Medicaid Mandatory Managed Long Term Care: Observations from Consumer Viewpoint in First Year

New York Legal Assistance Group
Evelyn Frank Legal Resources Program
David Silva, Ass’ t. Director & Valerie Bogart, Director
(212) 613-7310 or eflrp@nylag.org
http://nylag.org
http://nyhealthaccess.org
Sept. 2013
Introduction

1. Background: What is MLTC? How does it compare to Medicaid and Medicare Managed Care programs?
2. Roll-out of Mandatory MLTC in NYS – Status
3. Nine Areas of Concern from Consumer’s View
Acronyms - Vocabulary

Dual Eligible = Someone who has Medicare & Medicaid

TYPES OF PLANS/ Agencies
- MLTC – Managed Long Term Care
- MA – Medicare Advantage or Medicaid Advantage (beware!)
- MAP – Medicaid Advantage Plus
- PACE – Program for All-Inclusive Care for the Elderly
- LDSS – Local Dept. of Social Services/ Medicaid program
- DOH – NYS Dept. of Health

Managed Care Concepts – in Dual Eligible plans
- Full Capitation – Rate covers all Medicare & Medicaid services (PACE & Medicaid Advantage Plus)
- Partial Capitation – Rate covers only certain Medicaid services – MLTC package of long term care services
More Acronyms!

**TYPES OF SERVICES**

- CBLTC - Community-Based Long-Term Care services
- LTC – Long Term Care generally
- PCS or PCA – Personal care services – Personal Care Aide
- CDPAP or CDPAS – Consumer Directed Personal Assistance Program
- CHHA – Certified Home Health Agency
- ADHC – Adult Day Health Care (medical model)
  - SAD – Social Adult Day Care
- PDN – Private Duty Nursing

**“Waiver” programs** – Home & Community Based Services (HCBS)

- Lombardi – Long Term Home Health Care Program
- TBI – Traumatic Brain Injury waiver
- NHTDW – Nursing Home Transition & Diversion Waiver
- OPWDD – Office of Persons with Developmental Disabilities Waiver
Part I

• Background – What is Managed Care?
• What are the different types of managed care in Medicaid and Medicare?
• Managed Long Term Care – the basics
  • Three kinds of plans offering Medicaid long term care to Dual Eligibles
  • Status of Implementation of Mandatory Enrollment
What is a managed care plan?

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

- Features of managed care:
  - Capitation rate = monthly premium
  - Provider network – must stay “in-network”
  - Utilization management – need Plan’s prior approval for certain services
  - Payor – may be Employer, Medicare, Medicaid paying the premium
  - Benefit package – which services covered depends on type of plan and who is payor
Managed care vs. Fee For Service (FFS)

- **Who does provider bill?**
  - FFS: They bill the payor -- Medicaid, Medicare or the private insurance company
  - Managed Care: They bill the managed care plan

- **What services does provider bill for?**
  - FFS: Providers bill and are paid for each service – more service, more money. But in Medicaid, some services require “prior approval” of local Medicaid agency.
  - Managed care: In some models, provider gets a “bundled” payment for a package of services, or for treating one patient for a certain period. Must get prior approval from plan for some services.

- Incentives – Govt. says FFS incentive to give too much care. Advocates say managed care incentive to give too little.
“Mainstream” Medicaid Managed Care (MMC)

• Has been in NYS for 20 years
• All counties now mandatory – just as of this year
• Now 3.44 million New Yorkers enrolled – 4/2013
• EXCLUSIONS from MMC –
  • All Dual Eligibles – anyone with Medicare. Only people with Medicaid-only are in these plans.
  • All people with a Spend-down/ surplus
  • Most other exemptions and exclusions eliminated since 2011
• LTC in Benefit Package – Until 8/2011, the only LTC service covered was short-term Certified Home Health Agency (CHHA). In 8/11, Personal Care and CDPAP now covered by Plans. Also Private Duty Nursing
Managed Medicare –

MEDICARE ADVANTAGE

Popular for Medicare beneficiaries in NYS – 1/3 of all on Medicare are enrolled (1 million out of 3 million).

Why appealing? Lower out of pocket Medicare costs

- Member just pays Part B premium, some charge additional premium
- Plan limits coinsurance - lower out-of-pocket costs
- No need for costly Medigap policies (minimum $150/mo)
- Trade-off is limited provider network, utilization controls

- Service Package – All Medicare services
  - May include Part D drugs, or if not, join separate Part D plan

- VOLUNTARY enrollment. Anyone may join but have lock-in
  - Annual enrollment period – locked in for year unless have Medicaid, some other exceptions, that allow changing plans mid-year
People with Medicare and Medicaid

- “Dual Eligibles” – about 600,000 in NYS
- For their MEDICARE – They have an option
  1. Medicare Advantage or
  2. “Original Medicare”
- For their MEDICAID – alternatives:
  1. Medicaid Managed care is NOT an option – they are EXCLUDED from these plans.
  2. Medicaid Fee for Service – most dual eligibles have a “regular” Medicaid card to receive Medicaid services
  3. THIS IS CHANGING!
     1. Managed Long Term Care is MANDATORY downstate for Medicaid long term care services (more later)
     2. New plans that combine Medicare and Medicaid – next slide
COMBO – Managed Care Plans that cover both MEDICARE & MEDICAID Services

- “MEDICAID ADVANTAGE” and PACE plans
  - These are Medicare Advantage Plans PLUS a Medicaid managed care plan in one - they manage, control and provide all (well sort of) Medicare and Medicaid services, include Part D drugs

- CONFUSING TERMINOLOgy –
  - “Medicare Advantage” covers only Medicare services but is available to people on Medicaid, as well as those on Medicare only but
    - “Medicaid Advantage” covers BOTH Medicare and Medicaid services!
  - Medicaid Advantage – Covers Medicaid EXCEPT LTC
  - Medicaid Advantage Plus (“MAP”) – Covers Medicaid INCLUDING LTC

- Voluntary enrollment – only about 3% of 600,000 duals statewide 7/2013-
  - PACE 4,996
  - Medicaid Advantage 9,891
  - Medicaid Advantage Plus 4,042
Primary Medical Care Included in MAP & PACE Plans

• Both PACE and MAP plans cover ALL Medicare and Medicaid services. Member must use providers in the plan’s network for all services.

• 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 plans are more a traditional insurance model. Plan contracts with various providers to provide care.
Managed Long Term Care

Managed Long Term Care is the next wave in the “managed care for all” mantra of State Government.

2011 – New State law requires MANDATORY enrollment in MLTC plans if one wants community-based long term care (home care) –

- Used to be a VOLUNTARY option.
- Grew out of MEDICAID REDESIGN TEAM (MRT)

9/2012 -- Federal govt. CMS approved “waiver” request”

9/2012 - Mandatory enrollment started in NYC – for those receiving or applying for personal care services

1/2013 – Started in Nassau, Suffolk & Westchester for personal care, CDPAP, and home health recipients
What is Medicaid Managed Long-Term Care?

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

**Managed (Care)**
- 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

**Long-Term Care**
- Home care
- Adult day care
- Physical therapy
- Nursing home
- SEE NEXT SLIDE
- NOT primary/acute/emergency care
Services authorized by MLTC – 
ALL are Medicaid services – No Medicare

- Home care:
  - Personal Care (home attendant a/k/a Level I personal care)
  - Consumer-Directed Personal Assistance Program (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

Above are partial capitation MLTC plans only. 
PACE, MAP include all primary and acute medical services
Services NOT covered by MLTC Partial Capitation Plans

- Primary Medical Care NOT part of MLTC
- MLTC partially capitated plans DO NOT provide primary, acute & specialty medical care, hospital inpatient or outpatient care, lab tests, prescription drugs
  - except for 4 specialties (audiology, dental, optometry, podiatry)
- MLTC Members use their ORIGINAL MEDICARE or MEDICARE ADVANTAGE or Medicaid cards for these services
Who *must* join an MLTC plan?

- Dual eligibles (must have Medicare & Medicaid)
- Living in “mandatory” counties – so far, NYC, Long Island, Westchester; later in 2013 - Rockland, Orange – Albany, Erie, Onondaga and Monroe
- Age 21 or older; and
- Receiving or need Medicaid Community-Based Long-Term Care services for >120 days in a calendar year
  - Personal care and Consumer-Directed Personal Assistance - CDPAP
  - Certified Home Health Agency services (CHHA)
  - Adult Day Health Care (medical model)
  - Lombardi Waiver (Long-Term Home Health Care) (since 4/1/13)
  - Private-Duty Nursing

Who does *not* have to join MLTC plan?

- **Don’t have Medicare** (not a dual eligible) (but MAY enroll if need home care and would otherwise qualify for nursing home care)
- **Under 21** (but MAY enroll if over 18)
- **Live outside mandatory counties** – Even if over 21 and have Medicare, if they need home care, they get it the way they always did
  - Local DSS -- for Personal care & Consumer-Directed Personal Assistance
  - State Dept. of Health -- for Private duty nursing services
  - Adult day care or Certified Home Health agency-apply directly to program
  - May voluntarily enroll in MLTC, PACE, or MAP
- **Those Excluded from Mandatory MLTC even in mandatory county:**
  - In Traumatic Brain Injury or Nursing home Transition & Diversion waiver
  - Have hospice care
  - In OPWDD waiver
Who does not have to join MLTC -2

- One criteria for eligibility is that person must need Community-Based Long Term Care (CB-LTC) services for > 120 days.
- State has recently changed the definition of who “needs” CB-LTC so that MLTC plans don’t cherry-pick low-need people.
- People who need ONLY “Social Adult Day Care” (SADC) are not eligible for MLTC if they don’t need personal care or other LTC service too. See more later.
- People who need an aide to only do “Housekeeping” and not assistance with Activities of Daily Living are not eligible for MLTC. In 8/2013 – State required MLTC plans to disenroll them and send them back to local DSS.*

* See MLTC Policy 13.21 posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
Affected Clients: LTC/ Medicare Options

Duals receiving Community-Based LTC

- MLTC *
- Medicaid Advantage Plus (MAP)
- PACE

+ Medicare Advantage or Original Medicare

• Client will be assigned to MLTC – NOT MAP or PACE - if no selection made.
Status of MLTC Implementation

- **Phase I-2** - NYC, Westchester, Suffolk, and Nassau -- Since Jan. 1, 2013 (since 9/2012 in NYC) – Managed Long Term Care (MLTC) is the only way to obtain new personal care, CDPAP, private duty nursing for adults > 21 with Medicaid AND Medicare, unless exempt
  - Current recipients of PCS, CDPAP, CHHA, ADHC, PDN, & Lombardi are receiving mandatory notices to enroll within 60 days or be assigned to MLTC plan
- **Phase III** (scheduled June 2013 but still delayed as of 8/27/13): Rockland and Orange counties
- **Phase IV** (December 2013): Albany, Erie, Onondaga and Monroe counties
- Front door is CLOSED to new Lombardi/LTHHCP applicants **STATEWIDE** who do not have Medicare (non-duals)
New Applicants for Home Care in Mandatory MLTC Counties

• All new applicants age 21+ for PCS, CDPAP, and Lombardi are being redirected in mandatory counties to enroll in MLTC plan – after they apply for and are approved for Medicaid

• New applicants seeking CHHA, Private-Duty Nursing, and Adult Day Health Care may still enroll directly with those providers “front door” still open.. But will close.

• Lombardi – CMS just approved mandatory enrollment after 4/1/13.

Current home care recipients in mandatory counties – Timeline of transition to MLTC

1. “Announcement” letter from DOH mailed to all personal care, CDPAP, CHHA, private duty nursing, adult day recipients

2. 30 days later – NOTICE from NY Medicaid Choice (Maximus) giving 60 days to select an MLTC plan, with option of picking MAP or PACE

3. SELECT & Enroll in PLAN –
   1. Find out which plans contract with preferred providers:
      • If MAP/PACE, must consider ALL providers
      • If MLTC, must consider home care agency, adult day program, podiatrist, dentist, etc.
   2. Call plans to schedule home visit for assessment – how much care?
   3. Enroll with plan or NY Medicaid Choice by deadline

4. Randomly assigned to MLTC plan if don’t enroll -- not to MAP or PACE
Confusion!

- How many insurance cards does client need if has Medicare and Medicaid?
- The next slides show the possible combinations
Combination Example 1

- Dual Eligible with Original Medicare and MLTC

**Medicare**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY:
JANE DOE

MEDICARE CLAIM NUMBER:
000-00-0000-A

SEX:
FEMALE

IS ENTITLED TO:

HOSPITAL (PART A):
07-01-1986

MEDICAL (PART B):
07-01-1986

**MedicareRx Plans**

RxBIN 610014
RxPCN 610014
RxGRP XYZRX1
ISSUER (XYZRX1)
MEMBERSHIP ID NAME
0123456789-1 John Q. Public

**SeniorHealthChoiceWell-PlusCare**

MLTC Plan
John Doe
Member ID: 123456ABC

**Medigap**

Plan F
John Doe
Member ID: 123456ABC
Combination Example 2

- Dual Eligible with Medicare Advantage and MLTC

**MediChoice**
Options Plus
Medicare Advantage
w/MedicareRx
John Doe
Member ID: 123456ABC

**SeniorHealthChoiceWell-PlusCare**
MLTC Plan
John Doe
Member ID: 123456ABC
Combination Example 3

- Dual Eligible with Medicaid Advantage Plus (MAP)

**MediChoice Options**
**Plus Complete**
Medicaid Advantage Plus (Dual-SNP)
John Doe
Member ID: 123456ABC

**Warning:** Many MAP plans do not call themselves “MAP;” they say Medicare Advantage Special Needs Plan for Duals (Dual-SNP). All MAPs are Dual-SNPs, but not all Dual-SNPs are MAPs!
Everyone else – options

- **Duals not receiving CBLTC**
  - Regular Medicaid
  - Medicare Advantage or Original Medicare

- **Medicaid only**
  - Medicaid Managed Care is mandatory. PCA is included
Part II – Problems in Implementation

1. No “Conflict-Free” Eligibility Determinations
2. Other Barriers to Enrollment – Coding, etc.
3. Continuity of Care – Keeping your aide
4. Transition – Plan must Grandfather in Past Services for 90 Days, appeal rights if plan reduces on Day 91
5. Appeal rights jeopardized if plans reduce services over time
6. Arbitrary standards for determining need and hours
7. Plans not processing requests for new or increased care
8. Excess Nursing Home Placement
9. Reporting and State Oversight
10. Consumer-Directed Personal Assistance
11. Spend-down problems
Issue 1: No “Conflict-Free” Eligibility Determinations – Hurt high-need users

- New applicants for home care who have Medicaid must contact MLTC plans individually, or be referred to one by NY Medicaid Choice.
- The PLANS, not HRA/DSS or any other entity, decide if the client is eligible for home care:
  - whether needs LTC > 120 days,
  - Whether capable of remaining in the home without jeopardy to health/safety,
  - Whether has someone to “direct” care if not self-directing)
- Plan has incentives to deny eligibility to clients who would need a lot of care or who are complicated – including those with dementia & other mental impairments.
Conflicted assessments –
Impact on High-Need Clients

- High-need MLTC client can’t transfer to Personal Care or CHHA. MLTC is only game in town.
- Pretexts for denying/discouraging enrollment –
  - You need family to cover night-time care.
  - We can’t give 24-hour care / our budget doesn’t allow.
  - You aren’t safe at home.
  - You need family to be a “backup” i.e. supplement care
  - We’re not right plan for you.
- Recourse if denied enrollment – No appeal rights if not yet an enrollee! Client has to shop around to find a plan to accept her – over 20 plans in NYC alone!
State tackles plan behavior in turning away high need people

- Advocates brought this problem to DOH attention, as reported in New York Times on May 1, 2013.
- On May 8, 2013, DOH released MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care* which attempts to bar plans from discouraging prospective members from enrolling.

  “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.”

- Will this work? Can DOH monitor compliance? Still no right of appeal.

Flip Side Result of No Conflict-Free Assessment – Social Adult Day Care scandal

• Incentive to enroll low-need people led to Social Adult Day Care (SADC) scandal – people recruited from Senior Centers to SADC centers with enticements of cash, coupons, free transportation, 2 meals. Though don’t actually need Long Term Care. Profits for MLTCs and SADC’s.

• Next slide shows total # receiving all CB-LTC increased by 20,000 from April 2012 to April 2013 in NYC – almost 25%. Can this huge growth be explained by increased need? Or by MARKETING to recruit low-need people.
  • Medicaid fraud?
  • How reduce spending if people NOT needing or eligible for long term care now folded into population?
# Snapshot enrollment growth - MLTC

<table>
<thead>
<tr>
<th></th>
<th>April 2012</th>
<th>April 2013</th>
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<tbody>
<tr>
<td><strong>NYC</strong></td>
<td></td>
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<tr>
<td>PCS*</td>
<td>37,900</td>
<td>16,315</td>
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<tr>
<td>MLTC</td>
<td>44,527</td>
<td>82,985</td>
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<tr>
<td>MAP/PACE</td>
<td>4,558</td>
<td>6,736</td>
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<tr>
<td><strong>Total</strong></td>
<td>86,985</td>
<td>106,036</td>
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<tr>
<td><strong>Nassau</strong></td>
<td></td>
<td></td>
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<tr>
<td>MLTC</td>
<td>568</td>
<td>1,205</td>
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<tr>
<td><strong>Suffolk</strong></td>
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<tr>
<td>MLTC</td>
<td>487</td>
<td>898</td>
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<tr>
<td><strong>Westchester</strong></td>
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<tr>
<td>MLTC</td>
<td>114</td>
<td>925</td>
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<tr>
<td><strong>Rest of State outside NYC total</strong>*</td>
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</tr>
<tr>
<td>PCS</td>
<td>19,729</td>
<td>19,516 (12/2012)</td>
</tr>
<tr>
<td>MLTC</td>
<td>2,318</td>
<td>4,810</td>
</tr>
<tr>
<td>MAP/PACE</td>
<td>1,631</td>
<td>1,709</td>
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Adult Day Care scandal -- con’d

• FALLOUT – April & May 2013
  • **Bronx Assemblyman arrested** for taking bribes from SADC operator
  • **Suspension of VNS Choice** 4/24/13 – largest MLTC plan in State - has 20,111 out of 92,488 in ALL MLTC plans (4/2013). In 6 counties (4 mandatories + Rockland, Dutchess)
  • **State issues Directives 13.05 and 13.11*** – Needing SADC not enough to qualify for MLTC – must need some home care. Plans required to re-assess eligibility of members to make sure they really need LTC. But – again, plan is doing that assessment and has a conflict of interest.

*All DOH directives, contracts etc. posted on [http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm)
Issue 2: Other Barriers to Enrollment

- Enrollment is effective only on the FIRST of any month. If accepted for Medicaid on the 2nd of a month, earliest could enroll in a plan is the 1st of the following month.
  - No mid-month pick-up dates
- To activate enrollment requires computer data exchange and entries by local DSS/Medicaid and by MLTC plans - - must be entered by the 15th of the month BEFORE enrollment.
  - If sign up with plan on the 20th of May, already too late for enrollment for June 1st. Have to wait for July 1st.
- Many delays due to coding issues –next slide.
Issue 2: Barriers to Enrollment – Coding Issues

- For new Medicaid applicants, and even for current recipients, enrollment in MLTC is often held up by mysterious “coding issues” apparently stemming from NY’s antiquated Medicaid computer system
- Community Medicaid but no Long-Term Care (because attested to resources)
- SPEND-DOWN - Medicaid approved but inactive because spend-down not met
  - NYC created a *provisional coverage* code 06 to prevent this
  - Plans wrongly tell applicants they must pay-in their spend-down to activate coverage and/or refuse to evaluate applicants unless they do so; this often leads to many months of paying-in when no services are being provided
- Medicaid active but has nursing home, Lombardi, or other mysterious code preventing enrollment
Issue 3 – Continuity of Aides

• Can client keep the aide she had from before – when received personal care from DSS/CASA? Or same visiting nurse she had before from a certified home health agency?

• Home care agencies and other providers must be IN-NETWORK in plan.

• To promote continuity, DOH requires all MLTC plans to contract with all home care agencies that were under contract to provide personal care in NYC, Nassau, Suffolk, Westchester, Orange & Rockland DSS if agency willing to accept past DSS rate. See **MLTC Policy 13.04 - Personal Care Contracting Policy** plus **MLTC Policy 13.12, 13.22.** MLTC plans do NOT have to contract with other home care agencies.
  • File complaints about MLTC plans that won’t contract with a vendor in order for the client to keep her aide with DOH: (866) 712-7197

These requirements end 12/31/13 (or 3/1/14)- WHAT HAPPENS Then? Plans will likely reduce the rates paid to the home care agencies that join their networks, causing reductions in wages and benefits. Aides will quit/disruption/reduced quality in care.

*Posted on http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
Issue 4: Transition Requirement – Grandfathering in Past Services

- Plans must continue previous level of and amount of services for 90 days or until the plan’s new assessment, whichever is LATER. [http://wnylc.com/health/news/41/](http://wnylc.com/health/news/41/)

- This was an increase from 60 days originally required. May 8, 2013– DOH Policy 13.10

- Includes personal care, CDPAP, private duty nursing, adult day care

- What happens on Day 91?
What happens AFTER 90-day Transition?

What are Appeal Rights?

- At end of 90-day period, Plan may reduce services from what the DSS/CASA/CHHA authorized--
  - Must give advance written notice explaining appeal rights.
  - Signing “Plan of Care” doesn’t mean client waives appeal rights! Plan must still give Notice if reduces services or hours.
  - Must give “Aid Continuing” if client appeals – continue services in the same amount as PREVIOUSLY authorized while an internal appeal, and then a hearing is held and decided about a PROPOSED reduction in services.
  - NEW – INTERNAL APPEAL – In MLTC, client must first request an Internal Appeal within the Plan. Only if she loses that may she request a state fair Hearing.

See APPEALS section and http://www.wnylc.com/health/entry/184/.
Issue 5: Appeal Rights when Plan Reduces Services Later – after Initial Transition

- Member has right to appeal an initial reduction of services after transitions from DSS/CASA/CHHA, with Aid Continuing pending appeal.

- Post-Transition
  - For all subsequent changes, aid continuing only goes through the end of the current authorization period (litigation to come).
  - Ex. MLTC plan authorizes 24 hour/day care for six months ending 12/31/13. Effective Jan. 1, 2014 it reduces care to 8 hours/day. Plan must give notice of reduction with appeal rights but does not have to provide Aid Continuing.

Issue 6: Inconsistent and arbitrary standards for amount of home care

- Managed care plans are supposed to use the same standards to determine medical necessity as are used by Medicaid outside of Managed Care.
- There has been **NO CHANGE** in the amount or type of services available under MLTC versus under PCA/CHHA.
- Plans use a uniform instrument to assess function (now SAAM, soon the UAT – Uniform Assessment Tool), but this does not determine the number of hours. Plan uses its own “tasking tool.”
- Plans apply arbitrary limits, such as no 24/hour care if not bedbound.
Issue 6 con’d. Standards for authorizing amount of hours

- MLTC plans must be required to follow rules established for personal care through litigation, e.g.,
  - 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

Issue 7: Failure to process requests for new or increased services

- Federal and state regulations, and the plans’ contracts, provide strict time limits for the plans to process requests for increases in hours, or for new services (range from 3-14 days – must be expedited if health in jeopardy)*

- Consumers are seeing not only delays, but failure to process these increases altogether – care manager never passes the request on to the appropriate personnel, etc.

- Consumers not receiving notices of appeal rights when these requests are denied

*Rules on prior authorizations and concurrent reviews, posted at http://www.wnylec.com/health/entry/114/#new%20service%20requests
Issue 8: Excess Nursing Home Usage

- Nursing home care is a covered service in MLTC.
- Can plans simply place someone in a NH? Advocates say no!
- Wide variation among MLTC plans in rate of NH admission
- People with high-hour needs, or who are difficult to serve due to dementia, etc. are at risk of NH placement
- The whole point of including NH care in the package is to incentivize plan to give more care at home and avoid the high cost of NH care. But.. MLTC plans can “game the system” – if they have small networks of undesirable nursing homes, push client to reject those choices and disenroll from plan. Now plan no longer has a high-need member!
Issue 9: Reporting and State Oversight

• With State budget deficit, and pressure to cut administrative costs, State Health Dept. lacks staff to monitor plans adequately, collect and analyze data on quality and monitor avoidable institutionalization. State asked for $$ in waiver request for staffing.

• GOOD PART OF CMS Approval of Waiver – 9/2012—“For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in [24-hour/day] services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions.”

• State delayed in requiring plans to report this data – finally reported for November 2012 – April 2013 – posted in August 2013 on MRT 90 page.

• Low numbers – advocates question validity

http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08_partnership_amendment_stc.pdf p. 17
Reporting and State Oversight

- INSUFFICIENT quality data reported by MLTC plans
  - Reporting not sufficient re quality of life measures, ability to perform ADLs, incidence of falls, prevention of bedsores, falls and other adverse outcomes, and nursing home placement.
  - Plans have authority to deny community-based services and require placement in nursing home. No outside oversight of these determinations.
  - Timeliness of plans’ assessments and initiating care
  - Where quarterly reporting by plans does exist - “MMCOR” data - State lacks staff or initiative to analyze and follow up on data, e.g.
    - disparity among plans in amount of home care authorized,
    - rate of nursing home placement varies among plans.
Reporting & Oversight Con’d.

  • Bonus for enabling people to leave nursing homes
  • Pay higher rates for keeping high-need people home and avoiding nursing home placement
• State issued Report on MLTC in 2012 – In April 2013, Consumer Advocates issued a critique -- New York’s 2012 Managed Long Term Care Report: An Incomplete Picture – State’s report selectively omits data showing concerns or weaknesses, and omits any data at all about how much services plans are providing – how else assess if Medicaid dollars well-spent?
  • Posted at http://www.wnylc.com/health/download/401/
Issue 10: CDPAP

- **Consumer Directed Personal Assistance** Program – All MLTC and Medicaid Advantage Plus plans must offer this option as of November 1, 2012.

- Plans have been slow to contract with existing CDPAP fiscal intermediaries as required under “continuity” policy” – and their staff not trained to understand CDPAP.

- CDPAP has inherent conflict with “managed care” – as it is not a medical model. Unclear whether MLTC plans, which are inherently medical/nursing model, will understand CDPAP and honor consumer choices

- See more concerns in advocates letter to DOH 05/2011, 3/12 and 12/11

See more on CDPAP at [http://wnylc.com/health/entry/40/](http://wnylc.com/health/entry/40/)
Issue 11 - Spend-Down

• One difference between PCA/CHHA and MLTC
  • Many PCA and CHHA clients failed to pay their full spend-down (because they couldn’t afford to)
  • Although it was a legal debt for which the home care agency could sue, the agencies were prohibited from discontinuing services due to non-payment
• MLTC plans **MAY** disenroll a member for non-payment of the spend-down! In their contract.
  • One more reason to help clients enroll in pooled income trusts
• ISSUE: Under federal regulations, medical expenses need only be incurred that meet the spend-down – do not have to be paid. How can an MLTC plan disenroll member?

http://wnylc.com/health/entry/176/
Other Advocacy Concerns

- **Case Management** – will it be more than limiting hours? Will it actually coordinate medical care, ensure access to transportation, other MLTC services?

- **Disability literacy** – understanding needs of people with disabilities, eg. Wheelchair fitting & authorization, “dignity of risk”.

- **Capacity** – Plans now have nearly 100,000 members, enrollment exponentially growing. Can they do it?

- **Medicaid applications and recerts** – How ensure home care not disrupted when glitches in recertifications?

- **See more** in advocates letter to DOH, 5/2011*

http://www.health.ny.gov/health_care/managed_care/appextension/ (under Public Comments)
Contact numbers & Other Info

- **New York Medicaid Choice** (Enrollment Broker)  **1-888-401-6582**
  - Dedicated Advocacy Complaint Number  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
  - [http://www.nymedicaidchoice.com/program-materials](http://www.nymedicaidchoice.com/program-materials) - Scroll down to *Long Term Care plans* - separate lists for NYC, Nassau-Suffolk, and Westchester, with separate list for each of the 3 types of plans - MLTC/MAP/PACE
  - [http://tinyurl.com/MLTCGuide](http://tinyurl.com/MLTCGuide)

- **NYS Dept. of Health MLTC Complaint Hotline**  **1-866-712-7197 and cc mltcworkgroup@health.state.ny.us**

- Related online articles on [http://nyhealthaccess.org](http://nyhealthaccess.org):