NEW YORK ASSOCIATION ON INDEPENDENT LIVING

# Medicaid Managed Care
# Managed Long-Term Care and
# Fully-Integrated Dual Advantage Plans

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CID-NY

# Community Health Advocates

- Community Health Advocates (CHA) is a network of 31 organizations that assist consumers and advocates to navigate New York's healthcare systems and services. NYAIL and CIDNY partner to serve people with disabilities statewide through individualized counseling and group presentations. We help consumers to obtain and navigate coverage, and we help the uninsured to find free or low-cost care.

# Outline

- Mainstream Medicaid Managed Care
- Managed Long-Term Care
- Fully-Integrated Dual Advantage Plans

# Mainstream Medicaid Managed Care

# Expansion of Medicaid Managed Care Key Recent Changes

- "Mainstream" Medicaid Managed Care (MMC) plans serve people who have Medicaid but not Medicare. Most enrollees must or will soon have to join a plan.
  - **August 2011- home attendant became a MMC plan benefit.**
  - **October 2011 - pharmacy became a MMC plan benefit.**
  - **January 2012 - personal emergency response (PERS) became a MMC plan benefit.**
  - **October 2012 – mandatory enrollment of Consumer Directed Personal Assistance (CDPAP) enrollees begins in NYC, eventually to be rolled out statewide.**
  - **November 2013 – nursing home becomes a MMC plan benefit, and non-dual-eligible nursing home residents must enroll in MMC (those with Medicaid and not Medicare).**

# Medicaid Managed Care Features

- **Managed care through an insurance company; same benefits as fee-for-service Medicaid.**
- **Provider network; primary care physician; specialist; referral (no referral required for emergency or carved-out services).**
- **Prior approval required for many services, but not emergency services or family planning.**
- **Case management (services vary by plan).**
- **Standing referral; specialist as PCP.**
- **Grievance; appeal; fair hearing rights.**

# Medicaid Managed Care Benefit Package

- Physician services
- Hospital services
- Laboratory/x-ray
- Medical equipment and supplies
- Rehabilitative services (PT, OT,ST)
- CHHA
- Home attendant (or personal care) services
- Dental
- Prescription

# Medicaid Managed Care
# Carved-Out Services

- The following services are “carved out” of managed care and covered fee for service:
  - **Mental health services (aged, blind, disabled)**
  - **COBRA case management**
  - **HIV adult day care**
  - **Medicaid service coordination and other long-term care services for developmentally disabled consumers**
  - **Non-emergency medical transportation (as of 1/2013).**

# Medicaid Managed Care
# Choosing a Plan

- Determine plans accepted by all or most important medical providers (PCP, specialist, homecare agency, DME providers).
- Can ask a provider to consider joining a plan.
- Verify with plan that provider is in network and accepting new patients.
- Ask plan if specialist could be PCP.
- Does any new provider treat enrollees condition, speak language, have convenient and accessible location and office hours?

# Medicaid Managed Care
# Choosing a Plan (Continued)

- Does plan cover medications or have restrictions (prior approval, step therapy, quantity limits)?
- Is pharmacy in plan's pharmacy network?
- Which hospitals are in network?
- How is transportation arranged to doctor visits?
- What are features of case management?

# Medicaid Managed Care
# Enrolling and Switching Plans

- **Have 30 days to choose plans once receive mandatory enrollment packet; otherwise, will be auto-assigned randomly. NY Medicaid Choice is enrollment broker in most counties; call 1-800-505-5678, TTY 800-329-1541.**
- **May switch plans within first 90 days of enrollment, then locked in for rest of the year unless "good cause" (e.g. plan does not have providers who can treat consumer's condition).**
- **Plan have customer service line, nurse line, provider directory, and member handbook.**

# Medicaid Managed Care Exemptions

- The following groups remain exempt from enrollment in Medicaid Managed Care:
  - **Native Americans.**
  - **People with a chronic condition under active treatment with specialist who accepts no MMC plan (duration of treatment or 6 months, whichever is less).**
  - **Persons enrolled in Medicare Advantage.**

# Medicaid Managed Care Exemptions Being Phased Out

- Exemptions Being Phased out:
  - **ESRD (4/1/2012)**
  - **Homeless (4/1/2012)**
  - **Low birth weight infants (4/1/2012)**
  - **HCBS waiver lookalikes (7/1/2012)**
  - **LTHHCP (Lombardi) (1/1/2013).**
  - **People in waivers or lookalikes (4/1/2013)**
  - **MBI-WPD (4/1/2013)**
  - **Nursing home residents (11/1/2013).**

# Medicaid Managed Care Exclusions

- Excluded from Enrollment:
  - **Dual eligibles with Original Medicare**
  - **Persons on spenddown**
  - **Persons with cost-effective 3rd party insurance**
  - **Persons with limited coverage (cancer, TB, family planning, Emergency Medicaid).**

# Consumer Rights in Managed Care

- Information about Plan and how to use it.
- Information about grievances/appeals.
- Free oral language interpretation at Plan customer service line and free written translated information.
- Access to Centers of Excellence – specialty care centers for cancer, HIV, and other conditions.

# Transitional and Out-of-Network Care

- If a consumer has a chronic, degenerative, disabling, or life-threatening condition and is new to managed care, plan must continue all current services; consumer may see current non-network doctors up to 60 days after enrollment or until plan sets up a continuing treatment plan with its network providers.
- If no network providers can treat consumer's medical condition, plan must pay for out-of network providers who can treat condition.

# Medicaid Managed Care
# Medical Emergencies

- **Plan must cover out-of-network care in case of emergency.**
- **Prudent layperson standard for medical emergency:**
  - Sudden symptoms (including pain) that manifest with sufficient severity that a prudent layperson with an average knowledge of medicine and health could expect that no medical attention would put own or others' health in serious jeopardy, seriously impair bodily functions, cause serious dysfunction of any organ or body part, or cause serious disfigurement.

# Handling Problems with a Medicaid Managed Care Plan

- Call Plan's toll-free Member Services line with any problems or questions, e.g.
  - **Plan won't approve services or let consumer have referral**
  - **Plan won't approve transportation to medical appointments**
  - **Plan won't approve enough homecare hours**
    - 24-hour homecare is still a covered benefit.

- Always get representative's name.
  - **Follow-up in writing.**

# Appeals and Grievances

- Grievances are complaints about service, plan, or provider.
- Appeals are request for plan to reconsider denial or reduction of medical services.
- If you lose first internal appeal with the plan:
  - **External Review**
  - **Fair Hearing**
    - Aid continuing may be available if requested within 10 days of notice.

# Medicaid Managed Care List of Plans

- **Information about managed care plans available in each county is available on the NYS Dept. of Health website at:**

  **http://www.health.ny.gov/health_care/managed_care/mcplans.htm**

# Medicaid Managed Care
# Personal Care Carve-In

- **Skilled (CHHA) care was already carved-in; now, home attendant service is also carved in.**

- **Plans are contracting with some homecare agencies; some consumers could lose access to aides not in a network agency. That is not "good cause" to switch plan.**

- **Plans receive flat rate (capitation) per consumer; plans have tried to restrict hours.**

# Medicaid Managed Care Pharmacy Carve-In

- Prescription now part of benefit package.
- Plans will each have own drug formularies.
- Plans must have exception and prior approval process.
- If drug is not covered, doctor may prescribe equivalent drug that is covered.
- Appeal and fair hearing rights apply.
- If drug is not covered, that is not “good cause” to switch managed care plan.

# Medicaid Managed Care
# Strategies if Prescription Not Covered

First, try working with prescriber to switch drug, if appropriate, or get prior approval.

- File internal, then external appeal (with medical documentation).
- File fair hearing (aid continuing if possible).
- Fair hearing trumps external appeal decision
  - **Describe plan policy preventing access**
  - **Explain why available drugs are not useful to consumer (ineffective or harmful).**

# Medicaid Managed Care Drug Formularies

- To check each plan's formulary online, visit: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-12-09_manage_care_pbm_formulary.pdf

# Managed Long-Term Care

# Managed Long Term Care (MLTC)

- A MLTC plan is a private managed care plan that authorizes and manages Medicaid home care and other long-term care, plus certain medical care.

- Medicaid pays plans a flat rate (capitation) per member per month – different from previous hourly payment for home care service. Advocates are concerned that capitation encourages plans to approve fewer hours of care.

# Managed Long Term Care Population

- Managed Long Term Care (MLTC) plans have been voluntary and serve individuals who are eligible for Medicare and Medicaid (duals) as well as non-duals.
- July 2012 – mandatory MLTC enrollment began for dual eligibles in New York City, age 21 and older, who require 120 days or more of community based long term services. Upstate expansion will be rolled out county by county as sufficient MLTC capacity is developed.
- September 2012 – Consumer Directed Personal Assistance Program becomes part of MLTC benefit.
- NY Health Access website has plan information, the state's MLTC guide, and "mandatory" letters being sent, at http://wnylc.com/health/entry/169/.

# MLTC Medicaid Plans

- So-called "MLTC Medicaid Plans" cover certain Medicaid long-term care and other medical services.
  - **Skilled homecare, personal care, visiting nurse, DME, supplies**
  - **Physical therapy, occupational therapy, speech therapy**
  - **Non-emergency transportation**
  - **Adult day care, social day care**
  - **PERS, home modifications, home-delivered meals**
  - **Nursing home**
  - **Audiology, optometry, dental, podiatry (specialty services)**
  - **Capitation rate for above services (partial capitation).**
- Any other care (e.g. PCP, specialist, hospital) is still covered through Original Medicare and fee-for-service Medicaid.

# Medicaid Advantage Plus and PACE

- Medicaid Advantage Plus (MAP) plans cover all Medicare and Medicaid medical services, including community-based long-term care. All providers must be in-network. Some plans have age restrictions; others are open to members age 18 and over. Must meet nursing home level of care.
- PACE (Program of All-Inclusive Care for the Elderly) is a variation of MAP and is available only to people over age 55 and nursing home eligible.
  - **Site-based adult day care model, with onsite doctor and care manager.**

# MLTC Care Management

- All managed long-term care enrollees work with a Care Manager, who works with the consumer and anyone else he/she wants in order to develop a Plan of Care outlining plan services. The Care Manager also assists with specific needs such as large print or other accessible formats, TTY, interpretation, translation, and finding providers with wheelchair access or other accommodations.

# Choosing a MLTC Plan

- Which type of plan do you want?
- If a service is covered by the plan, do your providers accept the plan (e.g. homecare agency, podiatry, dental, audiology, optometry)? If MAP or PACE, consider provider network for all medical services.
- What is plan's track record for approving adequate homecare hours?
- You may switch plans at any time.
- Many plan handbooks are posted on NY Health Access at http://wnylc.com/health/entry/169/.

# MLTC Enrollment

- Will happen gradually 2012-2015.
- Enrollment broker (NY Medicaid Choice) provides educational material and plan list, answers questions, and helps you contact plan.
- 1-888-401-6582; TTY 1-888-329-1541.
- When receive mandatory letter, must choose plan within 60 days or be randomly assigned.
- Existing services are continued for 30 days while MLTC plan does assessment.

# Populations Exempt from MLTC

- Native Americans
- Dual eligibles ages 18-20 who need 120+ days of community-based long-term care
- Dual eligibles ages 18-20 and non-dual-eligibles over age 18 who are assessed as nursing home eligible
- MBI-WPD enrollees who are nursing home eligible

# Populations Currently Excluded from MLTC

- CDPAP participants (until 9/2012)
- Assisted Living Program,
  TBI, NHTD, and LTHHCP waiver participants
- Hospice, and residents of psychiatric or residential care facility or nursing home
- Developmentally disabled, receiving care in a facility, the community, or through a waiver program, and those with similar needs.
- Dual eligibles who do not require community-based long-term care.

# MLTC Member Rights

- Timely access to medically necessary services
- Information about where, when and how to get needed services from plan or outside plan
- How to give informed consent about care
- Participation in healthcare decisions, including the right to refuse treatment
- Freedom from any form of restraint or seclusion used as means of force, discipline, convenience, or retaliation

# MLTC Member Responsibilities

- Use network providers when required by plan rules.
- Get Care Manager's approval before receiving a covered service.
- Tell plan about care needs and concerns.
- Tell Plan when you go away or out of town.
- Pay spend down to Plan.

# MLTC Concerns

- Care management – will plans coordinate care and ensure access to services, or will care management limit services?
- Disability literacy –will plans understand, communicate, and partner with people with disabilities with an understanding of' our perspectives and beliefs regarding health behavior?
- Will MLTC plans have sufficient capacity to enroll the mandatory population?

# MLTC Links

- NYC MLTC plan list is at http://wnylc.com/health/download/317/
- Letter to new NYC enrollees is at http://wnylc.com/health/download/318/
- MLTC guide (available in CD and braille) is at http://wnylc.com/health/download/319/
- Tools for choosing a MLTC plan is at http://wnylc.com/health/entry/169/

# Fully-Integrated Dual Advantage (FIDA)

# Fully Integrated Dual Advantage (FIDA)

- New York State received federal funding to develop a demonstration program to coordinate care for dual eligibles – called Fully-Integrated Duals Advantage (FIDA).
  - **Tests and evaluates model for delivering integrated care.**

- The final FIDA proposal that NYSDOH submitted to CMS 5/25/2012 is at http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf .

- NYAIL and CIDNY are part of a duals advocacy group that commented on NYSDOH's draft FIDA plan and helped improve the program model. The comments are available at http://www.ilny.org/advocacy/nyail-position-papers/112-updated-comments-on-the-nysdoh-demonstration-proposal-to-integrate-care-for-dually-eligible-individuals.

# FIDA Benefits

- FIDA expands Managed Long-Term Care.
- Similar to Medicaid Advantage Plus (MAP)
  - **more comprehensive benefits, improved access, and enhanced consumer protections.**
- Covers all physical and behavioral healthcare, long-term care services, prescriptions, and waiver-type services (including HCSS, peer support, home-delivered meals, environmental modifications).

# FIDA Population

- Medicare plus Medicaid
- Age 21 and over
- Need community-based long-term care
- Live in New York City, Nassau, Suffolk, or Westchester county.
- Not receiving services through OPWDD or in an OMH facility

# FIDA Enrollment

- Passive enrollment – automatic assignment with ability to opt out, starting in 1/2014.
- In Fall of 2013, enrollment broker sends letter to affected consumers informing them that they will be enrolled in the FIDA plan offered by current MLTC sponsor, if available, or counseling them regarding plan choice.
- Once enrolled, consumer may leave plan at any time. However, may only switch and re-enroll every January and July.

# FIDA Network

- Cannot use regular Medicare nor Medicaid cards; must use providers in FIDA plan network.
- 60-day transition period with existing providers.
- Must consider all providers and services when selecting a FIDA plan, including Part D formulary.

# Features of FIDA

- Participant centered, like waivers.
- Interdisciplinary care coordination team.
- Independent enrollment broker.
- Independent participant ombudsman.
- Integrated grievance and appeal processes.
- Maximum travel, distance, and wait times.
- Consolidated statement of rights and responsibilities.
- No cost sharing, even for Part D drugs.

# FIDA OPWDD

- A second type of FIDA is a small statewide program that will cover up to 10,000 dual eligibles age 21 and over and receiving OPWDD services.
- All FIDA services plus OPWDD services.
- Enrollment starts 1/2014.

# Managed Fee for Service (MFFS) Health Homes

- A third type of FIDA is a MFFS Health Home.
- A health home is a broad partnership among primary, specialty, and mental health providers, substance abuse providers, and community-based organizations.
- Health homes feature communication among all professionals involved in care; health records are shared among providers.
- All medical, behavioral, social needs are to be addressed comprehensively.

# MFFS Health Homes Eligibility and Goals

- Managed fee-for-service (MFFS) Health Home enrollees must have at least two chronic conditions; one chronic condition (HIV/AIDS) and at risk for another; or one serious and persistent mental health condition.
- Goals are to reduce avoidable hospitalization and ER admissions, provide timely follow-up care, reduce costs, rely less on long-term care facilities, and improve quality of care.

# MFFS Health Homes Population and Benefits

- MFFS health homes are for dual eligibles who meet health home criteria but who do not need long-term care services.
- Medicare A/B/D services.
- Medicaid State Plan services provided by FFS Medicaid (mandatory and optional).
- All coordinated by a care manager.
- Statewide passive enrollment starts 1/2013.

# MFFS Health Homes
# Care Manager

- Care manager oversees and coordinates access to needed services, communicates with all health home team members.
- Ensures that care plan is followed by coordinating and arranging services, supporting adherence to treatment recommendations, and monitoring and evaluating enrollees' needs.
- Has expertise with unique needs of dual eligible population.

# Contact Information

- Community Health Advocates website – www.communityhealthadvocates.org
- Community Health Advocates one pager - http://www.cidny.org/community-health-advocates.php
- Greg Otten, Community Health Advocates Coordinator
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