

Medicaid

Medicaid Matters New York

Matters

Managed Care Workgroup

MEDICAID MANAGED CARE FACT SHEET

The Personal Care Benefit

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Effective August 1, 2011, personal care/home attendant services provided to non-dual eligible individuals who are enrolled in Medicaid managed care will be the responsibility of the Medicaid Managed Care Organizations (MMCOs).

Consumers participating in Consumer Directed Personal Assistance Program (CDPAP) will not be affected by this change until July 1, 2012.

REGULATORY CHANGES AFFECTING PERSONAL CARE SERVICES

Under the terms of the revised Medicaid Managed Care/Family Health Plus Model Contract, the individual MMCO providers are now responsible for setting procedures and standards specific to personal care/home attendant services currently set by 18 NYCRR § 505.14.

Regulations governing Medicaid Managed Care Programs, enacted by the State's emergency rule making authority, repeal various sections of Title 18 NYCRR that contain managed care regulations and replace them with a new Subpart 360-10, which consolidates all managed care regulations in one place and makes them consistent with Section 364-j of the Social Services Law.

MANAGED CARE WILL CHANGE CONSUMERS' ACCESS TO PERSONAL CARE SERVICES

MMCO contractors are now responsible for determining the enrollee's need for personal care agency services, including the level of care needed (Level I or Level II) according to assessment tools *to be provided by SDOH* (in New York City, the M11Q is still in use until the Statewide Uniform Assessment Tool is released). Authorization solely for Level I services may not exceed eight hours per week.

MMCO contractors are now responsible for coordinating with the consumer's personal care agency to develop a plan of care.

MMCO contractors must provide case management services to enrollees receiving PCS and coordinate with appropriate local government programs to address social and environmental issues necessary to maintain health and safety in the home.

TRANSITION POLICIES AS OF AUGUST 1, 2011

Enrollees in receipt of PCS as of August 1, 2011 must be allowed to continue their course of treatment as authorized by the local social services districts, regardless of whether their home care provider participates in their MMCO's network, until the MMCO has assessed the enrollee's needs and an approved plan has been put into place.

For new enrollments after August 1, 2011, the MMCO must provide transitional care consistent with the Model Contract and the State Department of Health's Transitional Care Policy which provide that:

- Transitional care for new enrollees undergoing a course of treatment with a *participating* provider is required until the health plan's approved treatment plan is in place;
- Transitional care for new enrollees undergoing a course of treatment with a *non-participating* provider is required for a period of up to 60 days from the date of enrollment if the new enrollee: 1) has an existing relationship with a non-participating provider, 2) elects to continue to receive care from that provider, and 3) has a life threatening disease or condition or degenerative or disabling disease or condition.

DUE PROCESS RIGHTS

NOTICE

Service Authorization Determinations

Service Authorization Determinations are the MMCO's approval or denial of a Service Authorization Request.

There are two kinds of Requests:

1. **Prior Authorization Requests:** Requests for coverage of a new service, whether for a new authorization period or within an existing authorization period, before such service is provided.
2. **Concurrent Review Requests:** Requests for home health services following an inpatient admission or for continued, extended or more of an authorized service than what is currently authorized by the MMCO.

Determinations involving PCS must include the number of hours per day, number of hours per week, and the personal care service function (Level 1 or Level 2) authorized by the MMCO:

- That were previously authorized, if any;
- That were requested by the enrollee or their designee, if so specified in the request;
- That are authorized for the new authorization period, if any;
- The original authorization period and the new authorization period, as applicable.

Time Frames for Notice of Service Authorization Determinations

For Prior Authorization Requests

MMCO contractors must make Service Authorization Determination and provide notice to consumers by phone and in writing as fast as the enrollee's condition requires and no longer than:

- Within three business days of receipt of necessary information but no more than 14 days after receipt of the Service Authorization Request;
- Expedited reviews must be made within three business days.

For Concurrent Review Requests

MMCO must make Service Authorization Determination and notice enrollee of the determination by phone and in writing as fast as the enrollee's condition requires and no longer than:

- Expedited reviews must be made within one business day after receipt of necessary information but no more than three business days after receipt of request.

- In cases of requests for home health care services following an inpatient admission, determinations must be made one business day after receipt of necessary information except when the return date falls on a weekend in which case determinations must be made within 72 hours but in any event no longer than three business days.
- In cases of requests for continued, extended or more of an authorized service than what is currently authorized, determinations must be made within one business day but no more than 14 days after receipt of request.

Time frame for determinations may be extended up to 14 days upon request of the provider or enrollee, or where there is a need for additional information. Notice of extension must be documented by the contractor and must be provided to the enrollee.

Time Frames for Notices of Actions other than Service Authorization Determinations

When contractor intends to reduce, suspend, or terminate a previously authorized service within an authorization period, it must provide enrollee with a written notice at least ten days prior to the intended action.

An Action is an activity of an MMCO or its subcontractor that results in:

- the denial or limited authorization of Service Authorization, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- denial, in whole or part, of payment for a service;
- failure to provide service in timely manner as defined in regulation or Model Contract;
- failure of MMCO to act within timeframes for resolution and notification of determinations regarding complaints, grievances and appeals with reasonable promptness; or,
- denial of request for out-of-network service where there is only one participating MMCO.

Whenever a Notice of Action is issued the MMCO must notify enrollee in writing of:

- Action taken or intended;
- Reason, including clinical rationale;
- Right to file an appeal;
- Right to fair hearing, and procedures for exercising rights;
- Circumstances under which expedited review available and how to request;
- Right to aid continuing and how to request it;
- Timeframes for MMCO actions and grievances systems.

FAIR HEARING RIGHTS

The social services district must notify enrollee in writing of right to fair hearing and how to request a hearing where the district denies request for exemption, exclusion, enrollment, disenrollment, or to change MMCO.

An MMCO must notify an enrollee in writing of their right to a fair hearing and how to request a hearing whenever a notice of action is issued.

AID CONTINUING

Available when an MMCO or its approved utilization agent has terminated, suspended or reduced previously authorized treatment or proposes to do so, if:

- Enrollee has filed a request within 10 days of Notice of Action or grievance determination, or by intended date of Action, whichever is later; and

- There exists a valid order for the treatment or service from a participating provider; and
- Enrollee requests that benefits continue pending outcome of fair hearing; and
- Period of original service authorization has not expired.

If aid continuing is granted, benefits will be reinstated by MMCO until:

- Fair hearing request is withdrawn by enrollee or representative; or
- The time period or service limits of the previously authorized service have been met; or
- The participating provider order expires; or
- An adverse fair hearing decision is issued.

MMCO ACTION APPEAL PROCESS

Enrollee or designee will have no less than 60 business days and no more than 90 days from the date of the Notice of Action to file an in-plan Action Appeal.

May file orally or in writing, but oral must be followed by written, signed Action Appeal.

The MMCO must resolve the appeal as fast as enrollee's condition requires but no later than 30 days.

The MMCO must make reasonable effort to provide oral notice of determination when made, and must send written notice within two business days of determination.

Expedited Appeal must be resolved no later than three business days from date of receipt of Appeal.

ADVOCACY

If services are discontinued prior to reassessment, remind the plan of their obligation to provide continued services until a new plan of care is put in place, and contact the vendor to determine if they participate with the consumer's MMCO.

Register a complaint with the State Department of Health's Managed Care Complaint Line at (800) 206-8125.

Contact the NYS Department of Health Division of Managed Care (518) 473-1134.

Submit timely request for Fair Hearing with Aid Continuing. Since a Fair Hearing trumps an internal or external appeal of the plan's action, if you obtain a favorable decision in the review process you should withdraw the request for a Fair Hearing.

Under the Model Contract, it appears that aid continuing may not be available where adverse change occurs at the point of reauthorization. Since this conflicts with due process principles articulated in several federal court decisions, there is uncertainty as to what the MMCOs will actually do. The Legal Aid Society would like to be kept informed of these cases, so please send us an email at HLU@legal-aid.org.

The phrase "as fast as the enrollee's condition requires" is not defined in the regulations. Therefore, in cases where the condition warrants a prompt resolution, it would be helpful to include a statement from the enrollee's physician that speaks to the need.

Simultaneously file Appeal Action. Expedited review will result in faster resolution than FH or Appeal Action.