Part 438; Article 49 of PHL; and 10 NYCRR Part 98.

a) Prior Authorization is a Service Authorization Request for coverage of a new service, whether for a new authorization period or within an existing authorization period, before such service is provided to the member.

b) Concurrent Review is a Service Authorization Request for continued, extended or more of an authorized service than what is currently authorized by the MMC plan OR for home health care services following and inpatient admission.

c) Expedited review must be conducted when a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The member or provider may request expedited review and/or the plan may determine that expedited review is warranted.

ii. Timeframe for Service Authorization Determinations

a) Prior Authorization:

1) Expedited – 3 business days after receipt of the request for review.

2) Standard – Within 3 business days of receipt of necessary information, but no more than 14 days after receipt of the request.

iii. Concurrent Review:

a) Expedited – 1 day after receipt of necessary paperwork but no more than 3 business days from receipt.

b) Home Health Care following an Inpatient Admission: 1 business day after receipt of necessary information; except when request falls on a weekend or holiday, then 72 hours after receipt of necessary information and no more than 3 business days after receipt of the request.

c) Standard – Within 1 business day of receipt of necessary information, but no more than 14 days after receipt of the request.

Practice Tips:

1. *Almost all Mainstream Managed Care plans in NYC require an M11q (available at http://www.wnylc.com/health/afile/176/30/) for prior authorization/concurrent review for home care cases.*
2. *Review the Plan's Member Handbook for contact information or other useful information regarding requests for long term supports and services benefits.*

2. MMC and MLTC Reversing Reductions or Terminations of Services

a. Eligibility for MLTC, PACE, and MAP is contingent on the need for more than120 days a year of community-based long-term home health services. These services support the needs of vulnerable Medicaid beneficiaries with chronic health conditions and provide the medically necessary care that allows them to remain in their own homes in the community. As long as the beneficiary needs

these home care services, the plans are required to cover them under their capitated rate. Because plans have a financial incentive to limit the amount paid for each beneficiary's care, it is not uncommon for plans to reduce long-term care services. Plans, however, cannot do so without complying with their obligations to conduct assessments, authorize medically necessary services, meet statutory and Constitutional due process requirements, and indicate the legal and factual basis for the proposed termination or reduction in the notices sent to enrollees, as outlined below.

b. Due process rights:

i. The 14th Amendment to the U.S. Constitution prohibits states from denying, reducing, or terminating Medicaid services without due process of law. The constitutional right includes the right to meaningful notice prior to the termination of Medicaid benefits, continued benefits pending a pre-termination hearing, and a fair and impartial pre-termination hearing. *Goldberg v. Kelly,* 397 U.S. 254 (1970).

ii. Federal Medicaid regulations explicitly implement the due process requirements set forth in *Goldberg*. 42 C.F.R. § 431.200-.250.

iii. Medicaid recipients are entitled to timely and adequate written notice when the Agency terminates, suspends, or reduces Medicaid eligibility or covered services. 42 U.S.C. § 1396a(a)(3); 42. C.F.R. §§ 431.206(c)(2), 431.210, 431.220(a)(2).

iv. "Timely notice" means notice issued at least 10 days prior to the proposed change. 18 N.Y.C.R.R. § 358-2.23.

v. The notice must contain: (a) a statement of what action the Agency intends to take; (b) the reasons for that action; (c) the specific regulations that support, or the change in Federal or State law that requires the action; (d) an explanation of – (1) the individual's right to request an evidentiary hearing, if one is available, or a State agency hearing; or (2) in cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) an explanation of the circumstances under which Medicaid is continued if a hearing is required. 42 C.F.R. § 431.210; *see also* 18 N.Y.C.R.R. § 358-3.1.

vi. Recipients are entitled to request a hearing when they believe that the agency has taken action erroneously. 42 C.F.R. § 431.220(a)(2); 18 N.Y.C.R.R. § 358-3.1(b).

vii. Because due process rights are interpreted to include the right to both timely and adequate notice as well as a *pre-termination* hearing, State law also requires continuation of benefits ("aid continuing") pending the issuance of the hearing decision, if the hearing is requested prior to the effective date of the termination, suspension, or reduction. 18 N.Y.C.R.R. § 358-3.6(a)(1)(i).

viii. Due process provisions apply equally to Medicaid Managed Care Organizations. 18 N.Y.C.R.R. § 360-10.8.

ix. Within the managed long-term care context, however, DOH has determined that enrollees in MLTC (including PACE and MAP) must "exhaust" appeal rights within the plan before the right to a State fair hearing arises. *See Managed Long-Term Care Partial Capitation Model Contract*, Appendix K; *Medicaid Advantage Plus Model Contract*, Section 24.2.

a) Note: DOH has recently indicated that it intends to remove the exhaustion requirement from MLTC so that appeal rights are identical throughout the Medicaid program. As of this writing, this change has not been made.

x. In the event of a denial or reduction of personal care services, the notice provided by the Managed Care Organization "must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or conditions have changed to warrant reduction or termination of previously approved services. "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care" ("Personal Care Guidelines") III(a), available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_personal_care_guidelines.pdf.

c. MLTC Plan Appeals

i. Appeals and Grievances are governed by Subpart F of 42 C.F.R. Part 438; New York Public Health Law § 4408-a and the utilization review and NY Pub. Health L. Article 49. The appeals process articulated in *Managed Long-Term Care Partial Capitation Model Contract*, Appendix K, seeks to combine the requirements of these federal and state sources.

ii. The appeals process articulated in *Managed Long-Term Care Partial Capitation Model Contract*, Appendix K, seeks to combine the requirements of these federal and state sources.

iii. An appeal is a request for review by the plan of an action it has taken, including determinations to reduce, suspend, or terminate long-term care services. *Managed Long-Term Care Partial Capitation Model Contract*, Appendix K (1)(B).

iv. The plan must issue a notice whenever it makes an adverse determination regarding an enrollee's coverage. Because MLTC is a Medicaid program, these notices must meet the timeliness and adequateness requirements set out in 18 N.Y.C.R.R. § 358.

v. Members have a right to request an expedited appeal if the delay of a standard appeal would "seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request." *Managed Long-Term Care Partial Capitation Model Contract,* Appendix K (1)(B).

vi. An appeal must be requested within 45 days of the date of the notice, or within 10 days and prior to the date of the proposed action, if aid continuing is requested. *Id.*

vii. The plan must send written acknowledgment of the appeal request within 15 days. *Id.*

viii. The plan must decide the appeal

a) Within 30 days for standard appeals, or

b) Within 2 days for expedited appeals.

d. Fair Hearings

i. In MLTC, the right to a fair hearing arises after the plan issues final determination on the requested appeal.

a) Note: DOH has recently indicated that it intends to remove the exhaustion requirement from MLTC so that appeal rights are identical throughout the Medicaid program. As of this writing, this change has not been made.

ii. A fair hearing is an adversarial, administrative hearing before an Administrative Law Judge (ALJ) to challenge determinations made by the Local DSS, managed care plans, or DOH.

a) While MLTC plans are clearly subject to state laws and regulations, internal appeals tend to follow the plan's own documented requirements, which do not always clearly comply with state law. (In other words, plans tend to follow only their own policy documents without extending the inquiry to DOH guidance or NY State laws and regulations.)

iii. Timeframes:

a) 60 days from date of action to request a fair hearing.

b) For aid continuing, hearing must be requested within 10 days, of the notice and prior to the proposed date of the action. 18 N.Y.C.R.R. § 358-3.6(a)(1)(i).

e. MLTC reductions in Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS)

i. PCS regulations: 18 N.Y.C.R.R. § 505.14.

a) DOH has issued specific guidance to managed care plans (both MMC and MLTC) interpreting the regulatory requirements: "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care" ("Personal Care Guidelines"), available

at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_personal_care_guidelines.pdf.

ii. CDPAS regulations: 18 N.Y.C.R.R. § 505.28.

a) Except where otherwise contradicted, community-based home care services provided through CDPAS are also subject to PCS regulations.

b) DOH has issued specific guidance to managed care plans (both MMC and MLTC) interpreting the regulatory requirements: "Guidelines for the Consumer Directed Personal Assistance Services" ("CDPAS Guidelines"), available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/cdpas_guidelines_final.pdf.

iii. Requirements for assessing and authorizing community-based long-term care services are set out in the regulations, Model Contracts, and the "Personal Care Guidelines" and/or the "CDPAS Guidelines." Challenged determinations that do not comply with these requirements may be reversed at the fair hearing by the ALJ.

iv. Both PCS and CDPAS are subject to prior authorization. Under the regulations, an assessment is required for receipt of Personal Care Services through the Consumer Directed Personal Assistance Program in Medicaid. 18 N.Y.C.R.R. §§ 505.14 (b) and 505.28 (d).

a) Approved services are subject to authorization periods not to exceed six months. 18 N.Y.C.R.R. § 505.28(e)(4).

b) Prior to the end of the authorization period, the beneficiary's continued eligibility for CDPAS and personal care services must be reassessed. 18 N.Y.C.R.R. § 505.28 (f)(1).

c) Both the authorization and reauthorizations of CDPAS services consist of three components: (1) a physician's order; (2) a nursing assessment; and (3) a social assessment. 18 N.Y.C.R.R. §§ 505.14(b)(2), 505.28(d) and (f)(1).

d) Upon receipt of a completed physician's order, social services district professional staff must conduct a social assessment. 18 N.Y.C.R.R. § 505.28(d)(2). The social assessment must include an evaluation of the potential contribution of informal supports, such as family members or friends, to the individual's care. 18 N.Y.C.R.R. § 505.14(b)(3)(ii); 18 N.Y.C.R.R. § 505.28(2)(iii).

1) Because the regulations are written to apply to local districts, as opposed to managed care plans, and because the Guidelines for both PCS and CDPAS are silent on the issue of how the social assessment is to be conducted, there is some disagreement about whether or not a person other than the nurse conducting the nursing assessment must

conduct the social assessment. For purposes of simplicity, plans generally maintain that assessments may be conducted by only one person who conducts both the nursing and social assessments. However, certain protections are connected to the requirement that these portions of the assessment be conducted by different people with different qualifications – e.g., the Local Professional Director (LPD) must be consulted where a discrepancy exists between the nursing and social assessments. 18 N.Y.C.R.R. § 505.28(d)(5); 18 N.Y.C.R.R. § 505.14(4)(i).

e) The nursing assessment must be completed by a registered professional nurse and must include: (a) a review and interpretation of the physician's order; (b) the primary diagnosis code from the ICD-9-CM; (c) an evaluation of whether the individual's medical condition would require frequent nursing evaluation or judgment; (d) an evaluation of the personal care services, home health aide services and skilled nursing tasks that the individual requires and whether the individual requires some assistance or total assistance with such services or tasks; (e) an evaluation, made in conjunction with the social assessment and physician's order, whether the individual is self-directing; (f) an evaluation whether the individual's need for assistance can be met totally or in part by specialized medical equipment; [….]; and (h) development of a plan of care in collaboration with the individual; and recommendations for authorization of services. 18 N.Y.C.R.R. § 505.28(d)(3).

f) If there is a disagreement among the physician's order, nursing and social assessments, or a question regarding the level, amount or duration of services to be authorized, or if the case involves continuous consumer directed personal assistance, an independent medical review of the case must be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the social services district. The local professional director or designee must review the physician's order and the nursing and social assessments and is responsible for the final determination regarding the level and amount of services to be authorized. The local professional director or designee may consult with the consumer's treating physician and may conduct an additional assessment of the consumer in the home. 18 N.Y.C.R.R. § 505.28(d)(5); 18 N.Y.C.R.R. § 505.14(4)(i).

1) It is expected that the local professional director would consult with the consumer's physician if there are discrepancies with the assessments presented for review. 12 OHIP/ADM-1 at 3.

g) In the event of a denial or reduction of personal care services or CDPAS, the notice provided by the Managed Care Organization "must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or conditions have changed to warrant reduction or termination of previously approved services." Personal Care Guidelines (III)(a).

f. On July 15, 2014, NYLAG filed a statewide class action, Taylor v. Zucker, U.S.D.C., S.D.N.Y, 14 CV 5317, challenging MLTC and MMC failure to follow basic due process notice and aid continuing laws for home care recipients. The lawsuit challenges lack of adequate notice when plans: REDUCE hours of home care services; STOP services altogether; or DENY a request for an increase in services. Please contact btaylor@nylag.org and vbogart@nylag.org if you have cases in which home care hours have been reduced with inadequate or defective notices.

3. Particular concerns for high needs patients in receipt of personal care or other LTSS through Mainstream Managed Care or Managed Long Term Care Plans.

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

b. MLTC and MMC may not deny, reduce, or terminate services without justification.

i. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

a) The client's medical, mental, economic or social circumstances have changed and the MCO determines that 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;

1) This is a two-prong test and requires the plan to document either a change in social circumstances or clinical improvement of the patient's health as well as a finding that the prior level of services is no longer appropriate or can be provided in fewer hours;

b) A mistake occurred in the previous personal care services authorization;

1) The plan must document this mistake and support it in the record;

c) The member refused to cooperate with the required assessment of services;

d) A technological development renders certain services unnecessary or less time consuming;

e) The member can be more appropriately and cost-effectively served through other Medicaid programs and services;

f) The member's medical condition is not stable;

g) The member is not self-directing and has no one to assume those responsibilities;

h) The services the member needs exceed the personal care aide's scope of practice.

1) 18 N.Y.C.R.R. § 505.14(b)(5)(v)(*c*); *see also* Personal Care Guidelines (III)(e)(iii).

2) If the plan fails to document any of these reasons, either in the notice or at the hearing itself, the proposed reduction or termination of previously authorized services cannot be sustained.

c. Legal criteria for split-shift and sleep-in care remains the same

i. "Continuous personal care services means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted." 18 N.Y.C.R.R.§ 505.14(a)(3).

ii. "Live-in 24-hour personal care services" means "the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted." 18 N.Y.C.R.R. § 505.14(a)(5). *See also* 18 N.Y.C.R.R. § 505.28(b)(8).

iii. "The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the

applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24-hour personal care, including continuous (split-shift or multi-shift) care, 24-hour sleep-in care or the equivalent provided by formal or informal caregivers." 18 N.Y.C.R.R. § 505.14(b)(5)(v)(d).

iv. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following (GIS 12 MA-026):

a) The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;

b) The specific task or tasks with which the person requires frequent assistance during the night;

c) The frequency at which the person requires assistance with these tasks during the night;

d) Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;

e) The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;

1) "The contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever." 12 OHIP/ADM-1 at 6.

2) The contribution of informal supports to the performance of care is secondary to the identification of the number of hours of care required; thus, the assessments must first identify how much care is required during the week, and only then reduce it by the number of hours an informal support has voluntarily committed to provide care.

3) *See* 18 N.Y.C.R.R. § 505.14(b)(5)(v)(d) ("The determination of the need for such 24-hour personal care, including continuous (split-shift or multi-shift) care, shall be made without regard to the availability of formal or informal caregivers to assist in the provision of such care").

v. The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and

vi. Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

a) GIS 12 MA-026

d. MMC and MLTC recipients are entitled to reinstatement of personal care services at the time of hospital or rehab discharge. Medicaid recipients who received personal care services immediately prior to entering a hospital are entitled to timely notice and the right to request aid continuing when plan proposes to reduce or discontinue their personal care services upon discharge. *See Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996); GIS 96 MA-023.

Practice Tips:

1. *Refer to Concurrent Review sections of the Model MLTC and MMC contracts. Plans must respond to these requests no later than 3 business days of receipt. A formal request by legal services provider will often result in efficient reinstatement of hours at discharge.*
2. *Medicaid recipient is entitled to prior plan of care with physician approval. A request for an increase in hours may be denied and recipient will have to appeal and demonstrate that she meets medical criteria for an increase in services.*

D. Fully Integrated Duals Eligible (FIDA) Demonstration Plan Overview

1. **The Medicare-Medicaid Coordination Office** of CMS was established pursuant to Section 2602 of the Affordable Care Act. The aim of this office is to ensure Medicare-Medicaid enrollees have full access to seamless, high quality health care and to make the system as cost-effective as possible. One initiative is to address the issue of financial misalignment between the Medicare and Medicaid program. Pursuant to 42 U.S.C. 1315(a) the Center for Medicare and Medicaid Innovation at CMS may assess new delivery models for dual eligibles by permitting states "to test and evaluate fully integrating care for dual eligible in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals." 42 U.S.C §1315(a)(b)(2)(B)(x).

a. New York State entered into a Memorandum of Understanding with CMS to implement a dual demonstration, called FIDA, on August 26, 2013. MEMORANDUM OF UNDERSTANDING BETWEEN CTR. MEDICARE AND MEDICAID SYS. & NEW YORK STATE DEP'T OF HEALTH, *REGARDING A FEDERAL-STATE PARTNERSHIP TO TEST A CAPITATED FINANCIAL ALIGNMENT MODEL FOR MEDICARE-MEDICAID ENROLLEES* (August 26, 2013) [hereinafter MOU] available at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm.

b. FIDA Enrollment Timeline:

i. Individuals in Bronx, Kings, Nassau, New York, Queens, and Richmond counties will be able to join the FIDA Demonstration on January 1, 2015. Passive enrollment will be phased in beginning April 1, 2015, until all eligible individuals who do not opt out are enrolled.

ii. Individuals in Suffolk and Westchester will be able to join the FIDA Demonstration no earlier than April 1, 2015. Passive enrollment will begin no earlier than July 1, 2015, until all eligible individuals who do not opt out are enrolled.

2. **Eligible Populations for FIDA** (*MOU* at Section III(C)(1)). The FIDA Demonstration will be available to individuals who meet all of the following criteria:
   a. Age 21 or older at the time of enrollment;
   b. Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
   c. Reside in a FIDA Demonstration county: NYC, Nassau, Suffolk and Westchester ONLY; and
   d. Individuals must also meet **one** of the three following criteria:
      i. Require community-based long term care for more than 120 days;
      ii. Are Nursing Facility Clinically Eligible and receiving facility-based long-term services and supports (LTSS)-contingent upon submission and approval of an amendment to the existing Partnership Plan demonstration under Social Security Act Section 1115(a);
      iii. Are eligible for the Nursing Home Transition & Diversion (NHTD) 1915(c) waiver contingent upon submission and approval of an amendment to the existing Partnership Plan demonstration under Social Security Act Section 1115(a) and an amendment to the NHTD Section 1915(c) waiver.
3. **Ineligible Populations** (*MOU* at Section III(C)(1)).
   a. Residents of a New York State Office of Mental Health (OMH) facility;
   b. Those receiving services from the New York State Office for People with Developmental Disabilities (OPWDD) system;
   c. Individuals under the age of 21;
   d. Residents of psychiatric facilities;
   e. Individuals expected to be Medicaid eligible for less than six months;
   f. Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services;
   g. Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services);
   h. Individuals receiving hospice services (at time of enrollment);
   i. Individuals eligible for the family planning expansion program;
   j. Individuals under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage;
   k. Residents of alcohol/substance abuse long-term residential treatment programs;
   l. Individuals eligible for Emergency Medicaid;

m. Individuals in the following section 1915(c) waiver program: Traumatic Brain Injury (TBI);

n. Residents of Assisted Living Programs; and

o. Individuals in the Foster Family Care Demonstration.

4. **Costs and Covered Benefits** (*MOU* at Section III(D); Appendix 7, Section V)

a. NO copayments allowed, including Part D drugs. Spend down or NAMI will continue to be billed by the FIDA plan.

b. Covered Services:

i. Medicare Part A, B, & D, and

ii. Medicaid State Plan including LTSS.

c. Services not covered by FIDA – must be accessed through Medicare or Medicaid Fee-For-Services:

i. Medicare and Medicaid Hospice services;

ii. Out of Network Family Planning services;

iii. Directly Observed Therapy for Tuberculosis; and

iv. Methadone Maintenance Treatment.

5. **Enrollment & Disenrollment** (*MOU*, Appendix 7, Section III)

a. Enrollment and disenrollment transactions will be processed through NY Medicaid Choice/Maximus. NYSDOH (or Maximus) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions.

b. Enrollment and Disenrollment will be effective the first of the following month so long as enrollment paperwork and follow up was completed before the 20th of the previous month.

c. Passive Enrollment

i. Eligible Populations (i.e., MLTC members in demonstration counties and later duals in Nursing homes) will be notified that they MAY enroll in a FIDA plan.

ii. They will be notified of this choice via multiple enrollment letters (Announcement letter; 90 day letter; 60 day letter and 30 day letter). The individual has three choices:

a) Opt Out of Demonstration by affirmatively responding to notice or calling NY Medicaid Choice/Maximus and continue to receive Medicaid-Medicare services without change;

b) Choose a FIDA Plan; or

c) DO nothing and client will be automatically assigned to a FIDA plan.

iii. The State will develop an "intelligent assignment" algorithm for passive enrollment (e.g., that prioritizes continuity of providers and/or services). The algorithm will consider Participants' previous Medicaid

Warning: *The FIDA plan may not contract with all of the client's Medicare providers – physicians, hospitals, specialists, etc.*

managed care enrollment and historic provider utilization.

d. Populations EXCLUDED from passive enrollment but who may voluntarily enroll in FIDA. (*MOU* at Section III(C)(1)).

i. Native Americans;

ii. Individuals who are eligible for the Medicaid Buy-In for the Working People with Disabilities and are nursing home certifiable;

iii. *Aliessa* Court Ordered Individuals;

iv. Individuals enrolled in PACE;

v. Individuals enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals;

vi. Individuals enrolled in Health Homes;

vii. Individuals assigned to a CMS Accountable Care Organization (ACO) as of the point in time they would otherwise be included in the passive enrollment phase;

viii. Individuals participating in the CMS Independence at Home demonstration; and

ix. Individuals enrolled in Employer or Union Sponsored coverage for employees or retirees.

> ***Warning:*** *If a consumer with Employer/Union sponsored coverage enrolls in FIDA, consumer and his/her dependents could permanently lose Employer/Union coverage.*

x. NYS DOH has also indicated the NHTD waiver participants will not be passively enrolled into a FIDA plan.

e. Ongoing Right to Opt Out of Demonstration (*MOU* at Section III(C)(2)).

i. Clients have the right to opt-out of FIDA and continue to receive Medicare and Medicaid services without change. During passive enrollment period, consumer must take an affirmative step to opt out of FIDA and stay in MLTC by responding to one of the above notices or calling Maximus/NY Medicaid Choice.

ii. Once enrolled client has the right to request prospective disenrollment from the Demonstration or switch FIDA plans. Disenrollment from FIDA Plans and transfers between FIDA Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month.

6. **Continuity of Care** (*MOU* at Section III(E); *see also* Appendix 7, Section V(f))

a. FIDA Plans must allow Participants to maintain current providers and service levels, including prescription drugs, at the time of enrollment for at least 90 days

after enrollment, or until a care assessment has been completed by the FIDA Plan, whichever is later.

b. For nursing facility services, FIDA Plans must allow Participants to maintain current providers for the duration of the Demonstration.

c. In addition, during the 90-day transition FIDA Plans will advise Participants and providers if and when they have received care that would not otherwise be covered at an in-network level.

7. **FIDA Integrated Appeals** (*MOU* at Section III(F); *see also* Appendix 7, Section IX)

a. Expanded Aid Continuing for Medicaid & Medicare Services. So long as the original appeal is requested to the FIDA plan within 10 calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later, participants are entitled to aid continuing for all prior-approved *Medicare* and Medicaid benefits that are terminated or modified, pending internal FIDA Plan appeals, Integrated Administrative Hearings, and Medicare Appeals Council.

b. Integrated Notice. FIDA Plan Participants will be notified of applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question.

c. Four Level Integrated Appeal Process:

i. Level One: Internal Appeal with FIDA Plan

a) For Aid Continuing: Appeal with aid continuing must be requested within 10 calendar days of the notice's postmark date or by the intended effective date of the Action, whichever is later.

b) No Aid Continuing: Appeal must be requested within 60 calendar days related to a denial or reduction or termination of authorized Medicare or Medicaid benefit coverage.

c) The FIDA plan must decide the appeal "as fast as the Participant's condition requires" but no later than within 72 hours for an EXPEDITED APPEAL and no later than 30 calendar days from the date of the receipt of the appeal for a STANDARD APPEAL. The FIDA Plan or Participant may seek an extension.

d) The Plan must provide oral and written notice of its decision.

ii. Level Two: Automatic Administrative Hearing

a) Any adverse decision by the FIDA Plan is automatically forwarded to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA).

b) FIDA Plan will provide Notice of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of recieving the record.

c) OTDA will provide the Participant with a Notice of Administrative hearing at least 10 calendar days in advance of the hearing date.

d) The Hearing Officer must issue a written decision that explains in plain language the rationale for the decision and specifies the next steps in the appeals process.

1) For STANDARD appeals the decision must be issued within 90 calendar days of the request for the first year of the Demonstration and 30 calendar days of the request for the 2nd and 3rd year. Note: Medicaid prescription drug coverage matters must be decided within 7 calendar days of receipt.

2) For EXPEDITED appeals the Participant must be notified of the decision within 72 hours of the forwarding of the FIDA Plan's appeal decision.

iii. Level Three: Medicare Appeals Council. If a Participant disagrees with the Hearing Officer's decision, the Participant may appeal to the Medicare Appeals Council.

a) The Administrative Hearing Decision may be appealed within 60 calendar days.

b) The appeal must be filed with FIDA Administrative Hearing Unit, which will forward the request for appeal and administrative record to the Medicare Appeals Council.

c) The Medicare Appeals Council will complete a paper review and will issue a decision within 90 days.

iv. Level Four: Federal District Court. An adverse Medicare Appeals Council decision may be appealed to the Federal District Court.

8. **FIDA Grievance Procedure** (*MOU* at Section III(F); *see also* Appendix 7, Section VIII)

a. A grievance is an expression of dissatisfaction about any matter that is not an action to deny, terminate, or reduce a benefit or service. 42 CFR Part 438.400.

b. Participants are entitled to file internal grievances directly with the FIDA Plan orally or in writing. Grievances must be filed within 60 days calendar days of the incident or whenever there is dissatisfaction (in the event there is not one specific incident). Appendix 7, Section VIII(1)

c. The FIDA Plan must send written acknowledgment of the grievance within 15 business days of receipt unless a decision is reached before that time.

d. For an EXPEDITED grievance the FIDA Plan must respond in no more than 7 days and in some circumstances within 24 or 48 hours. For a STANDARD grievance the FIDA plan must provide notification of the decision within 30 calendar days of the FIDA plan receiving the written or oral grievance. The

FIDA Plan must provide written notice for the decision within 3 business days of the decision (expedited and standard).

9. **Ombudsman Program** (*MOU,* Appendix 1; *see also* DOH: *Fully Integrated Duals Advantage (FIDA) Demonstration Frequently Asked Questions (FAQ),* September 2013 available at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm)

a. FIDA Participant Ombudsman will be an independent entity under contract with the DOH to help Participants and their caregivers access the care Participants need through the FIDA Demonstration.

b. An independent conflict-free entity under contract with NYSDOH to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their FIDA Plan. The Participant Ombudsman will be accessible by phone and, where appropriate, in-person. The Participant Ombudsman will provide advice, information, referral and assistance in accessing benefits and assistance in navigating FIDA Plans.

c. The Ombudsman Program will assist all Medicaid beneficiaries in receipt of community based long term care services, not only those enrolled in FIDA.

E. Staying Informed: Government and Advocate Resources

1. **Government Resources**

a. State Department of Health
at http://www.health.ny.gov/health_care/medicaid/redesign/

2. **Advocate Resources**

a. New York Health Access at http://wnylc.com/health/
This site is the product of the work of a group of legal services attorneys and paralegals who work in the field of health and public benefits law in New York State. The organizations who author and maintain this site are Empire Justice Center, The Legal Aid Society and New York Legal Assistance Group. The site contains regularly updated materials on a diverse set of issues related to Medicaid and other public health insurance.

b. Medicaid Matters New York at http://www.medicaidmattersny.org/
Medicaid Matters New York (MMNY) is a statewide, consumer-oriented coalition that advocates on behalf of New York's Medicaid program and the people it serves. MMNY is made up of over 140 organizations united in their determination to ensure that the concerns and needs of Medicaid consumers are understood, included and met in any discussion on the state's public health insurance programs – Medicaid, Child Health Plus, and Family Health Plus.

III. THE IMPACT OF MEDICAID REDESIGN ON PERSONS WITH MENTAL HEALTH DISABILITIES

A. Medicaid Redesign[1]

1. Governor Andrew M. Cuomo, upon taking office, sought to radically restructure New York State's Medicaid program. The two main reasons given were Medicaid's high programmatic cost and poor quality of care results. New York spends more than twice the national average on Medicaid per capita, but ranked 21st out of all states in overall health system quality and last among all states for avoidable hospital use and costs. Spending on the Medicaid program had risen from $46 billion in April 2007 to approximately $53 billion in 2011.[2] With Executive Order No. 5, Governor Cuomo convened the Medicaid Redesign Team ("MRT"). The Governor tasked the MRT with the responsibility of reforming the Medicaid healthcare system, specifically lowering the cost of Medicaid while improving the quality of healthcare delivery and its outcomes. The MRT came up with 79 reform recommendations. Of those, 73 were passed into law in 2011.

   a. Medicaid Redesign's Focus on People with Mental Disabilities[3]

      i. People with mental health disabilities rank high among those Medicaid recipients who are high-cost or high-need users of health care services.

      ii. In 2011, at the time of MRT implementation, approximately 40% of Medicaid recipients diagnosed with multiple "chronic" conditions were also diagnosed with mental illness or substance use disorder.[4] New York State's Department of Health ("DOH") estimated over $1billion was spent on avoidable hospital readmissions. The majority of those hospitalized included individuals with mental health or substance use conditions along with other serious medical conditions.

      iii. These individuals similar to "dual eligibles" (recipients of both Medicaid and Medicare) are the primary targets of Medicaid Redesign. Several of the early MRT changes previously discussed had an immediate impact upon this group of individuals.[5] For example, mental health consumers were previously exempted from having to join managed care plans if they were Supplemental Security Income ("SSI") recipients or had severe and persistent mental illness ("SPMI"). Additionally, the drastic reduction in time from 90 days to 30 days to evaluate and select a managed care plan or be subject to auto-assignment, had a tremendous

[1] N.Y. Exec. Order No. 5 (Jan. 5, 2011), http://www.governor.ny.gov/executiveorder/5; *see also* Medicaid Redesign Team website, http://www.health.ny.gov/health_care/medicaid/redesign/.
[2] N.Y. Dep't of Health, "A Plan to Transform the Empire State's Medicaid Program: Better Care, Better Health, Lower Costs, https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf.
[3] *See* N.Y. Dep't of Health, "MRT Behavioral Health Reform Work Group Final Recommendations," (Oct. 15, 2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf.
[4] *See* Greg Allen, M.S.W., N.Y. Dep't of Health, "New York State Care Management for High Need Patients – Transforming Care through Health Homes" presented at NYAPRS' 30th Annual Conference (Sept. 2012), http://www.nyaprs.org/conferences/annual-conference/documents/NYAPRSgallen.pdf.
[5] *See* N.Y. Dep't of Health, Section 1115 Waiver Amendment Request (Apr. 13, 2011) and CMS Section 1115 Waiver Amendment Approval, http://www.health.state.ny.us/health_care/managed_care/appextension/#mrt_waiver_materials.

impact on this group of Medicaid recipients, particularly those diagnosed with SPMI.

B. Health Homes (First Wave)[6]

1. Overview

a. Under the Affordable Care Act ("ACA"), states were given the option of creating a new form of health care delivery whereby all health care services – physical, behavioral, long-term care and social work support – for Medicaid recipients with chronic conditions would be coordinated. The concept envisaged treatment of the "whole person" as opposed to uncoordinated care from different sources that may not communicate with one another regarding the best treatment options. Beneficiaries would have a "health home" and the providers of these health homes would integrate and coordinate all care including but not limited to primary, acute, behavioral and long-term health care services. The twin goals of health homes are improved health outcomes and significant lowering of Medicaid costs.

b. Federal approval by CMS was required before the health home program could take effect. States had to make necessary amendments to their respective State Medicaid Plans. In turn, any state approved by CMS to implement health homes would receive a 90% federal match for health home services for the first eight (8) fiscal quarters that a health home state plan amendment ("SPA") is in effect.

c. New York State responded to this opportunity and focused on individuals with mental health or substance use disorders and other chronic conditions as the first wave of health home enrollees.[7] The MRT acted and included health homes as one of its 73 recommendations passed into law.

d. In its proposal, the MRT cited data from the State showing that 16% of the total Medicaid population had two or more chronic illnesses, one of which is often mental illness, and that the cost of care for these beneficiaries ranged from $2300 – $3900 per month compared to an average of $890 per month cost across the total Medicaid population. The data also identified this group as driving 50% of all Medicaid costs, most attributable to hospital inpatient stays.[8]

e. On February 3, 2012, CMS approved phase 1 of the health home rollout with an effective date of January 1, 2012.[9] On December 4, 2012, CMS approved two

[6] *See* N.Y. Soc. Servs. L. § 365-l; *see also* Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, §2703(b), 124 Stat. 119, 318-319 (2010); 42 U.S.C. § 1396w-4.

[7] Subsequent waves of health home rollouts will target long-term care recipients and beneficiaries with developmental disabilities, respectively. *See* N.Y.S. Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions ("SPA") – SPA #11-56, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf.

[8] *See* MRT "Proposal to Redesign Medicaid: Proposal Number 89, MRT Number 57," (Jan. 2011), https://www.health.ny.gov/health_care/medicaid/redesign/docs/descriptions_of_recommendations.pdf.

[9] *See* SPA #11-56, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf.

additional state plan amendments for phase 2 and phase 3 with effective dates of April 1, 2012 and July 1, 2012, respectively.[10] The combined approval of all aforementioned SPAs allowed for statewide implementation of the Health Home Program.

f. DOH's Office of Health Insurance Programs ("OHIP") in conjunction with DOH's Office of Health Information Technology Transformation ("OHITT"), the AIDS Institute, the New York State Office of Mental Health ("OMH"), the New York State Office of Alcohol and Substance Abuse Services ("OASAS"), the New York City Department of Health and Mental Hygiene ("DOHMH") and a provider advisory group developed the design of the health home initiative.

2. **What is a Health Home?**

a. A Health Home is not a physical, bricks-and-mortar building, but rather a network of care providers with a central point where a participant's individual caregivers communicate with one another so that all of the patient's needs are addressed in a comprehensive manner. The network of partners includes but is not limited to:

i. One or more hospital systems;

ii. Multiple ambulatory care sites (physical and behavioral health) including clinical group practices, rural health clinics, community health centers;

iii. Home care agencies;

iv. Community-based organizations, including existing case management and housing providers; and

v. Managed care plans.

b. One of these entities is identified as the lead health home provider or the central point. That lead health home provider can directly provide or subcontract for the provision of all health home services. It must assign a "care manager" or "care coordinator" to the Medicaid recipient. He or she oversees and provides access to all of the services the individual requires to ensure healthy outcomes, specifically avoidable emergency and hospital admissions and readmissions, skilled nursing facility admissions and emergency room visits. The lead health home ensures that the beneficiaries' health care needs are understood and met. The lead health home also bears the ultimate responsibility for guaranteeing positive health outcomes. All health records are shared among the network of providers and all health services are provided by the same. These partners are the collective "health home." A Medicaid recipient's participation in a health home is voluntary not mandatory.

3. **Who Is Eligible for a Health Home?**

[10] *See* SPA #12-10, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/12-10_spa_approval_plan_pgs.pdf; SPA #12-11, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-12-11_spa_approval_plan_pgs.pdf.

a. A Medicaid recipient with:
    i. Two or more chronic conditions;
    ii. One chronic health condition and is at risk of having a second; or
    iii. One serious and persistent mental health condition
b. Examples of "chronic conditions" include but are not limited to:
    i. A mental health condition,
    ii. Substance use disorder,
    iii. Heart Disease,
    iv. Respiratory Disease,
    v. Diabetes,
    vi. HIV / AIDS, or
    vii. Body Mass Index ("BMI") over 25.

4. **Health Home Services**
    a. Health Homes are required to provide:
        i. Comprehensive care management;
        ii. Care coordination;
        iii. Health promotion;
        iv. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
        v. Patient and family support
        vi. Referral to community and social support services, if relevant (*i.e.*, housing, legal, food); and
        vii. Use of health information technology to link services.

5. **Health Home Provider Qualifications, Geographic Rollout and Program Implementation**
    a. Qualifications
        i. The State implemented an application process and review to designate the lead health home providers. Standards consistent with federal and state laws set forth the following general qualifications for all applicants:
            a) Providers / plans must be enrolled or eligible for enrollment in NYS Medicaid program and agree to comply with all Medicaid requirements;
            b) Health home providers can either directly provide or subcontract for the provision of all health home services;
            c) Health home providers remain responsible for all health home program requirements, including services performed by subcontractors;
            d) Provision of care coordination and integration of health care services for health home participants under the direction of a dedicated care manager;

e) Care manager must assure access to medical and behavioral health care and community social supports;

f) Hospitals included within the health home network must have procedures in place to refer any eligible individual with chronic conditions who seek or need treatment in the ER; and

g) Provider must furnish written documentation clearly demonstrating how requirements are being met.

b. Health Home Geographic Rollout[11]

i. Phase 1 rollout (effective January 1, 2012):

a) Bronx, Kings, Clinton, Essex, Franklin, Hamilton, Nassau, Schenectady, Warren and Washington.

ii. Phase 2 rollout (effective April 1, 2012):

a) New York, Queens, Richmond, Dutchess, Erie, Monroe, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester.

iii. Phase 3 rollout (effective July 1, 2012):

a) Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates.

c. Program Implementation

i. Lead health home providers received lists of eligible Medicaid fee-for-services recipients from DOH. DOH identified and assigned these individuals using a combination of clinic risk groups[12] and an "intelligent assignment" which considered factors like existing relationships with care management, inpatient providers, ambulatory and emergency care usage.

ii. Managed care plans contracted with lead health home providers as part of their network of providers and assigned their health home eligible members into health homes. DOH provided managed care plans with a list of eligible members and other information based on its "intelligent assignment" algorithm.

[11] The list of New York State Counties with their Designated Lead Health Homes, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/list_by_county.htm#new_york.

[12] This is an assessment tool utilized by DOH to develop a risk-factor score that corresponds with prospective enrollees' health home service need level. Chronic behavioral and medical conditions are the primary focus. Additionally, items such as recent homelessness or incarceration, adherence concerns, untreated mental health /substance use concerns and concurrent medical conditions are considered. Additional psycho-social and cultural factors that present barriers to care acquisition and/or retention in care are also of interest.

iii. Existing community-based case management providers like OMH's Targeted Case Management programs continued to provide services to their clients while also converting to or assigning members to appropriate lead health homes.

iv. Letters of enrollment and assignment issued from either the lead health homes for fee-for-service recipients or the managed care plans.

v. All participants in health homes were required to sign the consent forms which allow for the member's health information to be shared within the network of health home partners – an essential component to the health home concept. However, lack of the signed consent form does not preclude the care manager from actively working with the Medicaid recipient.

6. **Health Home Update – Two Years of Implementation**

a. By January 2014, the State approved 32 lead health home providers and established 48 health homes in 57 counties.[13] As of early 2014, New York State has enrolled approximately 183,000 Medicaid recipients into health homes.[14]

b. Not included in these numbers are those individuals who have been engaged and are in the process of enrolling in a health home. They include:

i. Beneficiaries identified for outreach efforts;

ii. Medicaid recipients already engaged by outreach; and

iii. Participants enrolled in existing case management programs, i.e., OMH's Targeted Case Management Program who are in the process of converting.

c. Policy Objectives Achieved[15]

i. Many states including New York said the flexibility inherent within the health home model allowed them to address gaps in care for Medicaid recipients with complex health needs during a time of fiscal difficulty. The policy objectives health homes enabled New York to tackle include:

a) Aligning and integrating a number of existing and varied care management models;

b) Focusing on high-need, high-cost beneficiaries;

c) Transforming previously separate programs into integrated networks of service providers with one point of accountability; and

[13] *See* Center for Health Care Strategies, Inc., "Seizing the Opportunity: Early Medicaid Health Home Lessons," (March 2014), http://www.chcs.org/media/Seizing_the_Opportunity-_Early_Medicaid_Health_Home_Lessons.pdf.

[14] *See* N.Y. Dep't of Health, "Health Home / Managed Care Work Group Update," (May 16, 2014), https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2014-05-16_presentation.pdf; *see also* CMS Health Home Information Resource, Fact Sheet – July 2014, http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Medicaid-Health-Homes-Overview.pdf.

[15] *See* Center for Health Care Strategies, Inc., "Seizing the Opportunity: Early Medicaid Health Home Lessons," (March 2014), http://www.chcs.org/media/Seizing_the_Opportunity-_Early_Medicaid_Health_Home_Lessons.pdf.

d) Mandating health networks broaden to address beneficiaries' other pressing needs like housing or employment.

ii. Snapshot of Lead Health Homes – New York City

a) Bronx County:
   1) Bronx Lebanon Hospital Center
   2) Bronx Accountable Healthcare Network Health Home
   3) Community Care Management Partners
   4) Community Health Care Network
   5) New York City Health and Hospitals Corporation

b) Kings County:
   1) Community Health Care Network
   2) Pathways to Wellness
   3) New York City Health and Hospitals Corporation
   4) Brooklyn Health Home

c) New York County:
   1) Community Care Management Partners
   2) Mount Sinai Health Home
   3) Heritage Health and Housing Home Network
   4) Pathways to Wellness
   5) New York City Health and Hospitals Corporation
   6) The New York and Presbyterian Hospital

d) Queens County:
   1) North Shore LIJ Health Home
   2) Queens Coordinated Care Partners
   3) New York City Health and Hospitals Corporation

e) Richmond County:
   1) Pathways to Wellness

f) The network of partners identified by the above lead health homes are many and varied. For example, The New York and Presbyterian Hospital Health Home includes community-based mental health, medical and substance use counseling clinics, home care agencies, adult day care centers, supportive and supported housing providers, child care counseling programs and programs specializing in persons with HIV / AIDS. The New York and Presbyterian Hospital Health Home network partners include:
   1) Puerto Rican Family Institute Mental Health Clinic,
   2) Village Care Health Center,
   3) FEGs,
   4) Brooklyn AIDS Taskforce,
   5) ACMH Care Management Services (case management program for persons with mental illness),
   6) Exponents Outpatient Drug Abuse Clinic,

7) Narco Freedom / Methadone Maintenance Treatment Program,
8) Project Renewal (supportive housing program),
9) Jewish Board of Family and Children Services,
10) Isabella Geriatric Center,
11) The Child Center of New York (program for at-risk kids),
12) Hebrew Home Adult Day Care, and
13) Lesbian Gay Bisexual and Transgender Community Center.

d. Ongoing Issues and Challenges

i. Two years into the implementation of health homes, only a little over 183,000 Medicaid recipients have been enrolled compared to approximately 800,000 Medicaid recipients identified as eligible for the first wave of health home services.

ii. Some of the health home implementation challenges encountered were:

a) Beneficiary disenfranchisement from health care system and services,
b) Lack of enrollee knowledge about the program,
c) Lack of information on part of outreach coordinator about enrollee needs,
d) Challenge of continued engagement with individuals,
e) Cultural or linguistic barriers,
f) Building external relationships,
g) Information exchange, and
h) Quality assurance and monitoring.

iii. During year one of its health homes initiative, New York set up a Health Homes Learning Collaborative so that health home provider organizations, as well as state and local policymakers, could convene and discuss some of the challenges faced and successes achieved. This learning collaborative was jointly coordinated by DOH, Center for Health Care Strategies and New York State Health Foundation. Best practices of program operation and enrollee engagement were identified and subsequently implemented. The collaborative's meetings continue through 2014.[16]

e. Future Horizons

i. New York intends to integrate health homes into a few of its upcoming initiatives – the transition of Medicaid behavioral health services from fee-for-service to managed care and the implementation of

[16] *See* N.Y. Dep't of Health, "Health Home Learning Collaborative," https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/learning_collaborative.htm.

the new waiver, the Delivery Service Reform Incentive Payments (DSRIP), that will allow the State to reinvest $8 billion in federal savings generated by MRT reforms.

C. Behavioral Health Organizations (BHOs)[17]

1. Another of the many MRT recommendations passed into law sought to examine Medicaid's provision of behavioral health services and establish a framework to transition it from fee-for-service ("FFS") to a managed care model fully integrating both physical and behavioral health care. Presently, behavioral health services remain carved out of the Medicaid managed care benefits package and continue on a FFS basis. Individuals requiring treatment go to providers of choice for as often and as long as needed. These providers are paid on a FFS basis with payment based on visits rather than outcomes. New York State estimates that the behavioral health systems serve approximately 600,000 people and that service accounts for about $7 billion annually. Substance use treatment services treat about 250,000 people at a cost of $1.7 billion annually.

2. The MRT formed the Behavioral Health Reform Work Group (the "Work Group") and charged it with the task of transitioning behavioral health services from FFS to managed care. The Work Group developed a two-phased plan to execute its mandate. The first step required the establishment of five regional BHOs selected for their experience and expertise in managing behavioral health services for individuals with substance use and serious mental illness. OptumHealth received the contract for BHO services in New York City.

3. **Phase 1 of BHO Transition**

   a. In Phase 1, the BHOs tracked and evaluated Medicaid recipients deemed to be high-need or high-cost consumers. BHOs focused their attention on people with serious mental illness and/or substance dependence who had a history of:

      i. multiple psychiatric hospitalizations / readmissions,
      ii. frequent emergency service use, or
      iii. dependence relapses and detoxification.

   b. When these individuals were psychiatrically hospitalized, the BHO flagged and monitored things like length of hospitalization, discharge planning and coordination of care as the Medicaid recipients integrated back into the community. The BHO tracked whether the discharge plan was adequate and appropriate and whether it was followed and to what result. With the focus primarily on hospitals and community providers, the BHOs hoped to:

      i. reduce unnecessary hospital readmissions,
      ii. improve rates of engagement in outpatient treatment following discharge,

[17] *See* N.Y.S. Section 1115 Behavioral Health Partnership Plan Wavier Amendment (Dec. 30, 2013), https://www.health.ny.gov/health_care/medicaid/redesign/docs/1115_waiver_behavioral_health_amendment.pdf; *see also* MRT Behavioral Health Reform Work Group Final Recommendations (Oct. 15, 2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf.

iii. profile provider performance, and
iv. facilitate cross-systems linkage.

c. The BHOs submitted the data they collected to OMH and OASAS, the two governmental agencies granted the authority to oversee this process. Some of the key findings arising from the BHO study included:

i. rates of hospital provider communication and coordination of post-discharge behavioral health services are low;
ii. rates of coordination with physical health providers are even lower;
iii. homelessness remains a significant barrier to care coordination; and
iv. inpatient readmission rates dropped throughout 2012 and several measures of care coordination and engagement improved, possibly due to the BHOs' review and "soft" enforcement measures.[18]

4. **Phase 2 of BHO Transition**

a. In Phase 2, the BHOs devised a plan to transform the current FFS system of mental health and substance use disorder services to a Medicaid managed care model. The Work Group held several meetings and sought input from various stakeholders including behavioral health providers, Medicaid recipients, and managed care plans, as well as other states in the country who offered managed care behavioral health and substance use services.

b. The Work Group examined various payment and delivery of services models that supported integration of mental health / substance use services with physical health. They also explored peer and managed addiction treatment services and integrating those concepts into the behavioral health managed care benefits package. The Work Group's Final Recommendations included:

i. delivery of care should be coordinated and efficient;
ii. payment for services should be tied to patient / consumer outcomes;
iii. consumer input is critical;
iv. in-person care coordination for high-need users should be available;
v. peer programs should be used to help engage patients and consumers;
vi. families should be integrated into care whenever possible;
vii. attention should be paid to social factors that influence individual behavior and outcomes, *e.g.*, employment and financial status; and
viii. housing resources need to be immediately available directly for timely use to avoid lengthy and repeat hospitalizations.

5. **Proposed Behavioral Health Benefits Design**

a. The Work Group concluded that behavioral health should be managed either by mainstream managed care plans that meet specific qualifications or, alternatively, act in partnership with BHOs or Health and Recovery Plans ("HARPs") which will be slated for individuals with significant behavioral health

[18] There were 45,029 Notifications of Readmissions in 2012. *See* New York State Behavioral Health Organizations 2012 Summary (rev. May 2013), http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-05-01_mrt_bh1_slides_resubmitted_5-7.pdf.

needs. Initial HARP eligibility will be determined by an individual's historic use of behavioral health services. Future eligibility will be based upon functional / clinical assessment and periodic review of historic utilization of services.

b. BHOs will contract with existing behavioral health providers and establish their own payment arrangements. Many of these providers will be small nonprofit community-based organizations that historically provide the majority of behavioral health care.[19]

c. In Phase 2, behavioral and physical health care will be managed by either mainstream managed care plans or HARPs. Both must meet the State's qualification review standards and offer the required services.

d. Qualified Managed Care Plans (mainstream managed care option)

i. must meet standards developed by the State to operate services directly; if not, must partner with BHO that meets standards

ii. a Request for Qualifications ("RFQ") assessment tool went out to Medicaid Managed Care ("MMC") Plans in March 2014 (RFQ responses from NYC were due in June 2014)

a) Plans will demonstrate via the RFQ whether they have the expertise to administer full services for mental health and substance use disorder services for adults, either in a review will identify who qualifies as a MMC Plan, in partnership with a BHO, or by establishing a HARP

iii. include Medicaid covered services and those added to the State Plan such as:

a) inpatient mental health and substance use treatment,
b) psychiatric emergency treatment,
c) comprehensive recovery oriented program for persons with severe and persistent mental illness,
d) intensive psychiatric rehabilitation treatment,
e) targeted case management,
f) assertive community treatment,
g) continuing day treatment programs,
h) partial hospitalization, and
i) opioid treatment.

iv. coordinate behavioral health with physical health management

v. set up performance metrics specific to behavioral health.

e. Health and Recovery Plans (HARPs)

i. are qualified through the RFQ process (see above)

ii. are specialized health plans for people with significant behavioral health needs

iii. integrate health and behavioral health services

[19] *See* The Medicaid Institute at United Hospital Fund, "Implementing Behavioral Health Care Reform in New York's Medicaid Program," (February 2012), http://www.uhfnyc.org/publications/880817.

iv. include Medicaid covered services and those added to the State Plan (see above list)

v. offer expanded recovery oriented services

vi. offer enhanced care coordination

vii. offer enhanced benefit package which includes services such as:

a) Crisis intervention (short-term and intensive),
b) Mobile crisis intervention,
c) Educational support services,
d) Case management,
e) Family support and training,
f) Non-medical transportation,
g) Employment support services,
h) Peer supports, and
i) Self-directed services

viii. must have full time dedicated Behavioral Health Medical and Clinic Director.

Note: HARP-eligible adults will receive health home care coordination. DOH will work with MMC Plans and Health Homes to assist in this transition.

6. **Timeline for Managed Care Implementation**

a. The initial rollout called for all behavioral services to be incorporated in some type of managed care plan beginning in 2014. However, after the BHOs engaged in Phase 1 and Phase 2 of the review and with further feedback from the advocacy community, it became readily apparent that such a radical change and alteration to existing services could not be achieved so quickly. Additionally, the State must still obtain approval from CMS to implement these health delivery services changes. The new implementation dates are:

i. January 1, 2015 – Implementation of Behavioral Health for Adults in NYC (HARP and non-HARP)

ii. July 1, 2015 – Implementation of Behavioral Health for Adults in the rest of state (HARP and non-HARP)

iii. January 1, 2016 – Implementation of Behavioral Health for Children statewide

b. The delay in implementation will allow the State to obtain additional feedback from the community stakeholders and look at options for savings reinvestment to improve overall services for behavioral health populations (*e.g.*, housing)

IV. IMPACT OF HEALTH REFORM ON LOW-INCOME COMMUNITIES OF COLOR

A. Demographic Overview – Pre & Post First Enrollment

1. NYS by the Numbers
   a. African-Americans
      i. Almost 15% of total population; ~ 20% uninsured

b. Latinos
    i. 19% of total population; 23% uninsured
c. Asian/Pacific Islanders
    i. 9% of total population; 17% uninsured
d. ~ 4.2 million immigrants in NY
    i. 2.2M naturalized citizens (52%)
    ii. 1.4M million lawfully residing (33%)
e. 700,000 undocumented (15%)
f. About 2.5 million people are limited English proficient
    i. 13% of the total population (40% increase since 1990)

2. Prevalence of Health Disparities & Barriers to Access to Care
3. Enrollment estimates by race, ethnicity, region and languages spoken
4. Post Enrollment Data (if available by race, ethnicity, etc.)

B. <u>ACA's Promise</u>

1. Review of Data Collection & Reporting Requirements
    a. Section 4302: Under Section 4302 of the Affordable Care Act, the Secretary is required to ensure that any federally conducted or supported health care or public health program, activity or survey collects and reports data, to the extent practicable, on **race, ethnicity, sex, primary language and disability status**, as well as **other demographic data** on health disparities as deemed appropriate by the Secretary
2. Review of Nondiscrimination Provision, Section 1557 of the ACA (42 U.S.C. 18116)
    a. "…[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 …, title IX of the Education Amendments of 1972 …, the Age Discrimination Act of 1975 …, or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title…. The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."
3. Review of Language Access & Cultural Competence Provisions
    a. Prior Protections
        i. Title VI
        ii. EO 13166
        iii. NYS laws (E.0. 26, etc.)
    b. Section 1001 (cultural competency/language access)
        i. "The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee."

c. Section 1311(cultural competency/language access)
    i. The term ‘‘plain language’’ means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing."
d. 45 CFR 155.205(c)(language access)
    i. “[(c)] Accessibility. Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—
    [(2)] Individuals who are limited English proficient through the provision of language services at no cost to the individual, including
    [(i)] Oral interpretation;
    [(ii)] Written translations; and
    [(iii)] Taglines in non-English languages indicating the availability of language services.”

4. Challenges Ahead
    a. Immigrant Eligibility
        i. Who is Left Behind?
    b. Insurance Coverage vs. Meaningful Equal Access to Care
        i. Documentation of Insurance-Based Steering Practices & Their Impact on Access to Health Care
        ii. Impact of Hospital Closures and Loss of Safety Net Services
5. Lessons Learned from First Enrollment Period

ACRONYMS GLOSSARY:

ACA – Affordable Care Act
APTC – Advanced Premium Tax Credits
BHO – Behavioral Health Organization
CBLTC – Community-Based Long Term Care
CDPAP – Consumer-Directed Personal Assistance Program
CDPAS – Consumer-Directed Personal Assistance Services
CHHA – Certified Home Health Care Agencies
CHP – Child Health Plus
CMS – Centers for Medicare & Medicaid Services
DACA – Deferred Action for Childhood Arrivals ("DACA")
DMH – Department of Health and Mental Hygiene (NYC)
DOH – Department of Health (NYS)
FHP – Family Health Plus
FIDA – Fully Integrated Duals Eligible
FPL – Federal Poverty Level
HARP – Health and Recovery Plan
HCBS – Home- and Community-Based Services
HRA – Human Resources Administration
ICF/IID – Intermediate Care Facilities for Individuals with Intellectual Disabilities
LDSS – Local Departments of Social Services
LTSS – Long-Term Services and Supports
MA – Medicaid
MAGI – Modified Adjusted Gross Income
MAP – Medicaid Advantage Plus
MCO – Managed Care Organizations
MLTC – Medicaid Managed Long-Term Care
MMC – Medicaid Managed Care
MMIS – Medicaid Management Information System
MMNY – Medicaid Matters New York
MRT – Medicaid Redesign Team
NAMI – National Alliance on Mental Illness
NHTD – Nursing Home Transition & Diversion
OASAS - Office of Alcoholism and Substance Abuse Services (NYS)
OHITT – Office of Health Information Technology Transformation (NYS)
OMH – Office of Mental Health (NYS)
OPWDD – Office for People with Developmental Disabilities (NYS)
PACE – Program of All-inclusive Care for the Elderly
PCS – Personal Care Services
PERS – Personal Emergency Response System
PRUCOL – Permanent Residence Under Color of Law
PTC – Premium Tax Credits
QHP – Qualified Health Plan
RFQ – Request for Qualifications
SHOP – Small Business Health Options Program
SPMI – Severe and Persistent Mental Illness
SSI – Supplemental Security Income
TBI – Traumatic Brain Injury
WMS – Waiver Management System

New York's Health Plan Marketplace: Medicaid Expansion and New Federal Subsidies

New York's Health Plan Marketplace: Medicaid Expansion and New Federal Subsidies

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September 11, 2014

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Today's Agenda

- Introduction to the Affordable Care Act
- Medicaid Expansion
  - Who are the expansion populations?
    - MAGI v. Non-MAGI
  - How do you determine financial eligibility?
  - What do you get?
- Qualified Health Plans
  - Who is eligible?
  - What do you get?
    - Premium Tax Credits, Cost Sharing

2

Patient Protection and Affordable Care Act (ACA)

The ACA aims to provide quality, affordable health insurance through the establishment of Insurance Affordability Programs (IAPs) accessed through an insurance Marketplace called New York State of Health.

nystateofhealth
The Official Health Plan Marketplace

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Health Insurance Exchanges

- "One stop shop" for public insurance programs, private insurance through qualified health plans (QHPs), and insurance affordability programs
- Streamlined enrollment process for Medicaid, Child Health Plus (CHP), and QHPs
  - Will accept applications by phone, mail, in person or web; assistance from Navigators and In-Person Assistors
  - Real time eligibility determination and enrollment
  - Data sharing – real-time & electronically verified
  - Built-in appeals systems

42 C.F.R. § 435.907(a).

Verification

- Data-matching
  - States must develop secure, electronic interfaces to allow for data-matching and eligibility determinations. States must use data-matching to the maximum extent practicable.
- Self-attestation
  - Applicants can attest to their MAGI household income for the upcoming year. Exchange may accept attestation of information and conduct database verification needed to determine eligibility without further documents.
- Reasonable Compatibility
  - Standard for assessing whether verification can be considered complete, or if additional information is necessary. When data obtained is "reasonably compatible" with an applicant's attestation, State agencies are prohibited from requiring additional documentation.
- Citizenship/Immigration Status
  - Verified through federal data hub. If data can't be matched, and otherwise eligible for Medicaid, will receive 90 days temporary coverage which will be discontinued for failure to provide documentation.

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42 CFR § 435.945; 42 C.F.R. § 435.952(c).

Local Medicaid Offices

- Remain accessible to consumers
- Will continue to process non-MAGI applications
- Paper applications received for MAGI-eligible will be forwarded to the Exchange
- Will screen walk-ins and refer appropriate consumers to the Exchange

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N.Y.S. Dept. of Health, Administrative Directive 13 OHIP/ADM-4, Dec. 3, 2013, *available at* http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/13adm04.pdf.

Medicaid Expansion

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Medicaid Expansion

- New York is one of 27 states (including DC) that have opted to expand Medicaid coverage, providing coverage to individuals with Modified Adjusted Gross Income (MAGI) at or below 138% of the Federal Poverty Level (FPL).
- New York had already expanded eligibility for public health insurance to higher income levels and to additional populations (including non-disabled singles and childless couples) through Medicaid waivers.

CMS, "Medicaid & CHIP: April 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report," Jun. 4, 2014, *available at* http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/April-2014-Enrollment-Report.pdf.

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Family Health Plus

- Family Health Plus (FHP) covered childless adults between 19-64 with income at or below 100% FPL and parents living with children under 21 with income at or below 150% FPL
- FHP stopped taking new enrollments after December 31, 2013; program will be eliminated entirely after 12/31/14
  - Those at or below 138% FPL will be transitioned to Medicaid
  - Those between 139-150% FPL will be insured through a QHP, and have their premium for a Silver Plan paid by N.Y. State and receive cost sharing subsidy (the "FHP Wrap")

N.Y. Soc. Serv. L. § 367-a(3)(e); 2013-14 N.Y.S. Executive Budget Art. VII , Part D § 14, 14a, 15, 16.

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Expansion Populations = MAGI

New Expansion Populations:

- 19-64 years old
- Not pregnant
- Not entitled to enroll in Medicare
- Not otherwise eligible for and enrolled in mandatory coverage under the State's Medicaid Plan, e.g. SSI

Existing categorical groups are now eligible under MAGI equivalent standard:

- Pregnant women
- Children
- Parents and caretaker relatives

42 U.S.C. § 1396a(a)(10)(VIII); N.Y. Soc. Serv. L. § 366(1)(b).

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Non-MAGI Populations

- Categorically eligible (e.g. SSI, children in foster care)
- Age 65+ when age is condition of eligibility
- Eligibility based on being blind or disabled
- Eligible for Medicare cost sharing (MSP)
- Medically Needy (spend down)
- Applicants for Medicaid Buy-In for Working People with Disabilities
- Applicants for Cancer Treatment Programs if income over 138% FPL
- Former foster care youth (now under 26, who were in foster care and receiving MA at 18)
- Residents of adult homes, residential treatment centers/community residences operated by OMH
- COBRA continuation of premium payments

42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 435.603(j); N.Y. Soc. Serv. L. § 366(1)(c).

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Eligibility Rules Unchanged for Non-MAGI Populations

- Individuals in a non-MAGI group follow pre-ACA budgeting methodologies
  - No changes to income and resource limits
  - Use SSI-related budgeting for disabled, adult, blind
  - Elderly and disabled can still use spend down
  - Disabled can still use SNT
  - MBI-WPD still option for some
  - No changes to MSP application process
  - If also eligible for MAGI, use most favorable budgeting

N.Y.S. Dept. of Health, Administrative Directive 13 OHIP/ADM-3, Sept. 25, 2013, *available at* http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/13adm03.pdf.

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Some Can Choose MAGI or Non-MAGI Budgeting

- Certified disabled under age 65, *but not yet receiving Medicare*
- Parent/caretaker relatives, *even if they are disabled, over 65 and/or receiving Medicare*
- Disabled children, *unless they are in a waiver program*

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Choosing Between MAGI and Non-MAGI

- MAGI more favorable
  - Higher income limit: 138% FPL vs. 83% FPL
  - No asset test
  - Some income not counted
- Non-MAGI more favorable
  - If disabled person is working, better income disregards and higher income limit
    - 50% gross income disregarded
    - 250% FPL for Medicaid Buy In for Working People with Disabilities
- If income >138% FPL, chose between
  - Non-MAGI Medicaid with a spend down
  - Exchange with premium subsidy (but no home care)

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Determining Medicaid/CHP Eligibility under MAGI

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What's New?

- **Unchanged Criteria**
  - **Residency: Intends to remain in New York "permanently or indefinitely"**
  - **Immigration: PRUCOL immigrants eligible; undocumented immigrants eligible only for emergency Medicaid; no immigration test for CHP or pregnant women through 60 days postpartum.**
- **Changed Criteria**
  - **Category**
  - **Household size**
  - **Income**

N.Y. Soc. Serv. L. § 366-a; 42 C.F.R. § 435.403; N.Y. Soc. Serv. L. § 122[1](c); *Aliessa et al. v. Novello* (96 N.Y. 2d 418); 8 U.S.C.A. § 1611(b)(1)(A); 8 U.S.C.A. § 1621. 16

MAGI Budgeting

- **Medicaid eligibility is determined from the perspective of each member of the household.**
- **Each household member could have different household income or family size as determined by taxpayer status and other factors**

42 C.F.R. § 435.603; 13 OHIP/ADM-03. 17

Step 1: Determine Household Composition

- **MAGI household is the IRS tax filing unit which includes the tax filer and all persons whom the taxpayer expects to claim as a tax dependent.**
- **Tax rules determine who is a qualified child and qualified relative.**

42 C.F.R. § 435.603(e); 26 I.R.C. § 152(b)(c)(e); 26 I.R.C. § 152(d). 18

Household Composition: Medicaid/CHP

- To determine individual's household, identify the individual as one of following:
  1. Tax filer not claimed as dependent by another taxpayer
  2. Tax dependent
  3. Non-tax filers not claimed as tax dependents

42 C.F.R. § 435.603; 13 OHIP/ADM-03.

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1. Tax Filer Not Claimed As Tax Dependent By Another

- Household consists of taxpayer and all persons whom s/he expects to claim as tax dependent.
- Spouses living together are counted in each other's household regardless of whether they are filing jointly or if claimed as dependent by the other.

42 C.F.R. § 435.603; 13 OHIP/ADM-03.

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2. Tax Dependents

- Tax dependent's household is the same as the taxpayer who is claiming him/her.
- THREE EXCEPTIONS:
  - Dependent is not child or spouse of taxpayer
  - Dependent less than 19 (or if full time student, less than 21) and lives with both parents who are not filing jointly and expects to be claimed by one
  - Dependent less than 19/21 and lives with one parent but expects to be claimed by non-custodial parent

42 C.F.R. § 435.603; 13 OHIP/ADM-03.

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3. Non Tax Filers Not Claimed as Tax Dependents

- Household consists of individual AND
- The following, if they are living with the individual:
  - Spouse
  - Children who are under 19 (or 21 if full time student)
  - If individual is under 19 (or 21 if full time student), his/her parents and siblings who are also less than 19 (or 21 if full time student).

42 C.F.R. § 435.603; 13 OHIP/ADM-03.

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Household Case Example

- Joe Taxpayer, Mary Spouse, their children Aaron and Andrew, both under 19, and Uncle Matt. Joe and Mary file joint tax returns:
  - Joe's HH size is 5 since he is a tax filer with 4 dependents
  - Mary's, Aaron's, and Andrew's HH size is 5, same as Joe's, since they are claimed as dependents by Joe, and Joe and Mary file jointly
  - Matt's household is 1 since he is neither a spouse nor child of Joe. If Matt had a child under 19 who lived with him, his HH size would be 2

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Step 2: Determine Income

- Income is defined by the Internal Revenue Code.
- Household income is the sum of the MAGI-based income of every individual included in the individual's household.

42 C.F.R. § 435.603; 13 OHIP/ADM-03.

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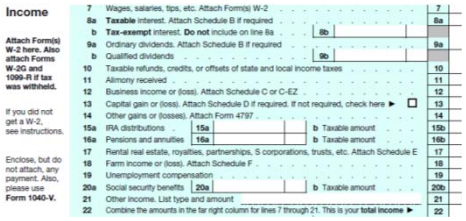
Tax Filing Requirements

Filing Status	Age at end of year	File return if gross income at least
Single	Under 65 65 or older	$10,000 $11,500
Married filing jointly	Both under 65 One over 65 One under 65	$20,000 $21,200 $22,400
Married filing separately	Any Age	$3,900
Head of Household	Under 65 65 or older	$12,850 $14,350
Qualifying widow(er) with dependent child	Under 65 65 or older	$16,100 $17,300

http://www.efile.com/tax/do-i-need-to-file-a-tax-return/

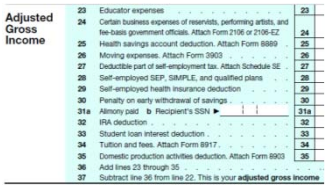
Gross Income



Wages, salary, tips, Social Security income, investment income, unemployment, pensions, IRA distribution, alimony, profit from self-employment, income tax refunds, interest, dividends. Gross income=Line 22

Internal Revenue Service, Form 1040, http://www.irs.gov/pub/irs-pdf/f1040.pdf.

Adjusted Gross Income



Disregard alimony paid, moving expenses, student loan interest, self employed health insurance contribution, contribution to flex spending plan. Adjusted gross income=Line 37

Internal Revenue Service, Form 1040, http://www.irs.gov/pub/irs-pdf/f1040.pdf.

Self-Employment Income

Self-employment income is income after expenses claimed on Schedule C.

SCHEDULE C (Form 1040) — Profit or Loss From Business (Sole Proprietorship) — 2012

Part I Income

1	Gross receipts or sales. See instructions for line 1 and check the box if this income was reported to you on Form W-2 and the "Statutory employee" box on that form was checked	1
2	Returns and allowances (see instructions)	2
3	Subtract line 2 from line 1	3
4	Cost of goods sold (from line 42)	4
5	Gross profit. Subtract line 4 from line 3	5
6	Other income, including federal and state gasoline or fuel tax credit or refund (see instructions)	6
7	Gross income. Add lines 5 and 6	7

Part II Expenses — Enter expenses for business use of your home only on line 30.

8	Advertising	8	18	Office expense (see instructions)	18
9	Car and truck expenses (see instructions)	9	19	Pension and profit-sharing plans	19
10	Commissions and fees	10	20	Rent or lease (see instructions):	
11	Contract labor (see instructions)	11	a	Vehicles, machinery, and equipment	20a
12	Depletion	12	b	Other business property	20b
13	Depreciation and section 179 expense deduction (not included in Part III) (see instructions)	13	21	Repairs and maintenance	21
14	Employee benefit programs other than on line 19	14	22	Supplies (not included in Part III)	22
15	Insurance (other than health)	15	23	Taxes and licenses	23
16	Interest:		24	Travel, meals, and entertainment:	
a	Mortgage (paid to banks, etc.)	16a	a	Travel	24a
b	Other	16b	b	Deductible meals and entertainment (see instructions)	24b
17	Legal and professional services	17	25	Utilities	25
26	Total expenses before expenses for business use of home. Add lines 8 through 27a	►	26	Wages (less employment credits)	26
			27a	Other expenses (from line 48)	27a
			b	Reserved for future use	27b
28					28

Exception to Income Rules

- **The MAGI-based income of a tax filer's child (biological, adopted, step) or non-child dependent other than spouse is not counted if they are not expected to be required to file a tax return (whether or not they do file).**

42 C.F.R. 435.603(b)(c).

Non-Taxable Income

- **Pre-taxable contributions for dependent care**
- **Child support received**
- **VA pension and disability benefits (retirement pay is counted)**
- **Gifts or inheritance**
- **Workers Compensation**

I.R.C. § 36B(d)(2); 13 OHIP/ADM-03.

Taxable Income Not Counted For Medicaid

- Lump sum counted as income only in month received
- Certain American Indian income
- Scholarship income if used for education and not living expenses
- 5% income disregard

42 C.F.R. §435.603(e); 42 C.F.R. §435.603(d).

Step 3: Determine Which Income Limit Applies

- Adults under age 65
  - 138% FPL
- Pregnant women/ Family Planning Benefit Package if not eligible for Medicaid
  - 223% FPL
- Children
  - Infants: 223% FPL
  - Children ages 1-18: 154% FPL
  - Children 19 & 20 living with parents: 155% FPL

42 U.S.C.§ 1396a(a)(10)VII); 42 C.F.R. § 435.603(a)(j); N.Y. Soc. Serv. L. § 366(b).

MAGI Income Levels

10. MAGI Levels for Medicaid and Related Program Eligibility

Family Size	1	2	3	4	5	6	7	8	9	10	Each Add'l Person
Pregnant Women and Infants Under Age 1 (223% FPL)	$2,169	$2,924	$3,678	$4,433	$5,187	$5,942	$6,696	$7,451	$8,205	$8,960	$755
Infant: Under Age 1 223% FPL	$2,169	$2,924	$3,678	$4,433	$5,187	$5,942	$6,696	$7,451	$8,205	$8,960	$755
Children Age 1 – 5 154% FPL	$1,498	$2,019	$2,540	$3,061	$3,582	$4,103	$4,624	$5,145	$5,666	$6,187	$522
Children Age 6 – 19 110% FPL	$1,070	$1,442	$1,815	$2,187	$2,559	$2,931	$3,303	$3,675	$4,048	$4,420	$373
Children Age 6 -19 (Expn'd - 154% FPL)	$1,498	$2,019	$2,540	$3,061	$3,582	$4,103	$4,624	$5,145	$5,666	$6,187	$522
Parent and Caretaker Relatives 138% FPL	$1,343	$1,809	$2,276	$2,743	$3,210	$3,677	$4,144	$4,611	$5,078	$5,545	$467
19 and 20 Year Olds Living With Parent 138% FPL	$1,343	$1,809	$2,276	$2,743	$3,210	$3,677	$4,144	$4,611	$5,078	$5,545	$467
19 and 20 Year Olds Living With Parent (Expn'd - 155%FPL)	$1,508	$2,032	$2,557	$3,081	$3,606	$4,130	$4,654	$5,179	$5,703	$6,228	$525
S/CCs and 19 and 20 Year Olds Living Alone (100% FPL)	$973	$1,311	$1,650	$1,988	$2,326	$2,665	$3,003	$3,341	$3,680	$4,018	$339
S/CCs and 19 and 20 Year Olds Living Alone (Expn'd 138% FPL)	$1,343	$1,809	$2,276	$2,743	$3,210	$3,677	$4,144	$4,611	$5,078	$5,545	$467

NYC Human Resources Administration, 2014 NYS Income and Resource Standards and Federal Poverty Levels, MAPDR-01, 6/24/14.

Individuals Without Income Limit

- Children currently in foster care
- Children previously in foster care
  - Under 21 and in foster care on their 18th birthday
  - Under 26 and in foster care on their 18th birthday and on Medicaid at the time
- Special needs children placed for adoption or have been adopted and who receive medical subsidy
- Children for whom kinship guardianship assistance payments being are made

42 U.S.C. § 1396a(a)(10)(IX); 42 C.F.R. § 435.603; N.Y. Soc. Serv. L. § 366(1)(b)(c).

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Medicaid Benchmark Benefits

- Most individuals covered under the new adult group must be enrolled in a Medicaid benchmark plan which includes all benefits covered by standard Medicaid with the exception of institutional long term care services.

N.Y. Soc. Serv. L. § 365-a(1); 13 OHIP/ADM-03.

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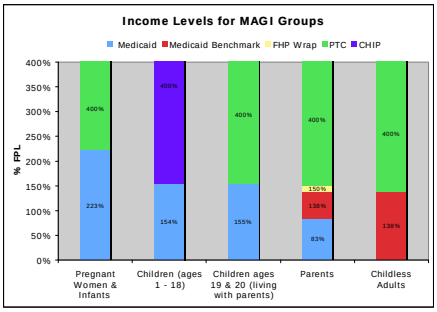
Income & Benefit Levels for MAGI Groups



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Marketplace Coverage for Qualified Health Plans

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Eligibility for Enrollment in QHP

- The Exchange must determine an applicant eligible for enrollment in a QHP if not Medicaid/CHP eligible and s/he meets the following requirements
  - Citizen/national or lawfully present (differs from Medicaid standard)
  - Not incarcerated
  - Resident: adults who intend to reside in service area of Exchange and their children living with them. Excludes children receiving payments for foster care or adoption assistance

45 C.F.R. § 155.305; 42 C.F.R. § 435.403.

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Qualifying Health Plans (QHP)

- QHPs offered are categorized by level of coverage into "metal tiers"
  - Metal tiers differ based on actuarial value which is the average share of total health spending on essential health benefits
    - Bronze: 60%
    - Silver: 70%
    - Gold: 80%
    - Platinum: 90%
  - Catastrophic plans offered for young adults under 30 or those with "hardship exemption" from insurance mandate.

https://www.healthcare.gov/can-i-buy-a-catastrophic-plan/; https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/plans-categories/.

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Evaluating Household for QHP Coverage

- As in Medicaid, "household" is determined by tax relationship and living arrangements
- Each individual in a QHP household will have the same family size
- Family size will almost always be the same as tax filer's household: tax filer and those expected to be claimed as dependents

26 I.R.C. § 152(b)(c(e).

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Household Composition

- Married couples must file jointly to be eligible for Advanced Premium Tax Credits(APTCs)/Cost Sharing Reductions.
  - Exception: married couples living apart and maintaining household for dependent child can file separately.
- Same sex marriages are recognized.
- Must be lawfully present, if not can file using Individual Taxpayer Identification Number to allow eligible dependents to apply for APTCs.

26 I.R.C. § 7703(b); IRS Publication 501; Rev. Rul. 2013-17; 2013-38 I.R.B. 201 (Aug. 30, 2013).

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Insurance Affordability Programs: Federal Tax Subsidies

- The Marketplace must provide financial assistance for those eligible for QHPs by providing:
  - Advanced Premium Tax Credits (APTC): Refundable credits are allowed against the tax imposed for any taxable year equal to the premium assistance credit amount
    - Income up to 400% FPL
    - Only individuals and families who are *not* eligible for public insurance programs or coverage through employer
    - Applicant must file taxes in the year the credit is received
  - Additional Cost-Sharing Reductions (CSRs) available for individuals and families if:
    - Eligible for APTCs; and
    - Household income that does not exceed 250% FPL; and
    - Enrolled through Exchange in Silver-level QHP

45 C.F.R. § 155.305.

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Advanced Premium Tax Credits

- Amount of tax credit is determined on a sliding scale based on an individual's or family's income and cost of premiums in benchmark plan
- Designed to ensure that people do not pay more than a certain percentage of their income for coverage

Income Level (%FPL)	*Premium limit (% income)*
Up to 133%	2%
133-150%	3-4%
150-200%	4-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.5%

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Cost-Sharing Reductions

- ACA also provides additional CSRs for individuals and families earning less than 250% FPL *enrolled in silver plan*
  - Those eligible will be automatically enrolled in silver plan with higher actuarial values depending on income level
  - Cost-sharing obligations and other out-of-pocket expenses will also be capped based on income

Income Level	*Actuarial Value*	*Out-of-pocket Limit*
Up to 150% FPL	94%	$2,250
150 – 200% FPL	87%	$2,250
200 – 250% FPL	73%	$5,200

45 C.F.R.155.305(f)(g).

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APTC Calculator

- APTC calculator can be found on New York State of Health website – provides premium cost for each participating QHP

	2014 Income (%FPL)	Estimated Monthly Tax Credit	Estimated Monthly Premium Contribution	% Income
Single	$20,000 (174% FPL)	$280	$79	4.74%
Family of 4	$50,000 (212% FPL)	$450	$268	6.43%

New York State of Health, Tax Credit and Premium Estimator, http://info.nystateofhealth.ny.gov/calculator.

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Questions?

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Contact Information

The Legal Aid Society, Health Law Unit
Helpline: (888) 663-6880
(Tuesdays 9:30-12:30)

hlu@legal-aid.org

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Medicaid Managed Care: Expansion and Impact on Fragile Populations

Medicaid Managed Care: Expansion and Impact on Fragile Populations

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Overview of Presentation

- Personal Care benefit in Mainstream Managed Care
- Managed Long Term Care (MLTC)
  - What to Expect in Albany, Erie, Monroe, and Onondaga Counties – and all other upstate counties by the end of 2014.
  - Transition Rights for Patients Mandated into MLTC.
- Due Process Rights and Patient Protections.
- Fully Integrated Duals Advantage (FIDA)

What is a *managed care* plan?

A type of private health insurance plan paid a fixed amount per capita to authorize, pay for and provide all covered services.

Enrollees must:

- Follow the plan's rules, including:
  - Choosing a PCP
  - Obtaining referrals to specialists
  - Prior authorizations for services
  - In-network treatment
  - Plan formulary

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Features of Managed Care

- Capitation rate – amount that the state pays the plan per member per month
- Provider network – must stay "in-network"
- Utilization management – need Plan's prior approval for certain services
- Benefit package – which services covered depends on type of plan and who is payer

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Medicaid Mainstream Managed Care (MMC)

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Who gets Mainstream Medicaid Managed Care?

All counties now mandatory
- Now 3.44 million New Yorkers enrolled.

EXCLUSIONS/EXEMPTIONS from MMC:
- All Dual Eligibles.
- All people with a Spend-down
- Waiver Enrollees:
  - OPWDD, TBI, NHTD, Care at Home Waiver for Children
- Individuals with other comprehensive health insurance;
- Limited Medicaid:
  - Emergency Medicaid, Medicaid Cancer Treatment Program, TB-related services

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What does MMC Cover?

Model Contract, Appendix K:

- Inpatient Hospital Services; Physician Services; Radiology; Drugs (prescription and OTC); Rehabilitation; EPSDT; Home Health; Emergency Services; Vision; Dental; DME; etc.

Community Based Long Term Care Services 'carved in' to MMC –

- Certified Home Health Agency (CHHA);
- Personal Care (August 2011);
- CDPAP (November 2012);
- Private Duty Nursing;
- Adult Day Health Care/AIDS Adult Day Health Care (August 2013)
- Hospice (October 2013)
- Nursing Home coverage (approximately October 2014);

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New Benefits Continue to be "Carved-In" Medicaid Managed Care

Nursing Home Carve-In

- Medicaid ONLY – MMC recipients
  - Adults age 21+ becoming permanent nursing home residents will be required to enroll in managed care plans.
    - Downstate starting in September 2014 (??) (NYC, Long Island, and Westchester) (delayed from March 2014) .
    - Upstate mandatory enrollment will begin in February 2015 (delayed from September 2014).
- Dual Eligibles entering the nursing home will have to enroll in Managed Long-Term Care (MLTC).

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Nursing Home Carve-In (cont'd.)

Continuity Guaranteed – no one will be forced to move

- People already in nursing homes as permanent residents will be grandfathered in and won't have to enroll in MLTC or MMC
- Can remain in their nursing home with FFS Medicaid

Transfer Penalties and 5-year look-back still apply

New permanent NH residents will have 60 days to select an MMC or MLTC plan or be auto-assigned to a plan that contracts with their NH.

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Managed Long Term Care (MLTC)

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What is Medicaid MLTC?

Medicaid + **Managed (Care)** + **Long-Term Care**

The public health insurance program for the poor, operated by the State

A type of private health insurance company paid a fixed amount *per capita* to authorize and pay for all covered services ("capitation")

- Capitation
- Provider network
- Utilization management

- Home care
- Adult day care
- Physical therapy
- Nursing home
- NOT primary/ acute/ emergency care

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Two Models for Managed Long-Term Care

Partial Capitation
- MLTC Plans

Full Capitation
- Program for All-Inclusive Care for the Elderly (PACE), or
- Medicaid Advantage Plus (MAP)

Availability varies by County
- http://www.wnylc.com/health/afile/114/371/
- http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

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Partially Capitated MLTC Plans

- Plan provides Medicaid LTC package of services;
- Plan does NOT provide Medicare-covered services.
- Most primary and acute medical care is not in the MLTC service package, so client keeps her regular Medicare card (or Medicare Advantage plan) for all Medicare primary/acute care.

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Partially Capitated MLTC Benefit Package

- Home care:
  - Personal Care (Level I and Level II)
  - CDPAP
  - Home Health Aide, PT, OT (CHHA Personal Care)
  - Private Duty Nursing
- Adult day care – Medical & Social
- PERS, home-delivered meals, congregate meals
- Medical equipment, supplies, prostheses, orthotics, hearing aids, eyeglasses, respiratory therapy, Home modifications
- **4 Medical specialties-Podiatry, Audiology, Dental, Optometry**
- Non-emergency medical transportation
- Nursing home

**** PACE & MAP also include primary and acute care ****

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MAP & PACE

Plan provides all Medicare and Medicaid services, including Long Term Care services.

- PACE
  - PACE plans provide services through a particular site – a medical clinic or hospital. Because all providers are linked, potentially more opportunity for coordinated care.
- MAP
  - Traditional insurance model. Plan contracts with various providers.
  - CAUTION: Medicaid Advantage Plus (MAP) is not the same as Medicaid Advantage (MA). Both include all Medicare services, but:
    - MA provides Medicaid without LTC
    - MAP provides Medicaid with LTC
- Not everyone eligible for MLTC is eligible for PACE or MAP: Must need Nursing Home level of care.

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When did Medicaid Mandate Managed Long Term Care?

Medicaid Redesign Team (MRT) changes:

- Approved in 2011
- Started in NYC (September 2012)
- Expanded to Nassau, Suffolk & Westchester Counties
  - For Personal Care Services; CDPAP; and Home Health Recipients.
- Rest of State by the end of 2014

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MLTC Timeline

Month	Counties
April 1	Columbia, Putnam, Sullivan, Ulster
May 1	Rensselaer, Cayuga, Herkimer, Oneida
June 1	Greene, Schenectady, Washington, Saratoga
July 1	Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, Oswego
August 1	Warren, Delaware, Niagara, Otsego, Chenango
September 1	Essex, Clinton, Franklin, Hamilton
October 1	Jefferson, Lewis, St. Lawrence, Steuben, Chautauqua, Cattaraugus, Alleghany
November 1	Yates, Seneca, Schuyler, Tioga, Cortland, Chemung
December 1	Genesee, Ontario, Livingston, Orleans, Tompkins, Wayne, Wyoming

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County	Partial Cap	MAP	PACE	Total	County	Partial Cap	MAP	PACE	Total
Albany	340	51	3	**394**	Putman	42			**42**
Cayuga	3			**3**	Rensselaer	72	26		**98**
Columbia	29			**29**	Rockland	1,156			**1,156**
Erie	682		168	**850**	Saratoga	14			**14**
Greene	12			**12**	Schenectady	30	25	137	**192**
Herkimer	59			**59**	Suffolk	2,778	109	85	**2,972**
Monroe	640		560	**1,200**	Sullivan	108			**108**
Nassau	4,356	166	62	**4,584**	Ulster	150			**150**
Oneida	465			**465**	Washington	4			**4**
Onondaga	340		463	**803**	Westchester	2,692	5	223	**2,920**
Orange	930			**930**	NYC	104,560	5,041	3,774	**113,375**

MLTC Enrollment as of 6/1/14: 130,360

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Who Must Join MLTC?

- Dual eligibles, who are:
  - Living in “mandatory” counties;
  - Age 21 or older; and
  - Receiving or in need of Medicaid Community-Based Long-Term Care services for >120 days in a calendar year
    - CDPAP
    - Certified Home Health Agency services (CHHA)
    - Adult Day Health Care (medical model)
    - Lombardi Waiver (Long-Term Home Health Care)
    - Private-Duty Nursing

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Who does NOT have to join MLTC?

- No Medicare (but MAY enroll if need home care and would otherwise qualify for nursing home care);
- Under 21 (but MAY enroll if over 18);
- Those Excluded from Mandatory MLTC even in mandatory county:
  - In TBI, NHTD or OPWDD waiver
  - Have Hospice Care or live in Assisted Living
- Need <120 days Community Based LTC;
- Need ONLY Level I PCS;
- Need ONLY Social Adult Daycare.

*** NOTE: Spend-Down does NOT keep patients out of MLTC as it does for MMC ***

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What Happens When MLTC Becomes Mandatory?

- How does Mandatory Enrollment Work?
- How to Select a Plan?
- What Rights do Members Have?

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Timeline in Mandatory Counties

- "Announcement" letter from DOH mailed to all personal care, CDPAP, CHHA, private duty nursing, adult day recipients;
  - http://www.health.ny.gov/health_care/medicaid/redesign/docs/1.1-am_notice-english-unenrolled.pdf
- 30 days later – NOTICE from NY Medicaid Choice (Maximus) giving 60 days to select an MLTC plan, with option of picking MAP or PACE;
  - http://www.wnylc.com/health/download/318/
- Recipients either:
  - Select & Enroll in Plan;
  - Randomly assigned to MLTC – not to MAP or PACE.

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Choosing a Plan

Full or Partial Capitation?

- Partial – MLTC:
  - If recipient wants to keep current doctors, hospitals, etc.
- Full – MAP or PACE:
  - Plan covers all Medicare and Medicaid services
  - Must use plan network
    - PACE provides services at a particular site;
    - MAP works like conventional insurance.

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Enrollment

Must have active Medicaid approved FIRST.

MLTC:

- May enroll through plan or through NY Medicaid Choice (Maximus – (888) 401-6582)
- Enrollment has no impact on Medicare.

MAP or PACE:

- Must enroll through the plan, not NY Medicaid Choice;
- Two parts to enrollment:
  - Enrollment in Medicare Advantage and in connected Medicaid plan;
- Automatically disenrolled from Medicare Advantage; Stand-alone Part D; and MMC.

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Enrollment (cont'd.)

No lock-in!

- Members can switch plans at any time;
- But cannot return to FFS for LTCS

Timing:

- Must enroll by the 20th to be effective by the first of the next month;
- But plans may extend disenrollment until the first of the second month;
- There should be no gap in services

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Transition to MLTC

Continuity of Care:

- 90-day continuation of services – or until the plan conducts a new assessment – whichever is LATER.
  - DOH Policy 13-10, May 8, 2013.
- Includes personal care, CDPAP, private duty nursing, and adult day care.
- MLTC Plan must contract with all PC vendors under contract with LDSS.

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After the Transition Period

Plan may reduce services

- Must give advance written notice of change
- Must describe available appeal rights
- Must give "Aid Continuing" if client requests fair hearing

In MLTC, enrollee must first request an Internal Appeal within the Plan.

Only if she loses the Internal Appeal may she request a state Fair Hearing.

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MLTC and Medicaid Surplus

1. MLTC plan will bill consumer for her spend down. If consumer does not pay her spend down, the MLTC plan ***MAY*** disenroll the consumer following a notice with appeal rights.
2. Spend down may lead to enrollment delays.
   - In NYC, HRA-DSS and the MLTC plan must take an extra step to enroll someone in an MLTC plan called a "conversion." The MLTC must submit "conversion" paperwork to HRA before enrollment can be completed because HRA must manually link the consumer to the MLTC plan of her choice in the WMS system.
   - The NYS DOH has taken steps to streamline this procedure through certain improvements to the WMS system. See GIS 14 MA 010 : https://www.health.ny.gov/health_care/medicaid/publications/gis/14ma010.htm.
3. New Strategies for Eliminating Medicaid Surplus for MLTC enrollees:
   - Spousal Impoverishment Budgeting
   - Special Housing Disregard for those transitioning for NH to MLTC enrollment.

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Enrollee Rights in Medicaid Managed Care

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Enrollee Rights

- Appeals and Fair Hearings
  - Internal appeals with the Plan
    - External Review with DFS
  - Fair Hearings
- Rights of people with disabilities and chronic conditions
- Access to care (e.g., long term care, emergency treatment)
- Requesting a new or increased level of service

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Requesting New or Increased Services

- **Prior Authorization**
  - A request by the Enrollee or provider on Enrollee's behalf for a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period.
- **Concurrent Review**
  - A request by an Enrollee or provider on Enrollee's behalf for
    - Additional services (i.e., more of the same) that are currently authorized in the plan of care; or
    - Medicaid covered home health care services following an inpatient admission.

Model Contract, Appendix K, ¶ (3) [p. 113 of PDF]

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Service Authorizations: Timing

- Both prior and concurrent can be standard or expedited. A request should be expedited if a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

- **Expedited** – No more than 3 business days from request for service.
- **Standard** – No more than 14 days of receipt of request for services.
- **Discharge from hospital or NH**: 1 business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, 72 hours after receipt of necessary information; but in any event, no more than 3 business days after receipt of the request for services.

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

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NEW: MLTC Consumers Must Request Internal Appeal First Before Fair Hearing

- An appeal may be filed orally or in writing.
  - Oral: plan must follow up with written confirmation of oral appeal. Date of oral request is treated as date of appeal.
- Plan must provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Plan must provide the opportunity to examine the case file and any other records.
- Consumer or provider may request an EXPEDITED appeal.

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

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Mainstream Managed Care (MMC) Appeals Procedure ****For people with Medicaid ONLY**	**Managed Long Term Care (MLTC) Appeals Procedure** ****For people with Medicare and Medicaid**

1. File a Fair Hearing with Office for Temporary Disability Assistance (OTDA) online or via fax.
   1. For AID CONTINUING the Fair Hearing must be requested before the effective date of the action or within ten days of receipt of the notice, whichever is later.
   2. You must request a Fair Hearing within 60 days of the date of the notice.
 	
OPTIONAL: File an internal appeal with the MMC plan.
	1. STEP ONE: MLTC participants must FIRST file an INTERNAL APPEAL with the MLTC plan. The deadlines for internal appeal:
	• For AID CONTINUING the internal appeal must be filed before the effective date or within ten days of receipt of the notice, whichever is later.
	• You must request the internal appeal within 45 days to the notice.
	2. STEP TWO: The MLTC plan must decide the appeal within 30 days STANDARD or two days EXPEDITED. If you lose the internal appeal, you may then file a Fair Hearing. Fair Hearing deadlines:
	• For AID CONTINUING the Fair Hearing must be filed within 10 days of the date the appeals decision was sent.
	• You must request the FH within 60 days of the date the appeal decision was sent.

Amount and Standards for Home Care Remain the Same

- There has been **NO CHANGE** in the amount or type of services available under MLTC versus under PCA/CHHA.
- If an individual was medically appropriate for 24-hour care (even split-shift) under the PCA regulations, then that person should also receive 24-hour care under MLTC.
  - 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).
    - Plans routinely misinform applicants about this point; this will require frequent advocacy to reinforce – see Policy 13.10

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Amount and Standards (Cont.)

- Can't use task-based-assessment when client has 24-hour needs ("Mayer-III")
- Must provide adequate hours to ensure safe performance of ADLs (NYS DOH GIS 03 MA/003)
- Non-self-directing people eligible if someone can direct care who need not live with them (92-ADM-49)(Illegal "Back-up" requirement).
- Cannot terminate services when hospitalized (Granato v. Bane, 74 F.3d 406 (1996))

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Fair Hearings: Due Process Issues

- MLTC and MMC may not reduce, suspend, or discontinue home care services without justification. 18 NYCRR § 505.14.

Notice:

- Timely
  - 10 days prior to proposed action
- Adequate
  - Must describe proposed action
  - Specific reasons for the action Legal basis for the action
  - Right to conference/fair hearing
  - Right to representation.

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Aid Continuing

- Plan must continue benefits unchanged whenever it proposes to reduces or terminate services if :
  - the appeal is timely requested (within 10 days of notice or before effective date of the action)
  - the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
  - the services were ordered by an authorized provider;
  - the enrollee has expressly requested Aid Continuing

Before April 1, 2014, Aid Continuing was required only if the original authorization period for the service has not expired. The State 2014-15 budget eliminated that requirement!!! Plan must continue services even if that period expired.

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Class Action Filed to Protect Due Process Rights

- Taylor v. Zucker, U.S.D.C., S.D.N.Y, 14 CV 5317
- NYLAG filed a class action filed July 15, 2014 on behalf of Medicaid recipients in New York State who receive home care services through Managed Care Organizations ("MCOs"), against New York State Department of Health and NYS Office of Temporary and Disability Assistance, challenging their failure to send timely and adequate notices of denial, reductions, and terminations, and to provide an opportunity for a Fair Hearing and aid-continuing, in violation of the Due Process Clause of the United States Constitution and the Medicaid Act and its implementing regulations.
- If you have a client who you believe may be a member of the Taylor class please contact vbogart@nylag.org or btaylor@nylag.org.

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How to Request a Fair Hearing

In person:	Local Department of Social Services
By fax:	(518) 473-6735
By telephone:	(800) 342-3334
By mail to:	NYS Office of Temporary and Disability Assistance Office of Administrative Hearings P.O. Box 1930 Albany, New York 12201-1930.
Online:	www.otda.state.ny.us/oah/forms.asp

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Rights of People with Disabilities or Chronic Conditions in MMC

- Specialist designated as PCP
  - Cannot be psychiatrist
- Standing referral to a specialist
- Out-of-Network authorization for specialty care and center of excellence
- Transitional care

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Fully Integrated Duals Advantage (FIDA)

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What is FIDA?

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

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

WHERE? NYC, Nassau, Suffolk and Westchester only

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

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

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When will FIDA begin?

- January 2015 in NYC and Nassau County
  - Voluntary January 2015
  - Passive April 2015
- April 2015 in Suffolk and Westchester Counties
  - Voluntary April 2015
  - Passive July 2015
- FIDA ends December 31, 2017
  - May be extended.

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FIDA uses *Passive* Enrollment

Eligible consumers will receive "60-day" letters. They must take action:

1. Select and enroll in FIDA plan, or
2. Affirmatively OPT OUT of FIDA and remain in MLTC
   - Use Maximus/NY Medicaid Choice for both
3. Otherwise: Passive Enrollment into a FIDA plan. DOH will develop an
   - "Intelligent Assignment" based on historic provider usage.
   - Most likely will assign them to the FIDA plan sponsored by their MLTC plan.
     - **WARNING:** While assignment to the FIDA plan linked to their MLTC plan will promote continuity of their home care providers and other MLTC providers (dentist, adult day care program, etc.), the FIDA plan may not contract with all of their MEDICARE providers - physicians, specialists, hospital, physical therapy clinic, etc.

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Right to OPT OUT of Demonstration

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

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Transition/Continuity of care

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

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More on continuity of old providers

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

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Integrated Appeals process

- FIDA combines Medicare and Medicaid Appeals processes;
  - AIM: simplify access to care for consumers, so that they don't have to separately navigate Medicare and Medicaid bureaucracies
- One notice, not separate notices from Medicare and Medicaid;
- Aid Continuing – if timely requested -- available for all services, MEDICARE and Medicaid.
  - A victory for advocates!

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Integrated Appeal Process – Stages of Appeal

There are 4 stages of appeal for all Medicare and Medicaid appeals. Aid Continuing applies through the 3rd stage.

1. Initial appeal is to the Plan.
2. If plan denies internal appeal, may appeal is to the State's integrated hearing officer – who will hear both Medicare and Medicaid appeals (except for Part D). This is reportedly going to be a new entity within OTDA (current hearing office)
3. If hearing is lost, may appeal to the Medicare Appeals Council – which will hear Medicaid issues as well as Medicare. Aid continuing applies if timely requested.
4. Federal district court appeal. (NO automatic aid continuing)

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Ombudsman Program & other Consumer Protections

OMBUDSMAN -Though the state declined federal funding for an Ombudsman program, NYS has committed to including an Ombudsprogram to assist and advocate for consumers navigating FIDA.

- An RFP was issued in late February 2014.

COSTS to CONSUMER – NO copayments allowed, including Part D drugs. Spend-down (NAMI in NH) will be billed for though.

Medical Loss Ratio (MLR) – 85% of all capitation rates must be spent on services and care coordination, not administration/ profit. Plan must remit difference to CMS if fails test.

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Info on FIDA

National resources on CMS Guidance on the Duals Demonstrations, the demo's in other States, best practices (enrollment, quality metrics, rate setting etc.)

www.dualsdemoadvocacy.org (Natl. Senior Citizens Law Center)

NYS FIDA website – includes Memorandum of Understanding between CMS and DOH, FAQ, other guidance –

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

Subscribe to state listserv
http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm

FAQ Sept 2013
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013_09_fida_faq.pdf

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

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Contact numbers & Other Info

- New York Medicaid Choice (Enrollment Broker) 1-888-401-6582 General
  - ADVOCATES HOTLINE 1-855-886-0570
  - Maximus Project Directors Marjorie Nesifort 1-917-228-5607
  - Awilda L. Martinez-Rodriguez 1-917.228.5610
  - Raquel Pena, Deputy Project Mgr. 1-917.228.5627
  - Website http://nymedicaidchoice.com/
  - http://www.nymedicaidchoice.com/program-materials - Scroll down to *Long Term Care plans* - separate lists for regions of state
  - http://tinyurl.com/MLTCGuide - Official Guide to MLTC
- NYS Dept. of Health MLTC Complaint Hotline 1-866-712-7197 mltcworkgroup@health.state.ny.us
- Mainstream Managed Care Complaint Line 1-800-206-8125 managedcarecomplaint@health.state.ny.us
- Related online articles on http://nyhealthaccess.org:
  - All About MLTC - http://www.wnylc.com/health/entry/114/
  - Tools for Choosing a Medicaid Managed Long Term Care Plan http://wnylc.com/health/entry/169/
  - Appeals & Grievances - http://www.wnylc.com/health/entry/184/ with advocacy contacts
  - MLTC News updates: http://www.wnylc.com/health/news/41/

Managed Care Appendix A

EVELYN FRANK LEGAL RESOURCES PROGRAM
CONTACT: 212-613-7310 EFLRP@NYLAG.ORG

EMPIRE JUSTICE CENTER
CONTACT: (585) 454-4060

PARTNERSHIP TRAINING APPENDIX PREPARED IN JULY 2014

NYS D'ept of Health Mainstream Medicaid Managed Care Complaints
Phone: 1-800-206-8125
Email: managedcarecomplaint@health.state.ny.us

NYS D'ept of Health Managed Long Term Care (MLTC) Complaints
Phone: 1-866-712-7197
Email: mltcworkgroup@health.state.ny.us

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

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

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

PLANS THAT OPERATE ONLY UPSTATE in limited counties – NOT IN NYC. List does not include all mainstream plans – only those with LTC plans (MLTC, MAP, PACE)							
Company	**MLTC PLAN**	**Medicaid Advantage PLUS**	**PACE**	**Medicaid Advantage *** NO HOME CARE!![2]**	**Main-stream managed care**	**FIDA Plan**	**# counties outside NYC - MLTC**
Catholic Health-LIFE			**x**				Erie
Complete Senior Care			**x**				Niagara
EDDY			**X**				Schenect'd y Albany
Elant	Elant Choice						Orange, Rockland Dutchess
First Choice Health	First Choice Health MLTC						Erie, Niagara
Hamaspik	Hamaspik Choice						Orange, Rockland, Sullivan, Ulster
Independent Living for Seniors dba/ ElderONE			**x**				Monroe
PACE CNY			**x**				Onondoga
Senior Network Health	Senior Network Health						Oneida, Herkimer
Total Aging in Place Program	Total Aging in Place Program						Erie
Total Senior Care, Inc			**x**				Cattaraug's Allegany
VNA Homecare Options, LLC	VNA Homecare Options						Albany, Cayuga Jefferson, Madison, Onondaga Oswego

Plans in top part of chart cover all NYC Boroughs except those marked as follows:

* * = does not cover Staten Island

** ARCHCARE Community Life MLTC covers only Bronx, Manhattan & Staten Island, and its PACE covers only Bronx and Manhattan

% AETNA Better Health MLTC covers only Brooklyn, Manhattan & Queens

$ Touchstone Health Medicaid Advantage does not cover Manhattan (and is NOT a long-term care plan!!)

Wellcare Liberty MA covers Brooklyn, Bronx and Queens only – and is not a long-term care plan!!

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

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

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

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

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

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

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

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

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

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

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

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

MA ADVANTAGE PLUS PLANS

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

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

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

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MANAGED LONG TERM CARE (MLTC) PARTIAL CAP PLANS

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

Managed Long Term Care, Medicaid Advantage Plus, and PACE plans by County in NYS with Enrollment as of June 2014

County and Date Became Mandatory	Name of plan/ company	Enrollment 6/2014	Type of plan
ALBANY[1] (1/2014)	NYS Catholic Health Plan	51	MAP
	FIDELIS MAP	0	MAP
	EDDY SENIOR CARE	3	PACE
	FIDELIS CARE AT HOME	104	MLTC
	VNS CHOICE	148	MLTC
	WELLCARE	38	MLTC
	HOMEFIRST (ElderPlan)	6	MLTC
	UNITED HEALTH CARE PERSONAL ASSIST.	5	MLTC
	VNA HOME CARE OPTIONS	39	MLTC
ALLEGANY	TOTAL SENIOR CARE	18	PACE
	FIDELIS CARE AT HOME	0	MLTC
BROOME	FIDELIS CARE AT HOME	12	MLTC
	UNITED HEALTH CARE PERSONAL ASSIST.	0	MLTC
CATTARAUGUS	TOTAL SENIOR CARE	80	PACE
	FIDELIS CARE AT HOME	1	MLTC
CAYUGA (6/2014)	FIDELIS CARE AT HOME	1	MLTC
	VNA HOME CARE OPTIONS	0	MLTC
CHAUTAUQUA	FIDELIS CARE AT HOME	1	MLTC
CHENANGO	FIDELIS CARE AT HOME	1	MLTC
COLUMBIA (4/2014)	FIDELIS CARE AT HOME	5	MLTC
	VNSNY CHOICE	24	MLTC
CORTLAND	FIDELIS CARE AT HOME	2	MLTC
DELAWARE	FIDELIS CARE AT HOME	9	MLTC
	VNYNY CHOICE	0	MLTC
DUTCHESS	ELANT	77	MLTC
	FIDELIS CARE AT HOME	21	MLTC
	VNS CHOICE	14	MLTC
ERIE (1/2014)	CENTERS PLAN FOR HEALTHY LIV	63	MLTC
	FIDELIS CARE AT HOME	178	MLTC
	TOTAL AGING IN PLACE PROGRAM	127	MLTC
	WELLCARE	145	MLTC
	FIRST CHOICE HEALTH	0	MLTC
	HOMEFIRST (ElderPlan)	3	MLTC
	UNITED HEALTH CARE	3	MLTC
	VNSNY CHOICE	103	MLTC
	Catholic Health CHS BUFFALO LIFE	168	PACE
ESSEX	FIDELIS CARE AT HOME	2	MLTC
FULTON	FIDELIS CARE AT HOME	12	MLTC
	VNSNY CHOICE	0	MLTC
GENESEE	FIDELIS CARE AT HOME	0	MLTC

GREENE (6/2014)	VNSNY CHOICE	12	MLTC
HAMILTON	FIDELIS CARE AT HOME	0	MLTC
HERKIMER (6/2014)	FIDELIS CARE AT HOME	11	MLTC
	SENIOR NETWORK HEALTH	48	MLTC
	VNSNY CHOICE	0	MLTC
JEFFERSON	VNA HOME CARE OPTIONS	0	MLTC
LIVINGSTON	FIDELIS CARE AT HOME	24	MLTC
MADISON	VNA HOME CARE OPTIONS	21	MLTC
	VNSNY CHOICE	0	MLTC
MONROE (1/2014)	FIDELIS CARE AT HOME	170	MLTC
	HOMEFIRST (ElderPlan)	453	MLTC
	UNITED HEALTH CARE Personal Ass	3	MLTC
	VNSNY Choice	14	MLTC
	ELDERPLAN	0	MAP
	ElderOne (Formerly "INDEPENDENT LIVING FOR SENIORS")(Rochester General Hospital)	560	PACE
MONTGOMERY	FIDELIS/ NYS Catholic Health Plan	4	MAP
	FIDELIS CARE AT HOME	14	MLTC
	VNSNY CHOICE	0	MLTC
NASSAU (Jan. 2013)	ELDERPLAN MAP	4	MAP
	GUILDNET GOLD	72	MAP
	HEALTHFIRST COMPLETE CARE	15	MAP
	EMBLEMHEALTH (HIP)	75	MAP
	VNSNY CHOICE TOTAL	0	MAP
	AETNA BETTER HEALTH	264	MLTC
	AGEWELL NEW YORK	363	MLTC
	CENTERLIGHT	132	MLTC
	ELDERPLAN (HomeFirst)	130	MLTC
	ELDERSERVE	93	MLTC
	EXTENDED	29	MLTC
	FIDELIS CARE AT HOME	583	MLTC
	GUILDNET	1,531	MLTC
	EMBLEMHEALTH (HIP)	253	MLTC
	INTEGRA	55	MLTC
	NORTH SHORE-LIJ	315	MLTC
	SENIOR HEALTH PARTNERS INC	201	MLTC
	VNSNY CHOICE	345	MLTC
	WELLCARE	62	MLTC
	CenterLIGHT	62	PACE

NIAGARA	COMPLETE SENIOR CARE	116	PACE
	CENTERS PLAN FOR HEALTHY LIV.	35	MLTC
	FIDELIS CARE AT HOME	0	MLTC
	FIRST CHOICE HEALTH	0	MLTC
	HOMEFIRST (ElderPlan)	0	MLTC
ONEIDA (6/2014)	FIDELIS CARE AT HOME	32	MLTC
	SENIOR NETWORK HEALTH	433	MLTC
	UNITED HEALTH CARE Personal Ass	0	MLTC
	VNSNY CHOICE	0	MLTC
ONONDOGA (1/2014)	FIDELIS CARE AT HOME	45	MLTC
	VNA HOME CARE OPTIONS	280	MLTC
	UNITED HEALTH CARE Personal Ass.	12	MLTC
	HOMEFIRST (ElderPlan)	1	MLTC
	VNSNY CHOICE	0	MLTC
	PACE CNY	463	PACE
ONTARIO	FIDELIS CARE AT HOME	1	MLTC
ORANGE (9/2013)	ELANT	283	MLTC
	FIDELIS CARE AT HOME	417	MLTC
	HAMASPIK CHOICE	90	MLTC
	HOMEFIRST (ElderPlan)	1	MLTC
	UNITED HEALTH CARE Personal Ass	0	MLTC
	VNSNY CHOICE	20	MLTC
	WELLCARE	119	MLTC
ORLEANS	FIDELIS CARE AT HOME	0	MLTC
OSWEGO	FIDELIS CARE AT HOME	6	MLTC
	VNA HOME CARE OPTIONS	3	MLTC
	PACE CNY	0	PACE
OTSEGO	VNSNY CHOICE	0	MLTC
PUTNAM (4/2014)	ARCHCARE	30	MLTC
	FIDELIS CARE AT HOME	12	MLTC
	VNSNY CHOICE	0	MLTC
RENSSELAER (6/2014)	FIDELIS MAP/ NYS Catholic Health Pl	26	MAP
	FIDELIS CARE AT HOME	14	MLTC
	HOMEFIRST (ElderPlan)	6	MLTC
	VNSNY CHOICE	52	MLTC

ROCKLAND (9/13)	CENTERLIGHT	231	MLTC
	CENTERS PLAN FOR HEALTHY LIV	23	MLTC
	ELANT	251	MLTC
	ELDERPLAN	13	MLTC
	FIDELIS CARE AT HOME	392	MLTC
	HAMASPIK CHOICE	96	MLTC
	HOMEFIRST (ElderPlan)	13	MLTC
	UNITED HEALTH CARE Personal Ass	1	MLTC
	VNSNY CHOICE	16	MLTC
	WELLCARE	133	MLTC
SARATOGA (6/2014)	VNSNY CHOICE	14	MLTC
	HOMEFIRST (ElderPlan)	0	MLTC
SCHENECTADY (6/2014)	HOMEFIRST (ElderPlan)	2	MLTC
	VNSNY CHOICE	0	MLTC
	FIDELIS CARE AT HOME	28	MLTC
	EDDY SENIOR CARE	137	PACE
	FIDELIS MAP/ NYS Catholic Health Pl	25	MAP
SCHOHARIE	FIDELIS CARE AT HOME	0	MLTC
	VNSNY CHOICE	0	MLTC
STEUBEN	FIDELIS CARE AT HOME	1	MLTC
SUFFOLK (Jan. 2013)	Guildnet GOLD (MAP)	83	MAP
	HIP (EMBLEMHEALTH)	26	MAP
	VNSNY CHOICE TOTAL	0	MAP
	CENTERLIGHT	85	PACE
	AETNA BETTER HEALTH	256	MLTC
	AGEWELL NEW YORK	148	MLTC
	CENTERLIGHT SELECT	170	MLTC
	ELDERPLAN (HomeFIrst)	41	MLTC
	ELDERSERVE	124	MLTC
	EXTENDED	3	MLTC
	FIDELIS CARE AT HOME	397	MLTC
	GUILDNET	1,394	MLTC
	HIP (EMBLEMHEALTH)	66	MLTC
	INTEGRA	24	MLTC
	VNSNY CHOICE	105	MLTC
	NORTH SHORE LIJ	35	MLTC
	WELLCARE	15	MLTC
SULLIVAN (4/2014)	FIDELIS CARE AT HOME	18	MLTC
	HAMASPIK CHIOCE	89	MLTC
	VNSNY CHOICE	1	MLTC
TIOGA	FIDELIS CARE AT HOME	4	MLTC
TOMPKINS	FIDELIS CARE AT HOME	2	MLTC

ULSTER (4/2014)	FIDELIS CARE AT HOME	82	MLTC
	HAMASPIK CHOICE	26	MLTC
	VNS CHOICE	1	MLTC
	WELLCARE	41	MLTC
WARREN	FIDELIS CARE AT HOME	1	MLTC
	VNSNY CHOICE	0	MLTC
WASHINGTON (6/2014)	FIDELIS CARE AT HOME	4	MLTC
	VNSNY CHOICE	0	MLTC
WAYNE	FIDELIS CARE AT HOME	1	MLTC
WESTCHESTER (Jan. 2013)	AGEWELL NEW YORK	293	MLTC
	ALPHACARE	9	MLTC
	ARCHCARE COMMUNITY LIFE	430	MLTC
	CENTERLIGHT	369	MLTC
	ELDERPLAN (HomeFirst)	329	MLTC
	ELDERSERVE	143	MLTC
	FIDELIS CARE AT HOME	252	MLTC
	GUILDNET	209	MLTC
	HIP / EMBLEMHEALTH	41	MLTC
	HHH CHOICES	89	MLTC
	INTEGRA	33	MLTC
	MONTEFIORE	49	MLTC
	SENIOR HEALTH PARTNERS	162	MLTC
	VNSNY CHOICE	254	MLTC
	WELLCARE	30	MLTC
	CENTERLIGHT	223	PACE
	ELDERPLAN	0	MAP
	HIP/EMBLEMHEALTH	5	MAP
	VNSNY CHOICE TOTAL	0	MAP
WYOMING	FIDELIS CARE AT HOME	0	MLTC
TOTAL UPSTATE			

TOTAL ENROLLMENT Jun. 2014

	NYC	Rest of State	Total statewide
PACE	3,774	1,915	5,689
MAP	5,041	386	5,427
MLTC	104,560	15,167	119,727
TOTAL	**113,375**	**17,468**	**130,843**

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

MEDICAID ADVANTAGE PLUS	
1. HealthFirst	2,836
2. Elderplan	798
3. HIP of Greater New York	523
4. Guildnet	540
5. VNS Choice Plus	223
6. NYS Catholic Health Plan	86
7. Senior Whole Health	29
8. HHH Choices	0
9. AmeriGroup	0
10. WellCare	0
NYC Total MAP	5,035

MLTC PACE PLANS	
1. ARCHCARE SENIOR LIFE	339
2. COMPREHENSIVE CARE MGMT	3,435
Total MLTC PACE Enrollment	**3,774**
MLTC PARTIAL CAPITATION PLANS	
1. VNS CHOICE	16,446
2. GUILDNET	11,229
3. SENIOR HEALTH PARTNERS INC	10,879
4. ELDERPLAN	9,620
5. ELDERSERVE	10,009
6. CENTERLIGHT	3,435
7. FIDELIS CARE AT HOME	5,767
8. WELLCARE	5,712
9. INDEPENDENCE CARE SYSTEMS	5,081
10. AMERIGROUP/HealthPlus	2,798
11. VILLAGE CARE MAX	2,944
12. HHH CHOICES	2,190
13. AGEWELL NEW YORK (Parker Jewish)	2,430
14. AETNA BETTER HEALTH	2,099
15. ARCHCARE COMMUNITY LIFE	1,407
16. CENTERS PLAN FOR HEALTHY LIVING	1,669
17. HIP OF GREATER NEW YORK	978
18. INTEGRA (Personal Touch)	1,151
19. SENIOR WHOLE HEALTH	916
20. UNITED HEALTHCARE	746
21. METROPLUS	577
22. ALPHACARE (Magellan)	545
23. NORTH SHORE-LIJ HEALTH PLAN	381
24. EXTENDED MLTC	228
25. MONTEFIORE HMO	290
TOTAL NYC MLTC	109,489

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

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

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

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

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

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

<Date>

<Case Name>
<Address>
<City, State> <Zip Code>

Important Medicaid Notice

<Dear Consumer Name.> <CIN#>

This is an important notice from the Medicaid Program. We are writing because you get home care or other long-term care services. The way you get these services will change in the next several months. To keep receiving your services, you will be required to join a Managed Long Term Care Plan.

The requirement that you must join a Plan is subject to approval by the federal Centers for Medicare & Medicaid Services (CMS). **You do not need to do anything at this time.** This letter is to tell you what this change means to you and how it will happen.

What this change means

We have enclosed a list of Managed Long Term Care Plans. These Plans are for people who have a long-lasting health problem or disability. You will be asked to choose one of these Plans. The Plan you select will arrange for all your long-term care services - not just home care but also the other services listed on the enclosed Plan List.

After you join a Plan, your Medicaid CASA office or local Social Services office will no longer be in charge of approving your services. Your Plan will do this for you.

(**Please turn this page over**)

What Happens Next

When federal approval is received, you will get another letter and more information from ***New York Medicaid Choice.*** This State program can help you choose a Plan. You have 60 days after you receive that letter to choose a Plan. If you do not select a Plan, the Medicaid Program will select a Plan for you.

What You Can Do Now

▪ Share this letter with your family or someone who knows about your health care needs.

▪ You may also speak to your CASA office or local Social Services office. They also know about this change and can keep you informed.

▪ Call ***New York Medicaid Choice***. Counselors can answer any questions you may have about joining a Plan. **They can tell you which Plan works with your home care agency or other providers.** Please have the name of your home care agency or other providers handy when you call.

If you have trouble reading or understanding this letter or if you have questions - call ***New York Medicaid Choice***:

Phone Number: **1-888-401-MLTC or 1-888-401-6582**
TTY Service: **1-888-329-1541**

Monday to Friday, 8:30 am – 8:00 pm
Saturday, 10:00 am – 6:00 pm

Thank you.

New York
Medicaid Choice New York State's Medicaid managed care enrollment program

1-888-401-6582 P.O. Box 5009, New York, NY 10274-5009
Ask ▪ Choose ▪ Enroll

July 8, 2012

John Sample
123 Main Street
Anytown, N.Y. 01234

Important! You Must Join a Managed Long Term Care Plan

Dear John Sample: AB1234C

The Medicaid program has changed the way you get home care and other long term care services. Your local Department of Social Services, CASA office or home health agency will no longer approve these services. Instead, you must now join a Managed Long Term Care Plan. (It is also called a Plan).

It is important that you join a Plan by September 6, 2012. If you do not choose a Plan by this date, the Medicaid Program will select a Plan for you.

If you want help in choosing a Plan, please call ***New York Medicaid Choice.*** This State program has counselors who will be glad to answer your questions about joining a Plan. If you want someone to speak to us on your behalf, please contact us to arrange this. You or the person you authorize can contact us for help in choosing a Plan **over the phone or TTY.**

New York Medicaid Choice – we are here to help.

Choosing your Plan is an important decision. You may want to share this letter with your family or someone who knows about your health care needs. If you have trouble reading or understanding this letter – a Medicaid Choice counselor can help.

(Please turn this page over)

Some people are exempt from joining a Plan. This means they do not have to join a Plan. In some situations, a person cannot join a Plan. Please see Page 21 in the enclosed Guide for more information.

Please contact ***New York Medicaid Choice.*** Counselors can:

- tell you about the different types of Plans, their services and how they work

- help you choose a Plan that works with your home care agency or other providers.

Please see the **Provider Worksheet** on Page 14 in the enclosed Guide. You can fill out this worksheet and have it handy when you call us.

Call: 1-888-401-MLTC or 1-888-401-6582. Monday-Friday from 8:30 am – 8:00 pm and Saturday, from 10:00 am- 6:00 pm. TTY Service: 1-888-329-1541.

Office of Health Insurance Programs

Division of Long Term Care

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

Date of Issuance: May 8, 2013

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

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

For Medicaid recipients who are in receipt of services and are transitioning to MLTC, plan representatives may inquire about the recipient's current plan of care and service provider only for informational purposes to assist with the required in home assessment process. The MLTC plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party.

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

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

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

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

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

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

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

MLTC FREQUENTLY ASKED QUESTIONS

(HRA/HCSP MEDICAID)

Human Resources Administration
Department of Social Services

HCSP QUICK REFERENCE-03…11/13/2013

Q1: What is the expected processing time for New York Access with Supplement A once it has been submitted to HRA?

A: Medicaid Applications are allotted 45 calendar days for processing. However, it should be noted that additional time may be required for actions, such as deferrals, referrals due to pooled trust, supplemental needs trusts, disability determinations, and estate/ real property matters.

Q2: What is the expected turn around time for surplus conversion packets submitted to the HCSP Centralized Medicaid Unit?

A: The turn around time is 10 business days.

Q3: What is the expected turn around time for a Medicaid deferral submitted to the HCSP Centralized Medicaid Unit?

A: The turn around time for a Medicaid deferral is 10 business days.

Q4: What is the expected turnaround time for RVI 3 (consumers who have not documented their resources) conversion submission that has been forwarded to the Centralized Medicaid Unit?

A: The turn around time is 10 business days.

Q5: What documents are needed for an RVI 3?

A: An individual applying for community-based long term care who has not previously submitted documentation for all of their resources must complete form DOH-4495A Access NY Supplement A, and provide documents to HRA that verify all of their resources.

Q6: What documents are needed for a surplus conversion case?

A: The plan must initially assess the nursing home individual and determine the Medicaid status if deemed appropriate for Managed Long Term Care. If the individual is Medicaid eligible, follow the Medicaid Alert - **MLTC Submissions of Nursing Home Enrollment Process,** which is posted on Medicaid Authorized Resource Center (MARC) website (www.nyc.gov/marc) on February 14, 2013.

Q7: How can a nursing home resident who is ready for discharge enroll in a MLTC?

A: The plan must assess the nursing home individual and determine the Medicaid status if deemed appropriate for managed long term care. If the individual is Medicaid eligible, follow the Medicaid Alert - **MLTC Submissions of Nursing Home Enrollment Process,** which is posted on Medicaid Authorized Resource Center (MARC) website (www.nyc.gov/marc) on February 14, 2013.

Q8: Who is the HCSP Medicaid Contact person for MLTC plans?

A: The Centralized HCSP Medicaid office has established a Provider Relations Unit that can address plan issues. Each plan has been assigned a HRA liaison who they can directly contact to address Medicaid related matters. MLTC plans can call 929-221-0849 to find out the name and contact information for their liaison assigned to them. Please note the HRA liaison will only interact with designated plan representatives.

Q9: How are surplus amounts reflected for supplemental needs trust and pooled trust?

A: Upon approval of the trust, the surplus information will be updated retroactive to the trust approval date.

Q10: What is the MLTC plan responsibility regarding a member who moves out of the county?

A: The plan should inform the member to contact the appropriate LDSS for the county from which they are moving, to initiate the transfer of Medicaid process.

Q11: How should a MLTC plan address a Medicaid case when ePACES screen indicates "NO COVERAGE-EXCESS INCOME" ?

A: This ePACES message means that the individual is eligible to enroll in a MLTC plan. The individual has been determined eligible for Medicaid and has a spend-down that they have not met. The plan should submit a conversion request to HRA via the HCSP 3022, MLTC Medicaid Cover Sheet, available on MARC. This will allow HRA to convert the Medicaid coverage and the plan will be able to enroll the individual in their plan of choice. The plan should **NOT** refer the individual to the MICSA/DARB 'pay-in" in unit.

Q12: How should a MLTC plan address a Medicaid case when ePACES screen indicates "ELIGIBLE ONLY – OUTPATIENT CARE"?

A: This ePACES message means that the individual has been determined eligible for Medicaid and has a spend down. The statement "eligible only – outpatient care" indicates that the individual has not met the spend down for 6 consecutive months. Therefore, they are not currently eligible for Medicaid coverage for an in-patient hospitalization. They are eligible to enroll in a MLTC plan. The plan should submit a conversion request to HRA via the HCSP 3022, MLTC Medicaid Cover Sheet, available on MARC. This will allow HRA to convert the Medicaid coverage and the plan will be able to enroll the individual in their plan of choice. The plan should **NOT** refer the individual to the MICSA/DARB "pay-in unit".

Q13: How should a MLTC plan address a Medicaid case when ePACES screen indicates "54-LONG TERM CARE NON COVERED"?

A: This ePACES message means that the individual "attested" to the amount of his/her current month resources at the time of application, but did not document them. The plan should ask the individual or representative of the consumer if they documented their resources at the time of application/renewal. If the consumer states that they did, the plan should submit form HCSP 3022, MLTC Medicaid Cover Sheet, to HRA requesting a conversion and annotate in the "other" section that the consumer has indicated their current month's resources were documented.

If the consumer states they did not document their current month resources, then the plan should submit form HCSP 3022 to HRA along with DOH-4495 Supplement A, and current documentation of bank accounts and other related resources.

Q14: How should a MLTC plan address a Medicaid case when ePACES screen indicates "NH CODE and/or COVERED SERVICES SKILLED NURSING HOME CARE"?

A: This ePACES message means that the Medicaid coverage for this consumer is only for institutional care. When a plan has assessed an individual in the community and determined eligible for enrollment into MLTC, the plan should request a Medicaid conversion via HCSP 3022, MLTC Medicaid Cover Sheet. Plans should refer to the Medicaid Alert of February 14, 2013, **MLTC Submissions of Nursing Home Enrollment Process,** which is posted on MARC website at: www.nyc.gov/marc

MLTC MEDICAID COVER SHEET

Human Resources Administration
Department of Social Services

HCSP-3022 09/26/2013

Home Care Services Program
Centralized Medicaid Eligibility Unit
Managed Long Term Care Division
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

DATE: _____

PLAN NAME: _____

CONTACT NAME: _____

CIN: _____

CONSUMER NAME: _____ SOCIAL SECURITY# _____
(Last four digits only)

You must indicate a requested action:

Section A:

- ☐ New Application – DOH-4220 with Supplement A (DOH-4495A)
- ☐ Return Deferral
- ☐ Pooled Trust, Supplemental Needs Trusts, Other Trusts
- ☐ Budget change request
- ☐ Demographic changes (Name, DOB, etc)
- ☐ Address correction
- ☐ NAMI request
- ☐ Budget review/correction
- ☐ Medicaid eligibility expired over 60 days

Section B:

- ☐ Consumer Returning to the Community from a Nursing Home (MAP-259f required)
  Date of discharge_____. Requested MLTC enrollment effective date_____
- ☐ RVI-3 Conversion (Supplement A and resource documents required)
- ☐ Conversion Request (Community surplus cases)
- ☐ Re-link to plan
- ☐ Withdrawal
- ☐ Rescind of Disenrollment
- ☐ Retroactive Disenrollment
- ☐ Other (Specify): _____

TO: Local District Commissioners, Medicaid Directors

FROM: Mark Kissinger, Director
Division of Long Term Care

SUBJECT: 06 to 30 Conversion for MLTC Enrollees

EFFECTIVE DATE: Immediately

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

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

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

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

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

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

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

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

Preliminary FIDA Plans

Aetna Better Health of New York	HHH Choices Health Plan
AgeWell New York	HIP/Emblem
AlphaCare of New York	Independence Care System
Amerigroup New York	Integra MLTC
Amida Care	MetroPlus Health Plan
Archcare	Montefiore
CenterLight Healthcare	North Shore-Long Island Jewish
Centers Plan for Healthy Living	*Partners Health Plan (OPWDD FIDA)*
Elderplan	Senior Whole Health of New York
ElderServe Health	UnitedHealthcare of New York
Fidelis	Village Care of New York
GuildNet	VNS Choice
HealthFirst	WellCare of New York

APPENDIX A – COVERED ITEMS AND SERVICES

Medical Necessity. The FIDA Plan shall provide services to Participants as follows:

The FIDA Plan shall authorize, arrange, coordinate, and provide to Participants all Medically Necessary Covered Items and Services as specified in Section 2.4, in accordance with the requirements of the Contract and the IDT Policy.

The FIDA Plan must provide all Covered Items and Services that are Medically Necessary, including but not limited to, those Covered Items and Services that:

> Prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap.

Notwithstanding this definition, the FIDA Plan will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.

> All care must be provided in accordance and compliance with the ADA, as specified by the Olmstead decision.

The FIDA Plan must cover all Items and Services outlined in the Contract and in the State and Federal guidance, including any guidance that may be issued during the Demonstration and may not impose more stringent coverage rules or Medical Necessity criteria for any Covered Items or Services.

The FIDA Plan and IDT shall not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Item or Service solely because of diagnosis, type of illness, or condition of the Participant.

The FIDA Plan and IDT shall not deny authorization for a Covered Item or Service that the Participant or the Provider demonstrates is Medically Necessary.

The FIDA Plan or the IDT may place appropriate limits on a Covered Item or Service, as relates to a given Participant. Any limits must be made on the basis of Medical Necessity, or for the purpose

of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The FIDA Plan's Medical Necessity guidelines must, at a minimum, be:

Developed with input from practicing Physicians in the Demonstration Plan's Service Area;

Developed in accordance with standards adopted by national accreditation organizations;

Developed in accordance with the definition of Medical Necessity in this Appendix;

Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

Evidence-based, if practicable; and

Applied in a manner that considers the individual health care needs of the Participant.

The FIDA Plan's Medical Necessity guidelines, program specifications and service components for Behavioral Health Services must, at a minimum, be submitted to the NYSDOH annually for approval no later than (thirty) 30 calendar days prior to the start of a new Contract Year, and no later than thirty (30) calendar days prior to any change.

Community-based LTSS shall be provided in a setting that has a home-like character by providing full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and visitors at times convenient for the Participant. The settings/services support community integration, including facilitation of employment and easy access to resources and activities in the community. Community-based LTSS are not provided in institution-like settings except when such settings are employed to furnish short term respite to Participants. The State, either directly or through its MCO contracts, must ensure that:(1) all Participants receive appropriate services in the least restrictive and most integrated home and community-based setting, in accordance with CMS community-based setting requirements outlined in the regulatory text at 42 CFR 441.530; and (2) all Participants' engagement and community integration is supported and facilitated to the fullest extent desired by each Participant and reflected in the

member's PCSP, per regulatory text at 42 CFR 441.301, as covered under that regulation. The State must ensure that all community-based settings comply with any revisions to Medicaid regulations.

Covered Items and Services. The FIDA Plan agrees to provide Participants access to the following Covered Items and Services:

All Items and Services provided under New York State Plan services (including Long-Term Services and Supports (LTSS)), excluding ICF/MR services, and those services otherwise excluded or limited in A.4 or A.5 of this Appendix A.

All Home and Community Based Waiver Services as Specified in Appendix A

All Items and Services provided under Medicare Part A

All Items and Services provided under Medicare Part B

All Items and Services provided under Medicare Part D

The integrated formulary must include any Medicaid-covered prescription drugs and certain non-prescription drugs that are excluded by Medicare Part D. The Medicaid-covered prescription and certain non-prescription drugs required for inclusion in the integrated formulary are those listed in the Medicaid State Plan. In all respects, unless stated otherwise in the MOU or the Contract, Part D requirements will continue to apply.

All other items and services identified in this Appendix and this Contract.

As a term and condition of this Demonstration, the FIDA Plan will be required to provide all Medically Necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) and 1915(c) waiver Items and Services. Table A-1 provides a list of FIDA Demonstration Covered Item and Services. Table A-1 will be updated to address any changes due to State Plan Amendments, 1115(a) demonstration amendments, and 1915(c) waiver amendments during the Demonstration.

The FIDA Plan must provide Medicaid coverage for all items and services that are covered by Medicare Parts A and B except as noted here or in the annual FIDA Plan Benefit Package Guidance Template. Specifically, Medicaid does not cover chiropractor services, which

are covered by Medicare. Medicaid covers all other Medicare covered items and services.

All Covered Items and Services must be covered in accordance with current NYSDOH coverage rules as found in State and Federal laws and regulations, the Medicare Benefit Policy Manual, all applicable local and national coverage determinations, the State Medicaid Plan, on the www.health.state.ny.us website, on eMedNY or in other policies or guidance published by NYSDOH. Covered Items and Services definitions are subject to changes over time and the FIDA Plan shall comply with any changes made during the Demonstration. The FIDA Plan is required to maintain compliance with all applicable State and Federal policies around applicable Covered Items and Services definitions and coverage rules.

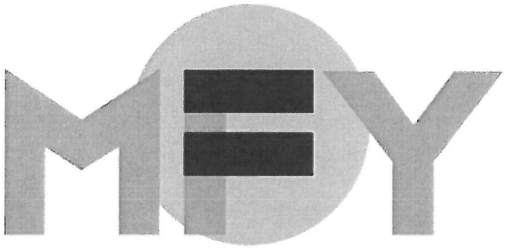
All Medically Necessary physical and Behavioral Health Services and all necessary long-term supports and services are to be provided at no cost to the Participant.

Supplemental Benefits in Addition to Required Covered Items and Services. The FIDA Plan may request NYSDOH and CMS approval to provide supplemental benefits in addition to all required Covered Items and Services listed in Table A-1. The approval must be sought annually and must apply to a full calendar year of the Demonstration. If approval is granted, the FIDA Plan must cover the approved Supplemental Benefits in Addition to Required Covered Items and Services as approved for the calendar year.

Court-Ordered Services. The FIDA Plan shall provide any Covered Items and Services to Participants as ordered by a court of competent jurisdiction, regardless of whether such services are provided by a Participating Provider or by a Non-Participating Provider. Non-Participating Providers shall be reimbursed by the FIDA Plan at the Medicaid fee schedule. The FIDA Plan is responsible for court-ordered services to the extent that such court-ordered services are included in Covered Items and Services list. Court Ordered Services are those services ordered by the court performed by, or under the supervision of a physician, dentist, or other Provider qualified under State law to furnish medical, dental, Behavioral Health Services (including mental health and/or chemical dependence services), or other Medicare and Medicaid Advantage Plus covered services.

All required Covered Items and Services are listed in Table A-1.

The Impact of Medicaid Redesign on Persons with Mental Health Disabilities



MFY LEGAL SERVICES, INC.

The Impact of Medicaid Redesign on Persons with Mental Health Disabilities

Orier Okumakpeyi
Senior Staff Attorney
MFY Legal Services, Inc.

I. Impact of Medicaid Redesign on Persons with Mental Health Disabilities — **30 Minutes**

A. Medicaid Redesign — 3 Minutes

1. Medicaid Redesign's Focus on People with Mental Disabilities

B. Health Homes (First Wave) — 12 Minutes

1. Overview
2. What is a Health Home?
3. Who is Eligible for a Health Home?
4. Health Home Services
5. Health Home Provider Qualifications, Geographic Rollout and Program Implementation
6. Health Home Update – Two Years of Implementation

C. Behavioral Health Organizations ("BHOs") — 15 Minutes

1. Phase 1 of BHO Transition
2. Phase 2 of BHO Transition
3. Proposed Behavioral Health Benefits Design
4. Timeline for Managed Care Implementation

The Impact of Medicaid Redesign on Persons with Mental Health Disabilities

Orier Okumakpeyi, Staff Attorney
MFY Legal Services, Inc.

I. The Impact of Medicaid Redesign on Persons with Mental Health Disabilities

A. Medicaid Redesign[1]

Governor Andrew M. Cuomo, upon taking office, sought to radically restructure New York State's Medicaid program. The two main reasons given were Medicaid's high programmatic cost and poor quality of care results. New York spends more than twice the national average on Medicaid per capita, but ranked 21st out of all states in overall health system quality and last among all states for avoidable hospital use and costs. Spending on the Medicaid program had risen from $46 billion in April 2007 to approximately $53 billion in 2011.[2] With Executive Order No. 5, Governor Cuomo convened the Medicaid Redesign Team ("MRT"). The Governor tasked the MRT with the responsibility of reforming the Medicaid healthcare system, specifically lowering the cost of Medicaid while improving the quality of healthcare delivery and its outcomes. The MRT came up with 79 reform recommendations. Of those, 73 were passed into law in 2011.

1. Medicaid Redesign's Focus on People with Mental Disabilities[3]

People with mental health disabilities rank high among those Medicaid recipients who are high-cost or high-need users of health care services.

In 2011, at the time of MRT implementation, approximately 40% of Medicaid recipients diagnosed with multiple "chronic" conditions were also diagnosed with mental illness or substance use disorder.[4] New York State's Department of Health ("DOH") estimated over $1billion was spent on avoidable hospital readmissions. The majority of those hospitalized included individuals with mental health or substance use conditions along with other serious medical conditions.

These individuals similar to "dual eligibles" (recipients of both Medicaid and Medicare) are the primary targets of Medicaid Redesign. Several of the early MRT changes previously discussed had an immediate impact upon this group of

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[1] N.Y. Exec. Order No. 5 (Jan. 5, 2011), http://www.governor.ny.gov/executiveorder/5; see also Medicaid Redesign Team ("MRT") website, http://www.health.ny.gov/health_care/medicaid/redesign/.
[2] N.Y. Dep't of Health, "A Plan to Transform the Empire State's Medicaid Program: Better Care, Better Health, Lower Costs, https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf.
[3] See N.Y. Dep't of Health, "MRT Behavioral Health Reform Work Group Final Recommendations," (Oct. 15, 2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf.
[4] See Greg Allen, M.S.W., N.Y. Dep't of Health, "New York State Care Management for High Need Patients – Transforming Care through Health Homes" presented at NYAPRS' 30th Annual Conference (Sept. 2012), http://www.nyaprs.org/conferences/annual-conference/documents/NYAPRSgallen.pdf.

individuals.[5] For example, mental health consumers were previously exempted from having to join managed care plans if they were Supplemental Security Income ("SSI") recipients or had severe and persistent mental illness ("SPMI"). Additionally, the drastic reduction in time from 90 days to 30 days to evaluate and select a managed care plan or be subject to auto-assignment, had a tremendous impact on this group of Medicaid recipients, particularly those diagnosed with SPMI.

B. Health Homes (First Wave)[6]

1. Overview

Under the Affordable Care Act ("ACA"), states were given the option of creating a new form of health care delivery whereby all health care services – physical, behavioral, long-term care and social work support – for Medicaid recipients with chronic conditions would be coordinated. The concept envisaged treatment of the "whole person" as opposed to uncoordinated care from different sources that may not communicate with one another regarding the best treatment options. Beneficiaries would have a "health home" and the providers of these health homes would integrate and coordinate all care including but not limited to primary, acute, behavioral and long-term health care services. The twin goals of health homes are improved health outcomes and significant lowering of Medicaid costs.

Federal approval by CMS was required before the health home program could take effect. States had to make necessary amendments to their respective State Medicaid Plans. In turn, any state approved by CMS to implement health homes would receive a 90% federal match for health home services for the first eight (8) fiscal quarters that a health home state plan amendment ("SPA") is in effect.

New York State responded to this opportunity and focused on individuals with mental health or substance use disorders and other chronic conditions as the first wave of health home enrollees.[7] The MRT acted and included health homes as one of its 73 recommendations passed into law.

In its proposal, the MRT cited data from the State showing that 16% of the total Medicaid population had two or more chronic illnesses, one of which is often mental

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[5] See N.Y. Dep't of Health, Section 1115 Waiver Amendment Request (Apr. 13, 2011) and CMS Section 1115 Waiver Amendment Approval, http://www.health.state.ny.us/health_care/managed_care/appextension/#mrt_waiver_materials.

[6] See N.Y. Soc. Servs. L. § 365-l; see also Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, §2703(b), 124 Stat. 119, 318-319 (2010); 42 U.S.C. § 1396w-4.

[7] Subsequent waves of health home rollouts will target long-term care recipients and beneficiaries with developmental disabilities, respectively. See N.Y.S. Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions ("SPA") – SPA #11-56, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf.

illness, and that the cost of care for these beneficiaries ranged from $2300 – $3900 per month compared to an average of $890 per month cost across the total Medicaid population. The data also identified this group as driving 50% of all Medicaid costs, most attributable to hospital inpatient stays.[8]

On February 3, 2012, CMS approved phase 1 of the health home rollout with an effective date of January 1, 2012.[9] On December 4, 2012, CMS approved two additional state plan amendments for phase 2 and phase 3 with effective dates of April 1, 2012 and July 1, 2012, respectively.[10] The combined approval of all aforementioned SPAs allowed for statewide implementation of the Health Home Program.

DOH's Office of Health Insurance Programs ("OHIP") in conjunction with DOH's Office of Health Information Technology Transformation ("OHITT"), the AIDS Institute, the New York State Office of Mental Health ("OMH"), the New York State Office of Alcohol and Substance Abuse Services ("OASAS"), the New York City Department of Health and Mental Hygiene ("DOHMH") and a provider advisory group developed the design of the health home initiative.

2. What is a Health Home?

A Health Home is not a physical, bricks-and-mortar building, but rather a network of care providers with a central point where a participant's individual caregivers communicate with one another so that all of the patient's needs are addressed in a comprehensive manner. The network of partners includes but is not limited to:

- One or more hospital systems;
- Multiple ambulatory care sites (physical and behavioral health) including clinical group practices, rural health clinics, community health centers;
- Home care agencies;
- Community-based organizations, including existing case management and housing providers; and
- Managed care plans.

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[8] See MRT "Proposal to Redesign Medicaid: Proposal Number 89, MRT Number 57," (Jan. 2011), https://www.health.ny.gov/health_care/medicaid/redesign/docs/descriptions_of_recommendations.pdf.
[9] See SPA #11-56, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf.
[10] See SPA #12-10, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/12-10_spa_approval_plan_pgs.pdf; SPA #12-11, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-12-11_spa_approval_plan_pgs.pdf.

One of these entities is identified as the lead health home provider or the central point. That lead health home provider can directly provide or subcontract for the provision of all health home services. It must assign a "care manager" or "care coordinator" to the Medicaid recipient. He or she oversees and provides access to all of the services the individual requires to ensure healthy outcomes, specifically avoidable emergency and hospital admissions and readmissions, skilled nursing facility admissions and emergency room visits. The lead health home ensures that the beneficiaries' health care needs are understood and met. The lead health home also bears the ultimate responsibility for guaranteeing positive health outcomes. All health records are shared among the network of providers and all health services are provided by the same. These partners are the collective "health home." A Medicaid recipient's participation in a health home is voluntary not mandatory.

3. Who Is Eligible for a Health Home?

A Medicaid recipient with:

- Two or more chronic health conditions;
- One chronic health condition and is at risk of having a second; or
- One serious and persistent mental health condition.

Examples of "chronic conditions" include but are not limited to:

- A mental health condition,
- Substance use disorder,
- Heart Disease,
- Respiratory Disease,
- Diabetes,
- HIV / AIDS, or
- Body Mass Index ("BMI") over 25.

4. Health Home Services

Health Homes are required to provide:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Patient and family support;

- Referral to community and social support services, if relevant (*i.e.*, housing, legal, food); and
- Use of health information technology to link services.

5. Health Home Provider Qualifications, Geographic Rollout and Program Implementation

i. Qualifications

The State implemented an application process and review to designate the lead health home providers. Standards consistent with federal and state laws set forth the following general qualifications for all applicants:

- Providers / plans must be enrolled or eligible for enrollment in NYS Medicaid program and agree to comply with all Medicaid requirements;
- Health home providers can either directly provide or subcontract for the provision of all health home services;
- Health home providers remain responsible for all health home program requirements, including services performed by subcontractors;
- Provision of care coordination and integration of health care services for health home participants must be under the direction of a dedicated care manager;
- Care manager must assure access to medical and behavioral health care and community social supports;
- Hospitals included within the health home network must have procedures in place to refer any eligible individual with chronic conditions who seek or need treatment in the ER; and
- Provider must furnish written documentation clearly demonstrating how requirements are being met.

ii. Health Home Geographic Rollout[11]

- Phase 1 rollout (effective January 1, 2012):

[11] The list of New York State Counties with their Designated Lead Health Homes, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/list_by_county.htm#new_york.

- Bronx, Kings, Clinton, Essex, Franklin, Hamilton, Nassau, Schenectady, Warren and Washington.

- Phase 2 rollout (effective April 1, 2012):
  - New York, Queens, Richmond, Dutchess, Erie, Monroe, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester.

- Phase 3 rollout (effective July 1, 2012):
  - Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates.

iii. Program Implementation

- Lead health home providers received lists of eligible Medicaid fee-for-services recipients from DOH. DOH identified and assigned these individuals using a combination of clinic risk groups[12] and an "intelligent assignment" which considered factors like existing relationships with care management, inpatient providers, ambulatory and emergency care usage.

- Managed care plans contracted with lead health home providers as part of their network of providers and assigned their health home eligible members into health homes. DOH provided managed care plans with a list of eligible members and other information based on its "intelligent assignment" algorithm.

- Existing community-based case management providers like OMH's Targeted Case Management programs continued to provide services to their clients while also converting to or assigning members to appropriate lead health homes.

[12] This is an assessment tool utilized by DOH to develop a risk-factor score that corresponds with prospective enrollees' health home service need level. Chronic behavioral and medical conditions are the primary focus. Additionally, items such as recent homelessness or incarceration, adherence concerns, untreated mental health /substance use concerns and concurrent medical conditions are considered. Additional psycho-social and cultural factors that present barriers to care acquisition and/or retention in care are also of interest.

- Letters of enrollment and assignment issued from either the lead health homes for fee-for-service recipients or the managed care plans.

- All participants in health homes were required to sign the consent forms which allow for the member's health information to be shared within the network of health home partners – an essential component to the health home concept. However, lack of the signed consent form does not preclude the care manager from actively working with the Medicaid recipient.

6. Health Home Update – Two Years of Implementation

By January 2014, the State approved 32 lead health home providers and established 48 health homes in 57 counties.[13] As of early 2014, New York State has enrolled approximately 183,000 Medicaid recipients into health homes.[14]

Not included in these numbers are those individuals who have been engaged and are in the process of enrolling in a health home. They include:

- Beneficiaries identified for outreach efforts;
- Medicaid recipients already engaged by outreach; and
- Participants enrolled in existing case management programs, *i.e.*, OMH's Targeted Case Management Program who are in the process of converting.

i. Policy Objectives Achieved[15]

Many states including New York said the flexibility inherent within the health home model allowed them to address gaps in care for Medicaid recipients with complex health needs during a time of fiscal difficulty. The policy objectives health homes enabled New York to tackle include:

- Aligning and integrating a number of existing and varied care management models;

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[13] See Center for Health Care Strategies, Inc., "Seizing the Opportunity: Early Medicaid Health Home Lessons," (March 2014), http://www.chcs.org/media/Seizing_the_Opportunity-_Early_Medicaid_Health_Home_Lessons.pdf.
[14] See N.Y. Dep't of Health, "Health Home / Managed Care Work Group Update," (May 16, 2014), https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2014-05-16_presentation.pdf; see also CMS Health Home Information Resource, Fact Sheet – July 2014, http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Medicaid-Health-Homes-Overview.pdf.
[15] See Center for Health Care Strategies, Inc., "Seizing the Opportunity: Early Medicaid Health Home Lessons," (March 2014), http://www.chcs.org/media/Seizing_the_Opportunity-_Early_Medicaid_Health_Home_Lessons.pdf.

- Focusing on high-need, high-cost beneficiaries;
- Transforming previously separate programs into integrated networks of service providers with one point of accountability; and
- Mandating health networks broaden to address beneficiaries' other pressing needs like housing or employment.

ii. Snapshot of Lead Health Homes – New York City

- Bronx County:
    1. Bronx Lebanon Hospital Center
    2. Bronx Accountable Healthcare Network Health Home
    3. Community Care Management Partners
    4. Community Health Care Network
    5. New York City Health and Hospitals Corporation

- Kings County:
    1. Community Health Care Network
    2. Pathways to Wellness
    3. New York City Health and Hospitals Corporation
    4. Brooklyn Health Home

- New York County:
    1. Community Care Management Partners
    2. Mount Sinai Health Home
    3. Heritage Health and Housing Home Network
    4. Pathways to Wellness
    5. New York City Health and Hospitals Corporation
    6. The New York and Presbyterian Hospital

- Queens County:
    1. North Shore LIJ Health Home
    2. Queens Coordinated Care Partners
    3. New York City Health and Hospitals Corporation

- Richmond County:
    1. Pathways to Wellness

The network of partners identified by the above lead health homes are many and varied. For example, The New York and Presbyterian Hospital Health Home includes community-based mental health, medical and substance use counseling clinics, home care agencies, adult day care centers, supportive and supported housing providers, child care counseling programs and programs

specializing in persons with HIV / AIDS. The New York and Presbyterian Hospital Health Home network partners include:

- Puerto Rican Family Institute Mental Health Clinic,
- Village Care Health Center,
- FEGs,
- Brooklyn AIDS Taskforce,
- ACMH Care Management Services (case management program for persons with mental illness),
- Exponents Outpatient Drug Abuse Clinic,
- Narco Freedom / Methadone Maintenance Treatment Program,
- Project Renewal (supportive housing program),
- Jewish Board of Family and Children Services,
- Isabella Geriatric Center,
- The Child Center of New York (program for at-risk kids),
- Hebrew Home Adult Day Care, and
- Lesbian Gay Bisexual and Transgender Community Center.

iii. Ongoing Issues and Challenges

Two years into the implementation of health homes, only a little over 183,000 Medicaid recipients have been enrolled compared to approximately 800,000 Medicaid recipients identified as eligible for the first wave of health home services.

Some of the health home implementation challenges encountered were:

- Beneficiary disenfranchisement from health care system and services,
- Lack of enrollee knowledge about the program,
- Lack of information on part of outreach coordinator about enrollee needs,
- Challenge of continued engagement with individuals,
- Cultural or linguistic barriers,
- Building external relationships,
- Information exchange, and
- Quality assurance and monitoring.

During year one of its health homes initiative, New York set up a Health Homes Learning Collaborative so that health home provider organizations, as well as state and local policymakers, could convene and discuss some of the challenges faced and successes achieved. This learning collaborative was jointly coordinated by DOH, Center for Health Care Strategies and New York State Health Foundation. Best practices of program operation and

enrollee engagement were identified and subsequently implemented. The collaborative's meetings continue through 2014.[16]

iv. Future Horizons

New York intends to integrate health homes into a few of its upcoming initiatives – the transition of Medicaid behavioral health services from fee-for-service to managed care and the implementation of the new waiver, the Delivery Service Reform Incentive Payments (DSRIP), that will allow the State to reinvest $8 billion in federal savings generated by MRT reforms.

C. Behavioral Health Organizations (BHOs)[17]

Another of the many MRT recommendations passed into law sought to examine Medicaid's provision of behavioral health services and establish a framework to transition it from fee-for-service ("FFS") to a managed care model fully integrating both physical and behavioral health care. Presently, behavioral health services remain carved out of the Medicaid managed care benefits package and continue on a FFS basis. Individuals requiring treatment go to providers of choice for as often and as long as needed. These providers are paid on a FFS basis with payment based on visits rather than outcomes. New York State estimates that the behavioral health systems serve approximately 600,000 people and that service accounts for about $7 billion annually. Substance use treatment services treat about 250,000 people at a cost of $1.7 billion annually.

The MRT formed the Behavioral Health Reform Work Group (the "Work Group") and charged it with the task of transitioning behavioral health services from FFS to managed care. The Work Group developed a two-phased plan to execute its mandate. The first step required the establishment of five regional BHOs selected for their experience and expertise in managing behavioral health services for individuals with substance use and serious mental illness. OptumHealth received the contract for BHO services in New York City.

1. Phase 1 of BHO Transition

In Phase 1, the BHOs tracked and evaluated Medicaid recipients deemed to be high-need or high-cost consumers. BHOs focused their attention on people with serious mental illness and/or substance dependence who had a history of:

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[16] See N.Y. Dep't of Health, "Health Home Learning Collaborative," https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/learning_collaborative.htm.

[17] See N.Y.S. Section 1115 Behavioral Health Partnership Plan Wavier Amendment (Dec. 30, 2013), https://www.health.ny.gov/health_care/medicaid/redesign/docs/1115_waiver_behavioral_health_amendment.pdf; see also MRT Behavioral Health Reform Work Group Final Recommendations (Oct. 15, 2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf.

- multiple psychiatric hospitalizations / readmissions,
- frequent emergency service use, or
- dependence relapses and detoxification.

When these individuals were psychiatrically hospitalized, the BHO flagged and monitored things like length of hospitalization, discharge planning and coordination of care as the Medicaid recipients integrated back into the community. The BHO tracked whether the discharge plan was adequate and appropriate and whether it was followed and to what result. With the focus primarily on hospitals and community providers, the BHOs hoped to:

- reduce unnecessary hospital readmissions,
- improve rates of engagement in outpatient treatment following discharge,
- profile provider performance, and
- facilitate cross-systems linkage.

The BHOs submitted the data they collected to OMH and OASAS, the two governmental agencies granted the authority to oversee this process. Some of the key findings arising from the BHO study included:

- rates of hospital provider communication and coordination of post-discharge behavioral health services are low;
- rates of coordination with physical health providers are even lower;
- homelessness remains a significant barrier to care coordination; and
- inpatient readmission rates dropped throughout 2012 and several measures of care coordination and engagement improved, possibly due to the BHOs' review and "soft" enforcement measures.[18]

2. Phase 2 of BHO Transition

In Phase 2, the BHOs devised a plan to transform the current FFS system of mental health and substance use disorder services to a Medicaid managed care model. The Work Group held several meetings and sought input from various stakeholders including behavioral health providers, Medicaid recipients, and managed care plans, as well as other states in the country who offered managed care behavioral health and substance use services.

The Work Group examined various payment and delivery of services models that supported integration of mental health / substance use services with physical health.

[18] There were 45,029 Notifications of Readmissions in 2012. See New York State Behavioral Health Organizations 2012 Summary (rev. May 2013), http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-05-01_mrt_bh1_slides_resubmitted_5-7.pdf.

They also explored peer and managed addiction treatment services and integrating those concepts into the behavioral health managed care benefits package. The Work Group's Final Recommendations included:

- delivery of care should be coordinated and efficient;
- payment for services should be tied to patient / consumer outcomes;
- consumer input is critical;
- in-person care coordination for high-need users should be available;
- peer programs should be used to help engage patients and consumers;
- families should be integrated into care whenever possible;
- attention should be paid to social factors that influence individual behavior and outcomes, *e.g.*, employment and financial status; and
- housing resources need to be immediately available directly for timely use to avoid lengthy and repeat hospitalizations.

3. Proposed Behavioral Health Benefits Design

The Work Group concluded that behavioral health should be managed either by mainstream managed care plans that meet specific qualifications or, alternatively, act in partnership with BHOs or Health and Recovery Plans ("HARPs") which will be slated for individuals with significant behavioral health needs. Initial HARP eligibility will be determined by an individual's historic use of behavioral health services. Future eligibility will be based upon functional / clinical assessment and periodic review of historic utilization of services.

BHOs will contract with existing behavioral health providers and establish their own payment arrangements. Many of these providers will be small nonprofit community-based organizations that historically provide the majority of behavioral health care.[19]

In Phase 2, behavioral and physical health care will be managed by either mainstream managed care plans or HARPs. Both must meet the State's qualification review standards and offer the required services.

Qualified Managed Care Plans (mainstream managed care option)

- must meet standards developed by the State to operate services directly; if not, must partner with BHO that meets standards
- a Request for Qualifications ("RFQ") assessment tool went out to Medicaid Managed Care ("MMC") Plans in March 2014 (RFQ responses from NYC were due in June 2014)

[19] See The Medicaid Institute at United Hospital Fund, "Implementing Behavioral Health Care Reform in New York's Medicaid Program," (February 2012), http://www.uhfnyc.org/publications/880817.

  - Plans will demonstrate via the RFQ whether they have the expertise to administer full services for mental health and substance use disorder services for adults, either in a review will identify who qualifies as a MMC Plan, in partnership with a BHO, or by establishing a HARP
- include Medicaid covered services and those added to the State Plan such as:
  - inpatient mental health and substance use treatment,
  - psychiatric emergency treatment,
  - comprehensive recovery oriented program for persons with severe and persistent mental illness,
  - intensive psychiatric rehabilitation treatment,
  - targeted case management,
  - assertive community treatment,
  - continuing day treatment programs,
  - partial hospitalization, and
  - opioid treatment.
- coordinate behavioral health with physical health management
- set up performance metrics specific to behavioral health.

Health and Recovery Plans (HARPs)

- are qualified through the RFQ process (see above)
- are specialized health plans for people with significant behavioral health needs
- integrate health and behavioral health services
- include Medicaid covered services and those added to the State Plan (see above list)
- offer expanded recovery oriented services
- offer enhanced care coordination
- offer enhanced benefit package which includes services such as:
  - Crisis intervention (short-term and intensive),
  - Mobile crisis intervention,
  - Educational support services,
  - Case management,
  - Family support and training,
  - Non-medical transportation,
  - Employment support services,
  - Peer supports, and
  - Self directed services
- must have full time dedicated Behavioral Health Medical and Clinic Director.

Note: HARP-eligible adults will receive health home care coordination. DOH will work with MMC Plans and Health Homes to assist in this transition.

4. Timeline for Managed Care Implementation

The initial rollout called for all behavioral services to be incorporated in some type of managed care plan beginning in 2014. However, after the BHOs engaged in Phase 1 and Phase 2 of the review and with further feedback from the advocacy community, it became readily apparent that such a radical change and alteration to existing services could not be achieved so quickly. Additionally, the State must still obtain approval from CMS to implement these health delivery services changes. The new implementation dates are:

- January 1, 2015 – Implementation of Behavioral Health for Adults in NYC (HARP and non-HARP)
- July 1, 2015 – Implementation of Behavioral Health for Adults in the rest of state (HARP and non-HARP)
- January 1, 2016 – Implementation of Behavioral Health for Children statewide

The delay in implementation will allow the State to obtain additional feedback from community stakeholders and look at options for savings reinvestment to improve overall services for behavioral health populations (*e.g.*, housing).

Biographies

Rebecca Antar Novick is the Supervising Attorney of The Legal Aid Society's Health Law Unit. Rebecca was a Staff Attorney in the Health Law Unit from 2008 until 2013, and represents clients on issues including access to and navigation of public health insurance; health care benefit and service denials; reduction and elimination of medical debt; and long term care. Rebecca also provides technical assistance and training to community based organizations, health advocates, and legal services advocates across the state.

Rebecca is the Chair of the Medicaid Matters New York managed care workgroup and a member of the Medicaid Matters Steering Committee. She is actively involved in consumer advocacy efforts regarding significant changes to the Medicaid program as a result of state Medicaid Redesign efforts and federal health reform.

Rebecca received a B.A. in History of Science from Harvard University in 2000 and a J.D. from New York University School of Law in 2008. Before law school, Rebecca was a Senior Legislative Assistant for Congressman Rahm Emanuel, working on health care, education, and other social issues. Rebecca also worked as a Legislative Analyst at Jennings Policy Strategies, a health policy consulting and communications firm, and as a Research Associate at the Advisory Board Company.

Christine Chiu is a Staff Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI). Her work focuses on access to insurance and quality health care for immigrant and limited English proficient communities in New York State. Prior to joining NYLPI, Christine was at African Services Committee doing primarily immigration representation as a Kirkland & Ellis New York City Public Service Fellow. Christine is a 2011 graduate of NYU Law School. While earning her J.D., Christine worked at the U.N. International Criminal Tribunal for Rwanda, Platform for Labour Action – advocating for the rights of marginalized workers in Uganda, and the Door Legal Services – providing legal assistance to New York City youth. She also co-authored a report on discrimination against Muslim communities in post-9/11 counterterrorism policy.

Belkys García has been a staff attorney with The Legal Aid Society since 2007 representing low-income New Yorkers in accessing various government benefits. In the Health Law Unit she represents clients and engages in policy and legislative reform on issues regarding access to healthcare. She also provides trainings on eligibility, accessing care and due process rights within public health insurance and insurance affordability programs. Previously in The Legal Aid Society's Bronx Neighborhood Office she represented clients on appeals of denials of public assistance, food stamps, and disability benefits in administrative hearings, New York State Courts and US District Court. Belkys is a steering committee member of the Coalition to Protect the Rights of New York's Dually Eligible. She is an active member of the Medicaid Matters New York managed care workgroup. Belkys is a graduate of CUNY School of Law and The New School.

Geoffrey A. Hale is a Senior Health Law Attorney at the Empire Justice Center, where he has worked since 2009 on legal issues in health, health policy, and disability advocacy. His health work focuses primarily on Medicaid and Medicare, ensuring access to needed health care through a combination of direct client representation, administrative and legislative advocacy, and litigation. Together with co-counsel from the National Health Law Program, he brought federal litigation challenging service limitations in the New York Medicaid program. As the Medicaid Redesign continues to transform Medicaid beneficiaries' access to care, he continues to work with clients to challenge issues from faulty eligibility determinations to service denials and reductions through the Medicaid fair hearing process. In particular, much of his recent work has focused on helping clients challenge improper reductions in home care services by their Medicaid Managed Care and Managed Long-Term Care plans. In addition to client advocacy, Geoffrey also provides training, legal support, and technical assistance to health advocates throughout New York State and has presented at numerous state-wide conferences on health and disability issues. He is the lead attorney for Empire Justice on their role in Community Health Advocates, a statewide network of agencies supporting individuals facing difficulties accessing care through their insurance plans for both public and private programs purchased through the New York State of Health Marketplace. His policy work involves collaborating with various state-wide coalitions as well as working with partners at the New York State Department of Health and the Centers for Medicare and Medicaid Services to ensure that the dramatic changes of our health care system through the Medicaid Redesign and the Affordable Care Act continue to meet the needs New York's most vulnerable populations.

Geoffrey earned his law degree at the University at Buffalo; he also holds degrees from the University of California at Berkeley and the Johns Hopkins University.

Linda R. Hassberg is an attorney in the Long Island office of the Empire Justice Center. Empire Justice is the only statewide, multi-issue, multi-strategy non-profit law firm focused on changing the "systems" within which poor and low income families live. With a focus on poverty law, Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to local legal services programs and community based organizations. As an advocacy organization, Empire Justice engages in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a non-profit law firm, it provides legal assistance to those in need and undertakes impact litigation in order to protect and defend the rights of disenfranchised New Yorkers.

Ms. Hassberg is a senior staff attorney in the Long Island office of the Empire Justice Center. Her primary responsibility is impact litigation in the areas of public benefits, access to health care, and disabilities. She has filed class action lawsuits against both counties in Long Island challenging untimely eligibility determinations for benefits applications, due process violations, and failure to provide emergency assistance. In addition, she has represented clients at administrative hearings and in court seeking assistance with child support, Medicaid coverage,

day care benefits, and adequate emergency housing. She is an active member of the Long Island Language Advocates Coalition and chairs its Courts Committee.

Orier Okumakpeyi is a Staff Attorney at MFY Legal Services, Inc. serving people with mental illness and the elderly. Ms. Okumakpeyi specializes in health law, providing advice, brief services and full representation. She has conducted numerous trainings to lawyers, social workers and benefits specialists on issues of public health insurance benefits. Ms. Okumakpeyi also practices in the areas of housing, disability and general public benefits law. She received her B.A. from Carleton College and her J.D. from City University of New York School of Law. Before law school, Ms. Okumakpeyi worked as the Housing Director for Pathways to Housing, Inc., a scatter-site housing program for psychiatrically-disabled, homeless New Yorkers. She was responsible for managing the organization's 400+ apartments and working with case managers to assist clients to maintain their independent housing.

Carol Santangelo has been a Staff Attorney in the Legal Aid Society's Health Law Unit since 2002. Before that, she worked in the Society's Criminal Appeal's Bureau. Carol also holds a Master's Degree in Nursing and a Certificate in Bioethics and Medical Humanities. Carol is a steering committee member of the Coalition to Protect the Rights of New York's Dually Eligible and an active member of the Medicaid Matters New York managed care workgroup. She is a co-moderator of the Health Law Taskforce, and an active member of the New York City Bar Association's Mental Health Law Committee. In the Health Law Unit, Carol's practice includes representation of individual clients, health policy advocacy and technical assistance and training for legal services providers and community based health advocates. The Health Law Unit handles a wide range of cases involving issues with managed care organizations, Medicaid, Medicare, medical debt, and patients' rights including those of the un/underinsured and immigrants access to health care.

Rebecca Wallach is a staff attorney with the Evelyn Frank Legal Resources Program. She was awarded the Skadden Fellowship in 2012 for her advocacy of "dual eligibles," those who receive both Medicare and Medicaid because they are both aged, disabled or blind and have low incomes and limited financial resources. As a result of mandates requiring dual eligibles to access medical services through managed care plans, there is an increased need for such assistance. Rebecca graduated from CUNY Law School in 2012 as a Haywood Burns Graduate Fellow in Civil Rights and Human Rights. She participated in a CUNY Health Law Externship at Selfhelp Community Services, Inc. Rebecca has extensive experience working as a consultant with a public affairs firm, helping obtain governmental and private funding for HIV/AIDS, environmental, and immigration organizations and expanding access for free mammograms and breast cancer treatment through the Medicaid program in multiple states. She received her undergraduate degree from Wellesley College.