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May 25, 2011

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To Whom It May Concern:

We respectfully submit the below comments in response to the April 27, 2011 Public Notice of proposed changes to the Partnership Plan and Federal-State Health Reform Partnership, New York State's two 1115 waivers.

**A. Expand MMC Enrollment of Non-Duals**

We write to stress the importance of a detailed implementation plan that is provided in writing, publicly available and understandable by all stakeholders including advocates, beneficiaries, health plans and providers. This plan should be sensitive to disability, linguistic and cultural issues.

The disability advocacy community is concerned about the ambitious timeline of mandatory enrollment of non-dual eligibles into Medicaid Managed Care (MMC). Considering the breadth of the populations to be mandated into MMC, more time to prepare for each phase of the expansion is necessary to evaluate the success of the program changes and their effect on enrollees. In light of transitional problems which occurred in the past when other high needs populations were mandated into MMC, ample time should be given between enrollments of mandatory populations to ensure efficient outreach and education to hard to reach populations. This is especially crucial for enrollments of the homeless, the institutionalized, and populations who are currently receiving home and community based services in the community to prevent institutionalization. This is particularly important because of past issues with mandatory enrollment of high needs, medically vulnerable populations, described in more detail below.

**Continuity of Care**

The state's waiver amendment request described its "track record of providing high quality care, effective enrollment education, and efficient methods of ensuring continuity of care which provided a strong foundation for enrollment of the SSI and SPMI/SED

populations beginning in 2006.” However, the SSI and SPMI/SED population experienced serious, sometimes life threatening problems with continuity of care upon enrollment. Many SSI recipients with serious emotional disturbance experienced interruptions to and termination of home health and specialty care services.

In order to avoid a repetition of these problems, the State Department of Health must detail in its implementation plan strategies for ensuring continuity of care including plan training on the transitional care requirements and provider training on the ability to bill out of network. There should also be a mechanism for monitoring and imposing sanctions for plans that repeatedly violate the Public Health Law, the Social Services Law and regulations and/or contract requirements.

The description of the Medicaid Redesign Initiatives indicates that all enrollees will be able to see current providers for up to 6 months from enrollment. We appreciate this commitment to continuity of care and hope that it minimizes service disruptions. However, it is important to note that current law only requires managed care plans to allow patients to continue to see their providers for 60 days from the effective date of enrollment, if they are undergoing an ongoing course of treatment with an out-of-network provider for a chronic, degenerative or disabling condition. Since the policy announced in the Medicaid Redesign Initiatives represents a significant expansion of existing requirements, we request that guidance be issued to new enrollees, advocates, health plans and providers.

#### Enrollment Outreach and Training

Beneficiaries, providers and health plans must be trained to understand implementation of the mandatory enrollment timeline and their respective responsibilities in its regard. This is especially crucial for the hard to reach populations referenced above. Outreach and education regarding the mandatory enrollment process, access to and continuity of care once enrolled, and provider billing issues is essential so that beneficiaries do not experience disruptions in care due to auto assignment, and providers are not forced to refuse care to patients based on their plan affiliation.

#### Network Capacity

The summary waiver amendment description describes all of the high needs populations that will be mandatorily enrolled over the proposed three year phase-in of the program. However, it does not provide any description of how these additional Medicaid beneficiaries will be managed by the existing Medicaid managed care plans. This is particularly concerning in the short term in regards to Special Needs Plans (SNPs) for people living with HIV and AIDS (PLWHA).

Network capacity for the necessary specialty care is a critical issue. Yet SDOH has not disclosed how network capacity will be expanded. Further, the Partnership Plan Special Terms and Conditions requires that network capacity be evaluated prior to enrollment of

disabled populations.<sup>1</sup> SDOH has published no such evaluations to date in regards to the HIV positive or other high needs populations.

The advocacy community remains concerned that New York's Medicaid managed care program, especially outside of NYC, does not have enough specialist providers to accommodate all new enrollees. Although a larger number of specialists participate in Medicaid managed care than fee-for-service Medicaid, not all providers participate in the same plans. Therefore, enrollees with multiple conditions will likely be forced to choose among their current providers.

In addition, it is crucial that network capacity be sufficient to ensure that disabled individuals and other high needs beneficiaries are able to access specialist appointments in a timely manner. We are interested in learning from the Department about mechanisms in place to monitor access to specialists for individuals with special needs, including how long it takes to schedule specialist appointments. Plans should also be monitored for their compliance with rules such as allowing standing referrals and specialists as Primary care Providers for individuals with disabilities and chronic conditions.

#### Enrollee Rights and Plan Oversight

Medicaid recipients newly enrolled in managed care plans have been denied their due process rights when their existing services are terminated without notice and they are not informed of their right to appeal or to receive aid-continuing. In addition, plan standards for denying services are often inconsistent with the medical necessity standard that governs the Medicaid program.

We strongly recommend that the Department develop procedures to ensure health plan and subcontractor compliance with due process requirements. These procedures should include an evaluation of utilization data to ensure that chronically ill individuals and/or recipients with disabilities do not lose access to critical services upon enrollment, and assurances that plans and their subcontractors are using the Medicaid program's medical necessity standard. Again, there should also be a mechanism for monitoring and imposing sanctions on plans for repeated violation of the Public Health Law and/or contract requirements.

PLWHA are entitled to choose a SNP as their managed care provider, which creates a special monitoring duty for the state. We are concerned that with the aggressive timeline in expanding mandatory enrollment to PLWHA upstate will not allow for this choice, or for sufficient network affiliation among existing providers. In addition, we are concerned that the state has not completed its evaluation of the roll-out and auto-assignment rates for this population in New York City before the roll-out begins upstate. The last borough mandated in New York City will not be auto-assigned until July 2011. It is unlikely that an analysis of the completed rollout and transition could be completed at least until early fall.

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<sup>1</sup> Center for Medicare and Medicaid Services, Special Terms and Conditions, The Partnership Plan, Dec. 15, 2004, p. 54.

## ADA Compliance

The Department of Health requires that managed care organizations sign Americans with Disabilities Act (ADA) compliance plans providing details of their efforts to ensure full program communications and physical accessibility for plan participants with disabilities. These compliance plans are reviewed by DOH to ensure completeness. Unfortunately, a review of these plans by the Legal Aid Society and Center for Independence of the Disabled, NY have revealed that the plans are incomplete and often reflect scant knowledge of ADA compliance requirements. We request that the Department work with the community to ensure that managed care plans have the capacity to develop compliance plans, review plans, provide appropriate training and undertake surveillance activities to ensure ADA compliance is more than a matter of paper compliance.

## B. Streamline Enrollment Process

The proposal to streamline the enrollment process by shortening the time period before beneficiaries are auto-assigned into plans, though designed to increase the efficiency of plan enrollments, may have the impact of interfering with access to care for those most in need of care. Any change that has the potential to increase auto-assignments magnifies the importance of oversight by DOH to ensure that plans are complying with their responsibilities regarding transitional care, health assessments of new members, and access to specialist care.

We recognize that for new enrollees who are not exempt or excluded from managed care, there may be little benefit in delaying such beneficiaries' enrollment into a plan. However, the new 30 day timeline could negatively impact disabled individuals, those who are exempt from enrollment, and those who are most in need of consistent access to care, such as pregnant women.

As SSI-related individuals have been mandated into Medicaid managed care, they have been given 90 days to enroll in a plan before being auto-assigned rather than the 60 days given to non-disabled individuals. This additional time to choose has served as an acknowledgement that individuals with disabilities may have more difficulty navigating the process of choosing a plan, including communicating with doctors and other service providers about the plans they take in order to ensure continuity of care.

We have not seen data on how long it has actually taken disabled individuals and others to choose a plan when mandated into managed care. If disabled individuals are in fact using 60 or even 90 days to enroll, this points to the need for this accommodation in order to ensure that these individuals can make a choice about plans. If statistics show that most individuals who do choose a plan do so within 30 days, we would be less concerned about the impact of this change on disabled individuals.

We have the same concern about those who are actually exempt from enrollment. If the additional 30 or 60 days affords these individuals an opportunity to request an exemption form and have their exemption request evaluated before being auto-assigned into

a plan, then there could be a serious and disparate impact of this change on disabled individuals.

The proposal also notes that pregnant women who do not choose a plan when they apply for presumptive eligibility will be auto-assigned within 30 days. If it is a requirement that an individual choose a plan at presumptive eligibility, any failure to do so would likely be the fault of the enroller, not the applicant. It is essential to maintain access to care for pregnant women. Pregnant women should be provided written notice that an auto-assignment will take place while they still have time to enroll. Even better would be a guarantee that pregnant women would only be auto-assigned to a plan in which the provider which they enrolled with presumptively participates.

We urge the Department to consider the feasibility of creating a system to ensure that individuals whose Medicaid cases are temporarily suspended are able to maintain coverage in their plans if their cases are restored in a timely manner. Often, when an individual loses Medicaid coverage because of a problem with recertification, that individual is disenrolled from his or her managed care plan, even if the coverage is eventually restored retroactively so that there is no break in coverage. If these individuals have providers who do not take fee for service Medicaid, their ability to access medical services during the time that they are disenrolled from the plan is compromised.

### **C. Pharmacy Carve-In; Other Benefit Changes**

#### **Pharmacy Carve-In**

We hope that the carve-in of benefits such as personal care and pharmacy will lead to better coordinated care for managed care beneficiaries. However, we are concerned that the carve-in may also lead to disruptions in care. With respect to pharmacy coverage, if plans' formularies and/or their policies regarding prior approval or other utilization limits differ from one another, beneficiaries will need access to this information upon enrollment. We have learned from communications with the Division of Managed Care that it is not expected that New York Medicaid CHOICE counselors will have access to this information when counseling beneficiaries on choosing or changing plans. We urge the Department to put procedures into place to ensure beneficiaries seamless access to prescription drugs, especially in the first months after the carve-in. This should include an easy way for beneficiaries to find out about plans' formularies at the same time that they are learning about which plans are accepted by their physicians.

The pharmacy carve-in model appears to be very similar to that provided under Medicare Part D. It is our understanding that managed care plans will be required to provide coverage for those categories of drugs currently included in the Medicaid fee-for-service program; however, they do not have to cover all drugs and they can include utilization management (UM) tools for covered drugs. We urge the Department to adopt critical protections afforded to dual eligibles in the Medicare Part D program, including guaranteed access to transition supplies for individuals who are already taking prescribed drugs and who are first enrolling into a managed care plan, moving to a new plan, or

experiencing a change in level of care. Plans should be required to post their formularies and UM requirements on their website and provide all of their members with a copy of this information. We request an expedited appeals process for coverage denials, as well as guidance to plans about providing Aid Continuing when a Fair Hearing is timely requested.

#### Personal Care Services and Nursing Home Services

It is also essential that the Department carefully monitor the process of the carve-in of personal care services to the plans. Recipients of long term care services are entitled to the services that they have been determined eligible for notwithstanding changes in the service delivery mechanism. We request information regarding guidance that is being provided to plans regarding standards specific to those receiving long term care services, such as the prohibition on using a task-based assessment for those needing 24 hour care and the reinstatement of care following a hospital stay.

Despite the provisions for transitional care for individuals currently receiving personal care services that have been described by the Department, advocates fear that individuals who are enrolled in plans that their service providers do not accept will experience problems receiving out-of-network care during the transition period. We request that the Department provide information about plan enrollments of personal care services providers and that the Department provide significant oversight over the transition process.

We are also concerned about the adequacy of plan networks for nursing services, which will be carved into the benefit package in October 2012. We request additional information regarding implementation plans, including provisions for individuals who are currently receiving nursing home care and are enrolled in a plan not accepted by their nursing home, and assurances regarding network capacity. There are many barriers to individuals seeking beds in nursing homes, including nursing home capacity, and we are concerned that individuals' plan enrollment could become an additional barrier.

We also request additional information about how capitation rates will be structured for both personal care recipients and nursing home residents. For nursing home residents, we request information regarding whether capitation rates will incorporate the regional nursing home facility rates, and how additional costs such as hospitalizations will be reflected in capitation rates. We are concerned that plans will be hesitant to approve requested services that need to be provided outside of the nursing home if rates will not reflect the provision of these services. With regard to personal care services, we are also concerned about how more intensive cases, such as 24-hour split shift cases, will be factored into the capitation rate.

**D. Mandatory Enrollment / Managed Long Term Care**

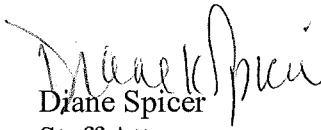
Regarding mandatory enrollment in managed long term care plans, we would like to incorporate into our comments the enclosed letter sent by Selfhelp Community Services, Inc. and other advocates to Jason Helgerson on May 2, 2011.

Thank you for your consideration of these comments.

Sincerely,



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Health Law Unit  
Legal Aid Society



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On behalf of:

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cc: Jaime Torres, New York Regional Director, U.S. Dept. of Health and Human Services  
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Enclosure.