Mandatory Managed Long-Term Care

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Visit our website at http://nyhealthaccess.org
What is Medicaid Managed Long-Term Care?

- **Medicaid** – the public health insurance program for the poor
  - Federal and State funded, operated by the State

- **Managed Care** – a type of health insurance
  - Private health insurance company paid a fixed amount *per capita* to pay for all covered services ("capitation")

- **Long-Term Care** – health care services that help people with disabilities and the elderly with activities of daily living
  - Home care, adult day care, physical therapy, nursing home, etc.
Why are we talking about this?

The 2011 N.Y. budget law included a provision authorizing the Department of Health to seek the necessary Federal waivers to require all Medicaid recipients age 21 and older who require community-based long-term care services for more than 120 days to receive such services through a Managed Long-Term Care plan or other coordinated care model.

Why are we talking about this?

Translation:
The privatization of Medicaid home care in New York state.

Old System

New System

[Images and logos of various organizations]
Old System

**Federal**
- Centers for Medicare & Medicaid Services (CMS)
- Pays 50% of cost
- Federal statute, rules, guidance and State Medicaid Plan

**State**
- N.Y. State Department of Health (DOH)
- Pays about 45% of cost
- State statute, rules, guidance

**County**
- County Dep’t of Social Services (DSS) / NYC Human Resources Admin. (HRA)
- Pays about 5% of cost
- Determines eligibility, prior approval for services, administers program, contracts with providers

**Providers**
- Paid Fee-For-Service (hourly rate for home care services) by DSS / HRA
New System

**Federal**
- Centers for Medicare & Medicaid Services (CMS)
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**State**
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- Pays about 45% of cost
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**Managed Care Plan**
- Private Managed Care Organization is paid predetermined amount per member per month (PMPM)
- Plan is at risk for all medically necessary care within benefit package
- Plan decides what is medically necessary; contracts with providers

**Providers**
- Paid Fee-For-Service (hourly rate for home care services) by plan
Managed Care vs. Fee for Service

The government wants to end Fee-for-Service in both Medicaid and Medicare.

1. **FEE FOR SERVICE** – like American Express card
   - Original Medicare or regular Medicaid
   - Client uses **any provider** that accepts Medicare or Medicaid – not limited to any network
   - Provider bills insurance (Medicare or Medicaid) directly
   - Some services require “prior approval” but many don’t – if doctor prescribes, insurance pays

2. **MANAGED CARE** – like having a MACY’s card only
   - Medicare Advantage or mainstream Medicaid Managed Care
   - Providers must be **in-network**, services & specialist referrals must be approved by a Primary Care Provider (PCP)
   - Provider bills managed care company, not Medicare or Medicaid. If client went out of network, provider may not get paid
Medicaid Redesign
(and other recent developments)
## Brief History

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1965</td>
<td>Medicare and Medicaid created</td>
</tr>
<tr>
<td>1990</td>
<td>PACE formally established (Medicare + Medicaid + LTC)</td>
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<tr>
<td>1991</td>
<td>Medicaid managed care began in NY (mandatory)</td>
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<tr>
<td>1997</td>
<td>Medicare managed care (Medicare Advantage) began (voluntary)</td>
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<tr>
<td></td>
<td>MLTC began in NY (voluntary)</td>
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<tr>
<td>2011</td>
<td>Medicaid Redesign initiatives made law in NY</td>
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<tr>
<td>2012</td>
<td>MLTC made mandatory for duals in NY</td>
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<td></td>
<td>Medicaid Advantage mandatory for duals in NY with corresponding Medicare Advantage plan</td>
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Medicaid Redesign

- Mandatory MLTC for all dual eligibles receiving community-based long-term care services
- Carve-in of personal care services to Mainstream Medicaid Managed Care benefit package (affects only non-duals)
- Gradual phase-out of most exemption/exclusion categories for Mainstream Medicaid Managed Care (again, only affects non-duals)
- New regulations managing high-hour personal care cases
- Housekeeping capped at 8 hours/week (instead of 12 hours/week)
- And about 200 other Medicaid changes...

http://www.health.ny.gov/health_care/medicaid/redesign/
CHHA Reimbursement Cuts

- Certified Home Health Agencies (CHHA)
  - CHHAs provide primarily short-term home care through Medicare, in concert with skilled nursing / rehabilitation services
  - Medicaid also covers CHHA, but can be long-term and without skilled needs

- 2009 Budget Law
  - Change from fee-for-service to episodic payment system
  - Instead of paying by the hour, Medicaid pays a fixed amount based upon patient’s medical condition and other factors

- In April 2011, preliminary per-patient cap went into effect, causing CHHAs to lose money on all high-hour cases
  - Result: CHHAs scrambled to dump these costly patients
Feldman v. City of New York

- False Claims Act suit brought by whistleblower medical reviewer, alleging that NYC committed Medicaid fraud by authorizing 24-hour personal care for certain elderly clients
  - “Fraud” allegations stemmed from City’s failure to comply precisely with certain State regulations governing assessments and reassessments
  - U.S. DOJ joined suit, claiming tens of millions of dollars in damages
- NYC settled for $70m; $14.7m to whistleblower
- Consumers lose
  - NYC personal care program purges virtually all 24-hour cases, claiming “mistake” in prior authorization, even with no improvement in patient’s condition
Types of Managed Care
Types of Managed Care Plans

- Managed Long-Term Care
  - Partially-Capitated MLTC
  - Program of All-inclusive Care for the Elderly (PACE)
  - Medicaid Advantage Plus (MAP)

- Other Managed Care
  - Medicare Advantage
  - Mainstream Medicaid Managed Care (MMC)
  - Medicaid Advantage
Two general types of MLTC plans in NYS

1. Most managed long term care plans are “partially-capitated” – the benefit package is solely Medicaid-only long-term care services and limited other health services – not all primary care. List follows.

2. “Full Capitation” – includes all Medicaid AND Medicare services – primary care, acute, hospital, behavioral and long term care services in the benefit package.
   a. Program of All-Inclusive Care for the Elderly (PACE)(Age 55+)
   b. Medicaid Advantage Plus (MAP or MAPlus)(Age 18+)
Services authorized by MLTC

- Personal Care (home attendant)
- Consumer-Directed Personal Assistance Program (CDPAP)
- Home Health Aide (CHHA)
- Adult day care, PERS, home-delivered meals
- Medical equipment, supplies, prostheses, orthotics, hearing aids, eyeglasses, respiratory therapy
- Home modifications
- Podiatry, Audiology, Dental, Optometry
- Non-emergency medical transportation
- Nursing home

Above are partial capitation only. PACE, MAPlus include more primary and acute medical services
## Comparison of Three Types of MLTC

<table>
<thead>
<tr>
<th></th>
<th>PACE (full capitation)</th>
<th>MAPlus (Full capitation)</th>
<th>Partial Capitated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurance</strong></td>
<td>Medicare &amp; Medicaid</td>
<td>Medicaid only</td>
<td></td>
</tr>
<tr>
<td><strong>Services Managed</strong></td>
<td>All Medical + Long Term Care</td>
<td>LTC only + dental, podiatry, audiology, DME</td>
<td></td>
</tr>
<tr>
<td><strong>Non-NYC</strong></td>
<td>6 plans 1,206 members</td>
<td>2 plans 307 members</td>
<td>7 plans 2174 members</td>
</tr>
<tr>
<td><strong>NYC</strong></td>
<td>2 plans 2,830 members</td>
<td>8 plans 1364 in NYC</td>
<td>10 plans 37,313 in NYC</td>
</tr>
</tbody>
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## Current Enrollment
Partial-cap MLTC Plans NYC

<table>
<thead>
<tr>
<th>Name</th>
<th>12/11 Enrollees</th>
</tr>
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<tbody>
<tr>
<td>VNS CHOICE</td>
<td>9,893</td>
</tr>
<tr>
<td>GUILDNET</td>
<td>6,357</td>
</tr>
<tr>
<td>ELDERPLAN</td>
<td>4,711</td>
</tr>
<tr>
<td>SENIOR HEALTH PARTNERS</td>
<td>3,353</td>
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<tr>
<td>CCM SELECT</td>
<td>3,337</td>
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<tr>
<td>ELDERSERVE</td>
<td>3,238</td>
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<tr>
<td>INDEPENDENCE CARE SYSTEMS</td>
<td>1,929</td>
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<tr>
<td>WELLCARE</td>
<td>1,846</td>
</tr>
<tr>
<td>AMERIGROUP</td>
<td>1,415</td>
</tr>
<tr>
<td>HHH CHOICES</td>
<td>1,234</td>
</tr>
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</table>
Partially-Capitated MLTC

Eligibility
- Community Medicaid w/LTC
- Age 18+
- Requires community-based LTC services (no longer required to have nursing home level of needs)
- Although only mandatory for duals, Medicaid recipients without Medicare may enroll

Enrollment
- Must already have active Community Medicaid w/LTC coverage
- Enrollment takes effect first of the month; never retroactive
- Can enroll directly with plan or via Maximus (NY Medicaid Choice)
Partially-Capitated MLTC

Assessment
- Plan conducts assessments for type/level of services, not the local district
- Currently all plans use a computerized standard assessment tool called SAAM (Semi-Annual Assessment of Members)
- Due to another initiative of Medicaid Redesign, all plans will eventually transition to a new standardized Uniform Assessment System (UAS-NY)
- No M-11q; procedural requirements of 18 N.Y.C.R.R. §505.14 no longer apply
- Request for services or increase may commence with as little as a phone call from physician
Partially-Capitated MLTC

- Appeal Rights
  - N.Y. Public Health Law governing Managed Care Organizations provides various appeals:
    - Grievance
    - Internal Appeal
    - External Appeal
    - Fair Hearing
  - Standards governing assessments
    - Federal law requires MCOs to make services available to same extent as fee-for-service Medicaid
    - Contract with State provides that covered services may not be defined more restrictively than fee-for-service Medicaid
Partially-Capitated MLTC

- Appeal Rights
  - Aid Continuing
    - Federal regulations governing Managed Care Organizations provides for aid continuing in narrower circumstances than currently provided under fee-for-service Medicaid
    - Plans are not required to provide aid continuing past the end of the current authorization period for services
    - Furthermore, settled law (Mayer v. Wing) regarding the local agency’s burden of proof on reductions/terminations may not apply to MCOs when authorization period expires
    - This policy raises Constitutional due process concerns (see Goldberg v. Kelly), yet to be litigated
Program of All-inclusive Care for the Elderly (PACE)

- Started as an innovative pilot in the 1970s, and later incorporated into Medicare law and expanded to sites throughout the country
- Fully-capitated: includes all Medicare-covered services and all Medicaid-covered services, including LTC
- Age 55+
- Must be dual eligible and nursing home level of needs
- Population required to enroll in MLTC may choose to enroll in a PACE, but nobody will be forced into a PACE
Medicaid Advantage Plus (MAP)

- Medicaid Advantage is like a combination of three plans:
  - **Medicare Advantage** – all Medicare-covered services
  - **Mainstream Medicaid Managed Care** – non-LTC Medicaid
  - **Managed Long-Term Care** – Medicaid LTC

- Age 18+
- Must be dual eligible and nursing home level of needs
- Population required to enroll in MLTC may choose to enroll in a MAP, but nobody will be forced into a MAP
- Anyone who wishes to enroll must first enroll in the company’s Medicare Advantage product
Medicare Advantage

- Managed care version of Federal Medicare program
- Voluntary under Federal law
- Includes all Part A and B covered services, and usually also Part D (drug coverage)
- No long-term care (because Medicare covers no LTC)
- Some additional services (dental, vision, hearing)
- Duals with Medicare Advantage can get their Medicaid in the following ways:
  - Fee-for-service Medicaid
  - Partial-cap MLTC (even different company)
  - Medicaid Advantage (if same plan offers)
  - Medicaid Advantage Plus (if same plan offers)
Mainstream Medicaid Managed Care (MMC)

- Managed care version of Medicaid program
- Mandatory for most Medicaid recipients
  - Few exemptions remain
- Historically did not include LTC services
  - Now includes personal care services due to carve-in under Medicaid Redesign
- Dual eligibles are excluded
  - They may opt-in to Medicaid Advantage
Map of Managed Care

- Medicare
  - Medicare Advantage
- Medicaid
  - Medicaid Advantage
  - Mainstream MMC
  - Partial-Cap MLTC
- Medicaid LTC
  - PACE
  - MAP

Personal Care carve-in

Dental, vision, hearing, etc.
Changes to Managed Long-Term Care
Mandatory Enrollment in Managed Long Term Care (MLTC)

- 2011 State Budget authorizes State to request permission from the federal Medicaid agency – CMS – to require all personal care and other long-term care recipients to enroll in a Managed Long Term Care plan, effective **April 1, 2012**.

- State filed request in April 2011; it’s still pending. State plans to start this only in NYC because there are already many MLTC plans. Rest of state later.

- As of February 2012, State delayed implementation to **July 1, 2012** because CMS had not yet approved
Who is the mandatory population?

- Dual eligible, aged 21 and over, receiving community-based LTC services for over 120 days, excluding the following for now:
  - Nursing Home Transition and Diversion (NHTD) waiver participants;
  - Traumatic Brain Injury waiver participants;
  - Nursing home residents;
  - Assisted Living Program participants;
  - Dual eligible that do not require community-based LTC
What are “community-based LTC services?”

- Personal care (PCA/home attendant)
- Certified Home Health Aide (CHHA)
- Adult Day Care
- Lombardi Waiver (Long-Term Home Health Care Services)
- Private-Duty Nursing
- Consumer-Directed Personal Assistance Program (CDPAP)
Who is the voluntary population?

- In addition to those who must enroll in a MLTC plan, the following people may voluntarily enroll:
  - Dual eligible, 18-21, in need of community-based LTC services for over 120 days.
  - Dual eligible age 18-21 and non-dual eligible age 18 and older assessed as nursing home eligible.
Implementation Schedule

- Phase I – NYC
  - Effective July 1, 2012, any new applicant for community-based LTC meeting the criteria for mandatory enrollment will be referred to the enrollment broker
    - Enrollment broker provides educational material, list of plans, answers questions, provide assistance enrolling in plan
    - Plan determines whether applicant is eligible and amount of services
    - Plan transmits enrollment to broker

Implementation Schedule

Phase I – NYC

- **July 1, 2012**: Begin transferring existing personal care cases in Manhattan.
- **September 2012**: Begin transferring existing personal care cases in Bronx; and begin CDPAP cases in Manhattan and Bronx counties.
- **October 2012**: Begin Brooklyn.
- **December 2012**: Begin Queens and Staten Island.
- **January 2013**: Add Lombardi, CHHA over 120 days, adult day care and private duty nursing cases.

Implementation Schedule

- **Phase II**
  - Nassau, Suffolk and Westchester Counties – Anticipated January 2013

- **Phase III**
  - Rockland and Orange Counties – Anticipated June 2013

- **Phase IV**
  - Albany, Erie, Onondaga and Monroe Counties – Anticipated December 2013.

- **Phase V**
  - Other counties with capacity – Anticipated June 2014.

Implementation Schedule

Phase VI

- Previously excluded dual eligible groups contingent upon development of appropriate programs:
  - Nursing Home Transition and Diversion waiver participants;
  - Traumatic Brain Injury waiver participants;
  - Nursing home residents;
  - Assisted Living Program participants;
  - Dual eligibles that do not require community based long term care services.

Auto-Assignment

First Notice – Enrollment Packet
- Notice stating that individual must enroll in an MLTC plan within 60 days or they will be randomly auto-assigned. Includes a list of plans and educational material.

Second Notice
- 30 days later

Third Notice
- 45 days later; includes name of plan to which individual will be auto-assigned

Fourth Notice
- 60 days later; informing individual of auto-assignment

Maximus, “Managed Long Term Care Informational Materials” posted at
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-02-08-presentation.pdf
Choice

Individuals subject to mandatory enrollment will have a choice among different types of plan:

- Partial-cap MLTC
  - This is the only type of plan into which people will be auto-assigned
- PACE
- Medicaid Advantage Plus
- “Other Care Coordination Model”
  - State has left door open for entities (such as Lombardi programs) to apply to become alternatives to MLTC; none have as of February 2012
Law requires MLTC plan to provide previous level of services for 30 days pending its new assessment.

After the 30 days, State will allow plans to reduce services.

Must give written notice and right to a hearing – but not AID CONTINUING.

- Advocates think this violates the Due Process clause of the U.S. Constitution.
Advocacy Concerns

- Meeting Needs of High Hour Clients.
  - **Capitation Incentive to Give Low hours** – Many MLTC plans in NYC have done heavy marketing to enroll large numbers of low-hour clients. They receive same capitation rate for all clients.
  - **High-need MLTC client can’t transfer** to Personal Care/home attendant program. Now, MLTC will be mandatory – will have to fight plan for more hours. Standards for 24-hour care unclear.

See more info at [http://wnylc.com/health/entry/114/](http://wnylc.com/health/entry/114/)
Advocacy Concerns

- **Consumer appeals/ fair hearings** – rights not as clear as in personal care/home attendant program.
- **Standards for authorizing care** – will MLTC plans be required to follow rules established through years of litigation, i.e., can’t use task-based-assessment when client has 24-hour needs.

See more info at [http://wnylc.com/health/entry/114/](http://wnylc.com/health/entry/114/)
Advocacy Concerns

- **Excess Nursing Home Usage**
  - MLTC benefit package includes nursing home care
  - 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.
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.

- **Capacity** – Plans now have 37,000 members, will more than double their enrollment from July – Dec. 2012. Can they do it?

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

- **See more** in advocates letters to DOH* and CMS**


The End

See updates at http://nyhealthaccess.org