

## **29. Medicaid Advantage--Dual Eligible—Managed Care Program**

### **Organization and Administration**

#### *Program Overview*

Effective January 1, 2005, Medicaid and Medicare dual eligibles, meeting eligibility criteria, may, on a voluntary basis, enroll in the same health plan for most of their Medicare and Medicaid benefits. Plans that participate in the program will offer dually eligible persons a uniform Medicare Advantage Product and a supplemental Medicaid Advantage Product. The Medicaid Advantage Product will cover benefits not covered by Medicare and beneficiary cost sharing (co-pays/deductibles, and premiums, if any) associated with the uniform Medicare Advantage Benefit product. Health plans will receive two monthly premiums: a Medicare Advantage Premium from CMS, and a payment from NYS that covers any Medicare supplemental premium and the premium for the Medicaid Advantage services provided. However, to participate in the program, the State must determine that the Medicaid Advantage premium is cost-effective as compared to the fee-for-service equivalent costs. Eligible duals, interested in participating in this program, will enroll in the same health plan's Medicare and Medicaid Advantage products. Some Medicaid services will continue to be available to plan enrollees on a fee-for-service basis.

#### *Program Development*

Building on the existing infrastructure of Medicare and Medicaid managed care plans in New York State, this program was developed by SDOH, with guidance from CMS, and with input from health plans that offered both Medicare Advantage and Medicaid Managed care products.

SDOH conferred with CMS on several occasions regarding this initiative. CMS guidance was sought on a number of issues including: the need to amend the 1115 Waiver Terms and Conditions; the applicability of Medicare and/or Medicaid rules to dual eligibles enrolled in managed care programs; and on education and outreach, enrollment and disenrollment, marketing and marketing materials, grievance and appeals, quality assurance, and plan qualification and monitoring in the Medicare Advantage Program.

In developing this initiative, the SDOH also addressed the issue of the scope of the federal Medicare Advantage Act's (MMA) preemption of State managed care laws. The SDOH Division of Legal Affairs issued an opinion in August 2004 concluding that under the proposed federal regulations, licensed plans that provide Medicare benefits would be subject only to Medicare laws and regulations with the exception of State licensing and solvency requirements.

In October 2003, the SDOH convened a Dual Eligible Initiative Work Group, consisting of representatives of health plans that participated in both Medicare and Medicaid managed care. This group met regularly and provided expert advice and experience which greatly assisted the SDOH in developing the dual eligible initiative. Issues addressed by the Work Group included: the target population for the initiative, the uniform Medicare Advantage benefit package, the Medicaid Advantage benefit package, the premium submission process, education and outreach

activities, the enrollment and disenrollment processes, marketing materials and activities, grievance and appeals processes, quality assurance activities, plan reporting requirements, and Medicaid Advantage contract provisions.

Throughout the development process, the SDOH outreached to stakeholders to inform them of plans to implement the Dual Eligible Initiative. Presentations were provided to the Medicaid Managed Care Advisory Review Panel (MMCARP); the Medicaid Advisory Committee (MAC); advocacy groups such as New Yorkers for Accessible Health Care (NYFAHC); other State agencies including Office of Alcohol and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), and the Office of Mental Retardation and Developmental Disabilities (OMRDD); and local governmental units including the local social services districts and New York City's Human Resources Administration (HRA) and the Department of Health and Mental Hygiene (DOHMH).

While New York did not seek any federal waivers to implement the Dual Eligible Initiative, it did, in April 2001, send a letter to CMS requesting approval to modify the Terms and Conditions of New York's 1115 Medicaid Demonstration Project to no longer reflect Medicare and Medicaid dual eligibles as an excluded population as of January 1, 2005, but rather to allow those meeting eligibility criteria to enroll in any managed care plan in their service area approved by the SDOH to enroll dual eligibles. Approval of this request was issued by CMS on December 15, 2004.

### *Health Plan Participation*

To participate in this initiative health plans must: 1) be approved by CMS as a Medicare Advantage Plan; 2) participate in the Medicaid managed care program or be qualified as a Medicaid Advantage Plan by SDOH, and 3) offer the standardized Medicare Advantage benefit package to dual eligibles enrolled in the program.

These plans must file the uniform Medicare Advantage benefit package with CMS and submit an acceptable Medicaid Advantage Premium Proposal to the SDOH for each calendar year.

### *SDOH Role*

For Medicare Advantage, the functional responsibilities for plan qualification, plan oversight, LDSS oversight and technical assistance, services coordination, program evaluation and improvement, and systems remain with the same Division of Managed Care (DMC) Bureaus as for mainstream Medicaid managed care. The DMC's Bureau of Program Planning and Implementation will have the added responsibility of reviewing and approving Medicaid Advantage plan marketing materials targeted to the dually eligible population jointly with the CMS Regional Office.

### *Local District Role*

As with Medicaid managed care, local districts will be responsible for determining Medicaid eligibility, educating beneficiaries about the availability of Medicaid Advantage plans within

their jurisdiction, processing Medicaid Advantage enrollments and disenrollments, updating recipients' Medicare status in the State's third party health information system, and overseeing health plan implementation of the Medicaid Advantage marketing guidelines, as applicable. The SDOH will hold the contracts with participating plans outside of New York City, starting in 2006. The NYC Department of Health and Mental Hygiene will contract with participating plans in New York City.

#### *Enrollment Broker Role*

As with Medicaid managed care, the Enrollment Broker will continue to be responsible for operating the hotline and for providing enrollment broker services on behalf of New York City, and Suffolk and Nassau Counties. This will entail educating beneficiaries about the availability of Medicaid Advantage plans, processing enrollments and disenrollments, and forwarding documentation to the LDSS to update recipients' Medicare status in the State's third party health information system.

#### *CMS Role*

CMS will retain responsibility and authority for plan's participating in the Medicare Advantage program. CMS and SDOH will jointly review Medicaid Advantage marketing materials. The CMS Regional Medicare Regional Office Plan Manager will be responsible for obtaining SDOH input in the review and approval process in accordance with CMS time frames for the review of marketing materials.

### **Eligible Populations**

Participation in the Medicaid Advantage Program and enrollment in an MCO's Medicaid Advantage Product will be voluntary for all Eligible Persons. To be eligible to enroll in the Medicaid Advantage Program, individuals must:

- have full Medicaid coverage;
- have evidence of Medicare Part A & B coverage; or be enrolled in Medicare Part C ;
- reside in the service area of the plan and district;
- be 18 years of age or older;
- enroll in the same plan's Medicare Advantage Product; and
- otherwise not be ineligible to enroll in the Medicaid Advantage Program.

Individuals not eligible to enroll in the Medicaid Advantage program are those traditionally excluded by State statute from participating in Medicaid managed care or those not eligible to enroll in a Medicare Advantage Plan. They include the following categories of persons:

- Individuals who are medically determined to have End Stage Renal Disease at the time of enrollment;
- Individuals who are only eligible for Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLIMB) or the Qualified Individuals (QI-s) and are not otherwise eligible for Medical Assistance.

- Individuals who become eligible for Medicaid only after spending down a portion of their income;
- Individuals who are residents of State-operated psychiatric facilities or residents of State-certified or voluntary treatment facilities for children and youth;
- Individuals who are residents of Residential Health Care Facilities ("RHCF") at the time of Enrollment, and Enrollees whose stay in a RHCF is classified as permanent upon entry into the RHCF or is classified as permanent at a time subsequent to entry;
- Individuals enrolled in managed long term care demonstrations authorized under Article 4403-f of the New York State PHL;
- Individuals with access to comprehensive private health care coverage, except for Medicare, including those already enrolled in an MCO. Such health care coverage purchased either partially or in full, by or on behalf of the individual, must be determined to be cost effective by the local social services district;
- Individuals expected to be eligible for Medicaid for less than six (6) months, except for pregnant women (e.g., seasonal agricultural workers);
- Individuals in receipt of long-term care services through Long Term Home Health Care programs (except ICF services for the Developmentally Disabled);
- Individuals eligible for Medical Assistance benefits only with respect to TB related services;
- Individuals placed in State Office of Mental Health licensed family care homes pursuant to NYS Mental Hygiene Law, Section 31.03;
- Individuals enrolled in the Restricted Recipient Program;
- Individuals with a "County of Fiscal Responsibility" code of 99;
- Individuals admitted to a Hospice program prior to time of enrollment (if an Enrollee enters a Hospice program while enrolled in the Contractor's plan, he/she may remain enrolled in the Contractor's plan to maintain continuity of care with his/her PCP);
- Individuals with a "County of Fiscal Responsibility" code of 97 (OMH in MMIS);
- Individuals with a "County of Fiscal Responsibility" code of 98 (OMRDD in MMIS) will be excluded until program features are approved by the State and operational at the local district level to permit these individuals to voluntarily enroll in Medicaid managed care;
- Individuals receiving family planning services pursuant to Section 366(1)(a)(11) of the Social Services Law who are not otherwise eligible for medical assistance and whose net available income is 200% or less of the federal poverty level;
- Individuals who are eligible for Medical Assistance pursuant to the "Medicaid buy-in for the working disabled" (subparagraphs twelve or thirteen of paragraph (a) of subdivision one of Section 366 of the Social Services Law), and who, pursuant to subdivision 12 of Section 367-a of the Social Services Law, are required to pay a premium; and
- Individuals who are eligible for Medical Assistance pursuant to paragraph (v) of subdivision four of Section 366 of the Social Services Law (persons who are under 65 years of age, have been screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the Federal Public Health Service Act).

## **Medicaid Advantage Benefit Package**

Enrollees in Medicaid Advantage will be entitled to all Medicaid services they would normally get under the State Medicaid Plan, either through a health plan's Medicare and Medicaid Advantage products, or through Medicaid fee-for-service.

The Medicaid Advantage Product includes certain Medicaid covered services and benefits, and the cost of beneficiary cost sharing (co-pays and deductibles) and the supplemental premiums, if any, associated with the CMS approved standard uniform Medicare Advantage Product.

Currently Medicaid Advantage Covered Services include: inpatient mental health in excess of Medicare's 190 day lifetime limit; non-Medicare covered home care; and private duty nursing services. Non-emergency transportation and dental services are optional Medicaid Advantage benefits, outside of New York City; these services are required to be included in the Medicaid Advantage Benefit package in New York City. In other areas of the State, non-emergency transportation and dental services will be available through either the health plan or Medicaid fee-for-service.

Certain other Medicaid services remained carved-out of the Medicaid Advantage Benefit package and will be covered through Medicaid fee-for-service.

The tables on the following pages show the Medicare and Medicaid Advantage benefit packages by region and identify the specific services that will continue to be covered on a fee-for-service basis.

## MEDICARE ADVANTAGE PRODUCT

<b>Medicare Advantage Benefit Package for Dual Eligibles – Upstate Counties</b>	
<b>Category of Service</b>	<b>Included in Medicare Capitation</b>
Inpatient Hospital Care Including Substance Abuse and Rehabilitation Services	Up to 365 days per year (366 days for leap year). \$300 per stay co-payment.
Inpatient MH	Medically necessary care. \$300 per stay co-payment. 190-day lifetime limit in a psychiatric hospital.
SNF	Care provided in a skilled nursing facility. Covered for 100 days each benefit period. No prior hospital stay required. No co-payment.
Home Health	Medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. \$10 per visit co-payment.
PCP Office Visits	Primary care doctor office visits. Subject to \$10 co-payment per visit.
Specialist Office Visits	Specialist office visits. Subject to \$20 co-payment for each specialist office visit.
Chiropractic	Manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified providers. Subject to \$20 co-payment.
Podiatry	Medically necessary foot care, including care for medical conditions affecting lower limbs, subject to \$20 co-payment. Visits for routine foot care up to 4 visits per year, not subject to co-payment.
Outpatient Mental Health	Individual and group therapy visits, subject to co-payment of \$20 per individual or group visit. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.
Outpatient Substance Abuse	Individual and group visits subject to \$20 co-payment per group or individual visit. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.
Outpatient Surgery	Medically necessary visits to an ambulatory surgery center or outpatient hospital facility. \$35 per visit to ambulatory surgery or outpatient hospital.
Ambulance	Transportation provided by an ambulance service, including air ambulance. Emergency transportation if for the purpose of obtaining hospital service for an enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency services while the enrollee is being transported. Includes transportation to a hospital emergency room generated by a “Dial 911”. \$50 co-payment.
Emergency Room	Care provided in an emergency room subject to prudent

<b>Medicare Advantage Benefit Package for Dual Eligibles – Upstate Counties</b>	
<b>Category of Service</b>	<b>Included in Medicare Capitation</b>
	layperson standard. \$50 co-payment per visit. Co-payment waived if admitted to the hospital within 24 hours for the same condition.
Urgent Care	Urgently needed care in most cases outside the plan's service area. Subject to \$20 co-payment.
Outpatient Rehabilitation (OT, PT, Speech)	Occupational therapy, physical therapy and speech and language therapy subject to \$20 co-payment.
DME	Medicare and Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g. tub stool; grab bars). No co-payment or coinsurance.
Prosthetics	Medicare and Medicaid covered prosthetics, orthotics and orthopedic footwear. No diabetic or temporary impairment prerequisite for orthotics. Not subject to co-payment or coinsurance.
Diabetes Monitoring	Diabetes self-monitoring training and supplies including coverage for glucose monitors, test strips, lancets and self-management training. No co-payment.
Diagnostic Testing	Diagnostic tests, x-rays, lab services and radiation therapy. No co-payment.
Bone Mass Measurement	Bone Mass Measurement for people at risk. No co-payment.
Colorectal Screening	Colorectal screening for people, age 50 and older. No co-payment.
Immunizations	Flu, hepatitis B vaccine for people who are at risk, Pneumonia vaccine. Vaccines/Toxoids. No co-payment.
Mammograms	Annual screening for women age 40 and older. No referral necessary. No co-payment.
Pap Smear and Pelvic Exams	Pap smears and Pelvic Exams for women. No co-payment.
Prostate Cancer Screening	Prostrate Cancer Screening exams for men age 50 and older. No co-payment.
Outpatient Drugs	Medicare Part B covered prescription drugs and other drugs obtained by a provider and administered in a physician's office or clinic setting covered by Medicaid.

<b>Medicare Advantage Benefit Package for Dual Eligibles – Upstate Counties</b>	
<b>Category of Service</b>	<b>Included in Medicare Capitation</b>
Hearing Services	Medicaid and Medicare hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. No co-payment or limitations.
Vision Care Services	Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage includes the replacement of lost or destroyed glasses. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed. No prerequisite of cataract surgery. No co-payment.
Routine Physical Exam 1/year	Up to one routine physical per year. Subject to \$10 co-payment per visit.
Health/Wellness Education	Coverage for the following: general health education classes, parenting classes, smoking cessation classes, childbirth education and nutrition counseling, plus additional benefits at plan option including but not limited to items such as newsletters, nutritional training, congestive heart program, health club membership/fitness classes, nursing hotline, disease management, other wellness services. No co-payments.
Additional Part C Benefits, if any	
Medicare Part D Prescription Drug Benefit as approved by CMS	

<b>Medicare Advantage Benefit Package for Dual Eligibles NYC, Nassau, Suffolk, Westchester, Rockland, Orange and Putnam Counties</b>	
<b>Category of Service</b>	<b>Included in Medicare Capitation</b>
Inpatient Hospital Care Including Substance Abuse and Rehabilitation Services	Up to 365 days per year (366 days for leap year) with no deductible or co-payment
Inpatient MH	Medically necessary care with no deductible or co-payment. 190-day lifetime limit in a psychiatric hospital.
SNF	Care provided in a skilled nursing facility. Covered for 100 days each benefit period. No prior hospital stay required. No co-payment.
Home Health	Medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. No co-payment.
PCP Office Visits	Primary care doctor office visits. No co-payment.
Specialist Office Visits	Specialist office visits. Subject to \$10 co-payment for each specialist office visit.
Chiropractic	Manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified providers. Subject to \$10 co-payment.
Podiatry	Medically necessary foot care, including care for medical conditions affecting lower limbs, subject to \$10 co-payment. Visits for routine foot care up to 4 visits per year, not subject to co-payment.
Outpatient Mental Health	Individual and group therapy visits, subject to co-payment of \$20 per individual or group visit. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.
Outpatient Substance Abuse	Individual and group visits subject to \$20 co-payment per group or individual visit. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.
Outpatient Surgery	Medically necessary visits to an ambulatory surgery center or outpatient hospital facility. No co-payment.
Ambulance	Transportation provided by an ambulance service, including air ambulance. Emergency transportation if for the purpose of obtaining hospital services for an enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency services while the enrollee is being transported. Includes transportation to a hospital emergency room generated by a "Dial 911". No co-payment.

<b>Medicare Advantage Benefit Package for Dual Eligibles NYC, Nassau, Suffolk, Westchester, Rockland, Orange and Putnam Counties</b>	
<b>Category of Service</b>	<b>Included in Medicare Capitation</b>
Emergency Room	Care provided in an emergency room subject to prudent layperson standard. \$50 co-payment per visit. Co-payment waived if admitted to the hospital within 24 hours for the same condition.
Urgent Care	Urgently needed care in most cases outside the plan's service area. Subject to \$10 co-payment.
Outpatient Rehab (OT, PT, Speech)	Occupational therapy, physical therapy and speech and language therapy subject to \$10 co-payment.
DME	Medicare and Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually not fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g., tub stool; grab bar). No co-payment or coinsurance.
Prosthetics	Medicare and Medicaid covered prosthetics, orthotics and orthopedic footwear. No diabetic prerequisite for orthotics. Not subject to co-payment or coinsurance.
Diabetes Monitoring	Diabetes self-monitoring training and supplies including coverage for glucose monitors, test strips, lancets and self-management training. No co-payments.
Diagnostic Testing	Diagnostic tests, x-rays, lab services and radiation therapy. No co-payments.
Bone Mass Measurement	Bone Mass Measurement for people at risk. No co-payment
Colorectal Screening	Colorectal screening for people, age 50 and older. No co-payment.
Immunizations	Flu, hepatitis B vaccine for people who are at risk, Pneumonia vaccine. No co-payment.
Mammograms	Annual screening for women age 40 and older. No referral necessary. No co-payment.
Pap Smear and Pelvic Exams	Pap smears and Pelvic Exams for women. No co-payment.
Prostate Cancer Screening	Prostrate Cancer Screening exams for men age 50 and older. No co-payment.
Outpatient Drugs	Medicare Part B covered prescription drugs and other drugs obtained by a provider and administered in a physician's office or clinic setting covered by Medicaid.

<b>Medicare Advantage Benefit Package for Dual Eligibles NYC, Nassau, Suffolk, Westchester, Rockland, Orange and Putnam Counties</b>	
<b>Category of Service</b>	<b>Included in Medicare Capitation</b>
Hearing Services	Medicare and Medicaid hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. No co-payment or limitations.
Vision Care Services	Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage includes the replacement of lost or destroyed glasses. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed. No prerequisite of cataract services. No co-payment.
Routine Physical Exam 1/year	Up to one routine physical per year. No co-payment.
Health/Wellness Education	Coverage for the following: general health education classes, parenting classes, smoking cessation classes, childbirth education and nutrition counseling, plus additional benefits at plan option including but not limited to items such as newsletters, nutritional training, congestive heart program, health club membership/fitness classes, nursing hotline, disease management, other wellness services. No co-payments.
Additional Part C Benefits, if any	
Medicare Part D Prescription Drug Benefit as approved by CMS	

## MEDICAID ADVANTAGE PRODUCT

<b>Medicaid Advantage Benefit Package for Dual Eligibles – Upstate Counties</b>	
<b>Category of Service</b>	<b>Included in Medicaid Capitation</b>
Inpatient Hospital Care Including Substance Abuse and Rehabilitation Services	Elimination of \$300 per stay co-payment.
Inpatient MH	Elimination of \$300 per stay co-payment, plus days in excess of the 190-day lifetime maximum.
Home Health	Elimination of \$10 co-payment per Medicare covered visit, plus value of Medicare non-covered visits including home health aid services with nursing supervision to medically unstable individuals.
PCP Office Visits	Elimination of \$10 co-payment
Specialist Office Visits	Elimination of \$20 co-payment
Podiatry	Elimination of \$20 co-payment for medically necessary foot care
Outpatient Mental Health	Elimination of \$20 co-payment
Outpatient Substance Abuse	Elimination of \$20 co-payment
Outpatient Surgery	Elimination of \$35 co-payment
Ambulance	Elimination of \$50 co-payment
Emergency Room	Elimination of \$50 co-payment
Urgent Care	Elimination of \$20 co-payment
Outpatient Rehab (OT, PT, Speech)	Elimination of \$20 co-payment
Dental <i>(Optional benefit)</i>	Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.
Routine Physical Exam 1/year	Elimination of \$10 co-payment
Transportation – Routine <i>(Optional benefit)</i>	Transportation essential for an enrollee to obtain necessary medical care and services under the plan’s benefits or Medicaid fee-for-service. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee’s medical condition and a transportation attendant to accompany the enrollee, if necessary.
Private Duty Nursing	Medically necessary private duty nursing services in accordance with the ordering physician, registered physician assistant or certified nurse practitioner’s written treatment plan.

<b>Medicaid Advantage Benefit Package for Dual Eligibles NYC, Nassau, Suffolk, Westchester, Rockland, Orange and Putnam Counties</b>	
<b>Category of Service</b>	<b>Included in Medicaid Capitation</b>
Inpatient MH	Days in excess of the 190-day lifetime maximum.
Home Health	Non-Medicare covered home health services, including home health aid services and nursing supervision to medically unstable individuals.
Specialist Office Visits	Elimination of \$10 co-payment.
Podiatry	Elimination of \$10 co-payment for medically necessary foot care.
Outpatient Mental Health	Elimination of \$20 co-payment.
Outpatient Substance Abuse	Elimination of \$20 co-payment.
Emergency Room	Elimination of \$50 co-payment
Urgent Care	Elimination of \$10 co-payment.
Outpatient Rehab (OT, PT, Speech)	Elimination of \$10 co-payment.
Dental <i>(Optional benefit outside of NYC)</i>	Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.
Transportation – Routine <i>(Optional benefit outside of NYC)</i>	Transportation essential for an enrollee to obtain necessary medical care and services under the plan’s benefits or Medicaid fee-for-service. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee’s medical condition and a transportation attendant to accompany the enrollee, if necessary.
Private Duty Nursing	Medically necessary private duty nursing services in accordance with the ordering physician, registered physician assistant or certified nurse practitioner’s written treatment plan.

## **NON COVERED SERVICES**

The following services will not be the responsibility of the MCO under the Medicare/Medicaid program:

### **Services Covered by Direct Reimbursement from Original Medicare**

- Hospice services provided to Medicare Advantage members
- Other services deemed to be covered by Original Medicare by CMS

### **Services Covered by Medicaid Fee-for-Service**

- Out of network Family Planning services under the direct access provisions of the waiver
- Skilled Nursing Facility (SNF) days not covered by Medicare
- Personal Care Services
- Medicaid-covered Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formula not covered under Medicare Part B or the Contractor's Medicare Part D Prescription Drug Benefit approved by CMS.
- Methadone Maintenance Treatment Programs
- Certain Mental Health Services, including
  - Intensive Psychiatric Rehabilitation Treatment Programs
  - Day Treatment
  - Continuing Day Treatment
  - Case Management for Seriously and Persistently Mentally Ill (sponsored by State or local mental health units)
  - Partial Hospitalizations Not Covered by Medicare
  - Assertive Community Treatment (ACT)
  - Personalized Recovery Oriented Services (PROS)
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- Office of Mental Retardation and Developmental Disabilities (OMRDD) Services
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for Tuberculosis Disease
- AIDS Adult Day Health Care
- HIV COBRA Case Management
- Adult Day Health Care
- Personal Emergency Response Services (PERS)

### **Medicaid Advantage Program Optional Benefits**

Optional benefits will be covered Medicaid fee-for-service if the MCO elects not to cover these services in their Medicaid Advantage Product. Currently the only 2 optional benefits are:

- Non-Emergency Transportation Services
- Dental Service

These services are mandatory in NYC.

## **Linkage/Coordination Activities**

Managed care organizations that participate in Medicaid Advantage will coordinate care for Enrollees with:

- The court system;
- Providers of healthcare for the homeless, and providers of services for victims of domestic violence;
- Family planning clinics, community health centers, migrant health centers, and rural health centers;
- Supplemental Program for Women, Infants and Children (WIC);
- Programs funded through the Ryan White Act;
- Other entities that provide services out-of-network
- Prenatal Care Assistance Providers (PCAP);
- Local governmental units responsible for public health, mental health, mental retardation, and chemical dependence services; and
- Specialized providers of long term care for people with developmental disabilities.

Coordination may involve contracts, linkage agreements, or other mechanisms.

## **Family Planning and Reproductive Health Services**

All Medicaid Advantage Enrollees will be permitted to access any qualified Medicaid provider for family planning services without regard to provider participation in the health plan or PCP referral.

MCOs that participate in Medicaid Advantage must have mechanisms in place to advise Enrollees and participating providers of the policy for free access to family planning services.

## **Medicaid Advantage Marketing Guidelines**

MCOs must follow the Medicaid Advantage Marketing guidelines when developing marketing materials and conducting marketing activities for the Medicaid Advantage Program. The Medicaid Advantage Marketing guidelines do not replace the CMS marketing requirements for Medicare Advantage, they supplement them.

### *Marketing Materials*

In addition to meeting CMS' Medicare Advantage marketing requirements and guidance on marketing to individuals entitled to Medicare and Medicaid, Medicaid Advantage marketing materials must meet the following criteria:

- Written materials for Medicaid consumers, including marketing materials and notices, must be written in prose that is understood at the 4<sup>th</sup> to 6<sup>th</sup> grade reading level, except when the MCO is using language required by CMS. Written materials must be printed in at least 12 point font.

- Written materials related to enrollment shall advise potential enrollees to verify with the medical services providers they prefer, or have an existing relationship with, that such medical services providers participate in the MCO's network and are available to serve the participant.
- Written marketing and enrollment materials must be made available in a language other than English whenever at least five percent (5%) of the potential Enrollees of the health plan in any county of the service area speak that particular language and do not speak English as a first language. As with mainstream Medicaid managed care, the SDOH will inform the local districts and local districts will inform the MCO when the 5% threshold applies.

The CMS and SDOH will jointly review and approve Medicaid Advantage marketing videos, materials for broadcast (radio, television, or electronic), billboards, mass transit (bus, subway or other livery) and statewide/regional print advertising materials. In addition, the CMS and SDOH will jointly review and approve the following Medicaid Advantage marketing materials:

- Scripts or outlines of presentations and materials used at health fairs and other approved types of events and locations;
- All pre-enrollment written marketing materials – written marketing materials include brochures and leaflets, and presentation materials used by marketing representatives;
- All direct mailing from the MCO specifically targeted to the Medicaid market.

Participating health plans will electronically submit all materials related to marketing Medicaid Advantage to dually eligible persons to the CMS Regional Office for prior written approval. The CMS Medicare Regional Office Plan Manager will be responsible for obtaining SDOH input in the review and approval process in accordance with CMS timeframes for the review of marketing materials. Similarly, SDOH will be responsible for obtaining LDSS input in the review and approval process.

MCOs may not distribute or use any Medicaid Advantage marketing materials that the CMS Regional Office and the SDOH did not jointly approved, prior to the expiration of the required review period. Approved marketing materials will be kept on file in the offices of the MCO, the LDSS, the SDOH, and CMS.

### *Marketing Activities*

MCOs must follow the State's Medicaid marketing rules and the requirements of 42 CFR 438.104 to the extent applicable when conducting marketing activities that are primarily intended to sell a Medicaid managed care product (i.e., Medicaid Advantage). Marketing activities intended to sell a Medicaid managed care product are defined as activities conducted pursuant to a Medicaid Advantage marketing program in which a dedicated staff of marketing representatives employed by the MCO, or by an entity with which the MCO has subcontracted, are engaged in marketing activities with the primary purpose of enrolling recipients in the MCO's Medicaid Advantage product.

Marketing activities that do not meet the above criteria will not be construed as having a primary purpose of intending to sell a Medicaid managed care product and shall be conducted in accordance with Medicare Advantage marketing requirements. Such activities include but are not limited to plan sponsored events in which marketing representatives not dedicated to the marketing of the Medicaid Advantage product explain Medicare products offered by the MCO as well as the MCO's Medicaid Advantage product.

#### *Marketing at LDSS Offices*

With prior LDSS approval, MCOs may distribute CMS/SDOH approved Medicaid Advantage marketing materials in the local social services district offices and facilities

#### *Responsibility for Marketing Representatives*

Individuals employed by the MCO as marketing representatives and employees of marketing subcontractors must have successfully completed the MCO's training program including training related to an enrollee's rights and responsibilities in Medicaid Advantage. MCOs shall be responsible for the activities of its marketing representatives and the activities of any subcontractor or management entity.

#### *Medicaid Advantage Specific Marketing Requirements*

The following Medicaid Advantage specific marketing requirements apply only if marketing activities for the Medicaid Advantage Program are conducted pursuant to a Medicaid Advantage marketing program in which a dedicated staff of marketing representatives employed by the MCO or by an entity with which the MCO has a subcontract are engaged in marketing activities with the sole purpose of enrolling recipients in the MCO's Medicaid Advantage product.

1. Approved Marketing Plan
  - a. The MCO must submit a plan of Medicaid Advantage Marketing activities that meet the SDOH requirements to the SDOH.
  - b. The LDSS is responsible for the review and approval of Medicaid Advantage marketing plans, using a SDOH and CMS approved checklist.
  - c. Approved marketing plans will set forth the terms and conditions and proposed activities of the Medicaid Advantage dedicated staff during the contract period. The following must be included: description of materials to be used, distribution methods; primary types of marketing locations and a listing of the kinds of community service events the MCO anticipates sponsoring and/or participating in during which it will provide information and/or distribute Medicaid Advantage marketing materials.

- d. An approved marketing plan must be on file with the SDOH and each LDSS prior to the MCO engaging in the Medicaid Advantage specific marketing activities.
  - e. The plan shall include stated marketing goal and strategies, marketing activities, and the training, development and responsibilities of dedicated marketing staff.
  - f. The MCO must describe how it is able to meet the informational needs related to marketing for the physical and cultural diversity of its potential membership. This may include, but not be limited to, a description of the MCO's other than English language provisions, interpreter services, alternate communication mechanisms including sign language, Braille, audio tapes, and/or use of Telecommunications Devices for the Deaf (TTY) services.
  - g. The MCO shall describe measures for monitoring and enforcing compliance with these guidelines by its marketing representatives including the prohibition of door to door solicitation and cold-call telephoning; a description of the development of pre-enrollee mailing lists that maintains client confidentiality and honors the client's express request for direct contact by the MCO; the selection and distribution of pre-enrollment gifts and incentives to prospective enrollees ; and a description of the training, compensation and supervision of its Medicaid Advantage dedicated marketing representatives.
2. Compensation for Dedicated Medicaid Advantage Marketing Staff

MCOs may not offer compensation to Medicaid Advantage dedicated marketing representatives, including salary increases or bonuses, based solely on the number of individuals they enroll in Medicaid Advantage. However, MCOs may base compensation of these marketing representatives on periodic performance evaluations which consider enrollment productivity as one of several performance factors during a performance period, subject to the following requirements:

- a. "Compensation" shall mean any remuneration required to be reported as income or compensation for federal tax purposes;
- b. MCOs may not pay a "commission" or fixed amount per enrollment;
- c. Bonuses may not be awarded more frequently than quarterly, and the annual amount awarded as bonus compensation to a marketing representative may not exceed 10% of his/her total annual compensation;
- d. Performance evaluations used as a basis for such bonus or salary increase shall be set forth in writing and available for inspection by SDOH or the LDSS;

- e. Other appropriate factors which may be considered by an MCO in awarding merit salary increase or bonuses to marketing representatives include but are not limited to:
  - i) Ratio of “clean” or successful enrollments submitted; quality of applications;
  - ii) Attendance; adherence to marketing schedules; timeliness;
  - iii) Observed marketing behavior; absence/paucity of complaints regarding marketing conduct.

### 3. Prohibition of Cold Call Marketing Activities

MCOs are prohibited from directly or indirectly, engaging in door to door, telephone, or other cold-call marketing activities.

### 4. Marketing in Emergency Rooms or Other Patient Care Areas

MCOs may not distribute materials or assist prospective Enrollees in completing Medicaid Advantage application forms in hospital emergency rooms, in provider offices, or other areas where health care is delivered unless requested by the individual.

### 5. Enrollment Incentives

MCOs may not offer incentives of any kind to Medicaid recipients to join Medicaid Advantage. Incentives are defined as any type of inducement whose receipt is contingent upon the recipients joining the MCO’s Medicaid Advantage product.

## *General Marketing Restrictions*

The following general marketing restrictions apply anytime the MCO markets its Medicaid Advantage product:

- MCOs are prohibited from misrepresenting the Medicaid program, the Medicaid Advantage Program or the policy requirements of the LDSS or SDOH.
- MCOs are prohibited from purchasing or otherwise acquiring or using mailing lists that specifically identify Medicaid recipients from third party vendors, including providers and LDSS offices, unless otherwise permitted by CMS. MCOs may produce materials and cover their costs of mailing to Medicaid recipients if the mailing is carried out but the State or LDSS, without sharing specific Medicaid information with the MCO.
- MCOs may not discriminate against a potential Enrollee based on his/her current health status or anticipated need for future health care. MCOs may not discriminate on the basis of disability or perceived disability of any Enrollee or their family member. Health assessments may not be performed by the MCO prior to enrollment. The MCO may inquire about existing primary care relationships of the applicant and explain whether and how such relationships may be maintained. Upon request, each potential Enrollee shall be

provided with a listing of all participating providers and facilities in the MCO's network. MCOs may respond to a potential Enrollee's question about whether a particular specialist is in the network. However, the MCO is prohibited from inquiring about the types of specialists utilized by the potential Enrollee.

- MCOs may not require participating providers to distribute plan prepared communications to their patients, including communications which compare the benefits of different health plans, unless the materials have the concurrence of all MCOs involved, and have received prior approval by SDOH, and by CMS, if Medicare Advantage is referenced.
- MCOs are responsible for ensuring that their marketing representatives engage in professional and courteous behavior in their interactions with LDSS staff, staff from other health plans and Medicaid clients. Examples of inappropriate behavior include interfering with other health plan presentations or talking negatively about another health plan.

### *Marketing Infractions*

As in Medicaid managed care, infractions of Medicaid marketing guidelines may result in the following actions being taken by the SDOH, in consultation with the LDSS to protect the interests of the program and its clients. These actions shall be taken by the SDOH in collaboration with the LDSS and the CMS Regional Office.

- If an MCO or its representative commits a first time infraction of marketing guidelines and the SDOH, in consultation with the LDSS, deems the infraction to be minor or unintentional in nature, the SDOH and/or the LDSS may issue a warning letter to the MCO.
- If the MCO engages in Marketing activities that the SDOH determines, in its sole discretion, to be an intentional or serious breach of the Medicaid Advantage Marketing Guidelines or the MCO's approved Medicaid Advantage Marketing Plan, or a pattern of minor breaches, SDOH, in consultation with the LDSS, may require the MCO to, and the MCO shall, prepare and implement a corrective action plan with a specified timeframe. In addition, or alternatively, SDOH may impose sanctions, including monetary penalties, as permitted by law.
- If the MCO commits further infractions, fails to pay liquidated damages within the specified timeframe, fails to implement a corrective action plan in a timely manner or commits an egregious first-time infraction, the SDOH, in consultation with the LDSS, may in addition to any other legal remedy available to the SDOH in law or equity:
  - a). direct the plan to suspend its Medicaid Advantage marketing activities for a period up to the end of the contract period;
  - b). suspend new Medicaid Advantage enrollments, for a period up to the remainder of the contract; or
  - c). terminate the contract pursuant to termination procedures described therein.

### **Education and Outreach**

At the start of the initiative, the SDOH will initiate an outreach campaign to eligible individuals. The campaign will include a direct mailing to those known to meet eligibility criteria for

Medicaid Advantage. The mailing will include a description of the new initiative, the option for enrollment, and the advantages of participating in the program. A description of the program, participation requirements, and a list of plans participating in each local district will also be included in the mailing.

Supplies of the descriptive materials and plan availability lists will also be made available to local social service districts, the enrollment broker, and local offices and other appropriate venues to promote outreach and education to the dually eligible population.

## **Enrollment and Disenrollment Processes**

### *Enrollment*

Local districts or the enrollment broker will be responsible for advising eligible recipients about the availability of Medicaid Advantage plans in the district. Participating MCOs will assist eligible recipients in completing Medicaid Advantage enrollment applications.

MCOs must follow the SDOH/CMS approved marketing checklist when advising prospective enrollees about Medicaid Advantage and will be responsible for obtaining evidence of the prospective enrollee's Medicare Part A and B coverage prior to sending a Medicaid Advantage enrollment to the LDSS or the enrollment broker for processing. For purposes of verifying Medicare coverage, the MCO may accept a Medicare Card or other form of documentation currently acceptable to CMS (a Social Security Administration award notice, a Railroad Retirement Board letter of verification; a statement from SSA or RRB verifying the individual's entitlement to Medicare Part A and enrollment in Part B; or verification of Medicare Part A and Part B through one of CMS' systems).

An eligible individual must fill out an enrollment form to enroll in a Medicaid Advantage Plan even if that individual is already enrolled in the Medicaid managed care product offered by the same plan.

MCOs will submit Medicaid Advantage enrollments electronically to the enrollment broker for NYC, Nassau and Suffolk counties. In all other areas of the State, plans will submit Medicaid Advantage enrollment forms along with documentation of the individual's Medicare coverage (preferably a copy of Medicare card) to the appropriate local district.

As with mainstream enrollments, the enrollment broker and local districts will process Medicaid Advantage enrollments received before the 15<sup>th</sup> of the month to take effect on the first day of the following month. In addition, the enrollment broker and local districts will be encouraged to process enrollments received up to the next to the last business day of the month to take effect on the first day of the following month. Extensive use will be made of secondary roster to coordinate, to the degree possible, timing of the effective date of Medicaid Advantage enrollments with those for Medicare Advantage enrollments.

Local districts and the enrollment broker will enter individual enrollment data and transmit that data to the State's Prepaid Capitation Plan subsystem. The documentation of Medicare coverage

provided by health plans with enrollment applications will be used by district staff to update recipients' eligibility in WMS and Medicare status in the Third Party Health Insurance subsystem.

The enrollment broker will run enrollment transactions through edits for Medicare coverage indicators on WMS and generate plan-specific reports identifying individuals for whom Part A and B coverage is not currently indicated in the Third Party Health Insurance subsystem. Health plans will be required to provide documentation of Medicare coverage for listed individuals to the enrollment broker as soon as possible and no later than within 30 days. Once the enrollment broker obtains the proof of Medicare coverage, the information will be forwarded to HRA or Nassau and Suffolk LDSSs to update eligibility in WMS and in the Third Party Health Insurance subsystem.

In no event, will enrollment transactions be delayed because Medicare coverage is not evident on the WMS system at the time the Medicaid Advantage enrollment transaction is processed.

Local districts and the enrollment broker will notify the health plans of Medicaid Advantage enrollment applications that are approved (through the 1<sup>st</sup> and 2<sup>nd</sup> roster) or denied.

Local districts will send an enrollment confirmation notice to each enrollee, indicating the effective date of enrollment in Medicaid Advantage, the name of the Medicaid Advantage Plan and the name(s) of the individual(s) enrolled. Local districts will also send a notice of denial of enrollment when an individual has been determined by the LDSS to be ineligible for enrollment into a Medicaid Advantage Plan. This notice to the individual will include fair hearing rights.

Health plans also will be required to notify new enrollees of their effective date of enrollment in Medicaid Advantage. To the extent practicable, such notification must precede the effective date of enrollment. Enrollment confirmation notices from both the plans and districts shall advise individuals that if the individual's Medicare Advantage enrollment is rejected by CMS, their Medicaid Advantage enrollment will be deleted retroactive to the effective date of enrollment; and that the individual may be responsible for the cost of any Medicaid Advantage benefit received, if the benefit was provided by a non-Medicaid participating provider.

If an individual's enrollment in a Medicare Advantage plan is rejected by CMS, or if the enrollee voluntarily disenrolls from the plan's Medicare Advantage product, the plan must notify the local district or the enrollment broker within 5 business days of learning of the enrollee's disenrollment status. Such notice shall include the effective date of the transaction so that the individual may be disenrolled by the local district or the broker from the health plan's Medicaid Advantage product effective the same date.

- If the individual's Medicare Advantage enrollment is rejected by CMS, the enrollee's Medicaid Advantage enrollment shall be deleted retroactive to the effective date of enrollment in Medicaid Advantage.
- If an individual voluntarily disenrolls from a plan's Medicare Advantage product to Original Medicare, or to another plan's Medicare Advantage Product, the disenrollment

in the plan's Medicaid Advantage product, shall be made effective the same date as the disenrollment from Medicare Advantage.

Health plans must notify the LDSS of any change in status of the enrolled members within 5 business days of such information becoming known to the health plan (through CMS Monthly Membership and Transaction Reply Reports or other means). This includes, but is not limited to factors that may impact an enrollee's eligibility for Medicaid or for Medicaid Advantage, including disenrollment from an MCO's Medicare Advantage product

### *Transfers*

Medicare managed care enrollees who will gain Medicare coverage may transfer to their health plan's Medicaid Advantage product or enroll in another health plan's Medicaid Advantage product, effective the date they have Medicare coverage, as long as they also enroll in the plan's Medicare Advantage product. In such instances, MCOs will submit a new Medicaid Advantage enrollment to the local district or to the enrollment broker to enable the transfer of the enrollee from the plan's mainstream product to the plan's Medicaid Advantage Product. The enrollment broker will be instructed to allow transfers from a plan's Medicaid managed care product to the plan's Medicaid Advantage product without a disenrollment form. A new enrollment transaction, however, is required.

### *Disenrollments*

Participating health plans may take Medicaid Advantage disenrollment forms from enrollees. Health plans must forward these disenrollments to the LDSS or the enrollment broker for processing. Local districts also will accept requests for disenrollment from Medicaid Advantage directly from enrollees and not require enrollees to approach the MCO for a disenrollment form.

Generally disenrollments from Medicaid Advantage will take effect the first day of the following month if the request is made before the 15<sup>th</sup> of the month (or pull down date). In no event, shall the effective date of disenrollment be later than the first day of the second month after the month in which an enrollee requests a disenrollment.

LDSS will promptly disenroll enrollees automatically upon death, or upon loss of Medicaid eligibility, or upon loss of Medicaid Advantage eligibility. Disenrollments will be effective at the end of the month in which the death or loss of eligibility occurs or at the end of the last month of guaranteed eligibility, if applicable.

Mainstream Medicaid managed care rules will apply for expedited disenrollment from Medicaid Advantage. An Enrollee may request an expedited enrollment from Medicaid Advantage under specific circumstances (urgent medical need, non-consensual enrollment, homeless in the shelter system in NYC).

Mainstream rules also will apply for retroactive disenrollment. Circumstances warranting a retroactive disenrollment are rare and include when an individual is enrolled while not meeting

Medicaid Advantage eligibility criteria, or when an enrollee's status changes such that he/she no longer meets Medicaid Advantage eligibility criteria.

In all cases of retroactive disenrollment, the local district must notice the health plan at the time of disenrollment of the health plan's responsibility to submit to the SDOH's fiscal agent, voided premium claims for any full months of retroactive disenrollment where the health plan was not at risk for the provision of benefit package services during the month. However failure by the LDSS to notify the health plan does not affect the right of the SDOH to recover the premium payment.

Local districts will notify health plans of disenrollment applications that are approved or denied. Local districts will also send a notice of disenrollment to enrollees advising them of the LDSS's determination regarding a disenrollment request, including the effective date of disenrollment, and fair hearing rights, if applicable.

### *Guaranteed Eligibility*

New enrollees in Medicaid Advantage, who would otherwise lose Medicaid eligibility during the first 6 months of enrollment, will retain the right to remain enrolled in the Medicaid Advantage plan for a period of 6 months from their effective date of enrollment as long as they remain enrolled in the plan's Medicare Advantage product (exceptions include death, incarceration, moving out of state).

An enrollee may not change Medicare or Medicaid Advantage health plans during the guarantee period. Enrollee-initiated disenrollment from the Medicaid Advantage plan terminates the guaranteed eligibility period.

If an individual loses Medicaid eligibility and is entitled to guaranteed coverage, the local district must send the enrollee a notice advising the enrollee that his/her Medicaid coverage is ending and how this affects his or her enrollment in Medicaid Advantage.

### *Newborns of Medicaid Advantage Enrollees*

There will be no automatic enrollment of newborns. Pregnant enrollees in Medicaid Advantage may choose to pre-enroll their unborn in any Medicaid managed care health plan.

However, health plans will still be required to notify the local district in writing of any enrollee that is pregnant within 30 days of knowledge of the pregnancy. Notification should include the pregnant woman's name, CIN, and expected date of confinement.

Upon the newborn's birth, the Contractor must send identification of the infant's demographic data to the LDSS, within 5 days after knowledge of the birth. The demographic data must include: the mother's name and CIN, the newborn's name and CIN (if available), sex, and the date of birth.

## **Systems Changes**

Each participating Medicaid Advantage Plan will be assigned a new Provider Identification Number and Plan Code.

Two new premium groups will be established: one for individuals ages 21-64, and one for individuals ages 65 and over. Rate code 2370 will be used for the 21-64 age group, and rate code 2371 for the 65 and over age group. Plans will be notified of enrolled recipients through the same roster process used for the mainstream Medicaid program.

System modifications to the Scope of Benefits file will allow providers of service and other authorized individuals to verify enrollment in the Medicaid Advantage Plan and view the list of services covered by the plan, just as they do for mainstream managed care enrollees.

## **Member Handbooks**

Not later than fourteen days after enrollment in Medicaid Advantage, MCOs are required to provide new enrollees with a copy of the Medicaid Advantage handbook. Designed to supplement the Medicare Advantage Explanation of Coverage (EOC), the handbook must follow the model Medicaid Advantage handbook, and be prior approved by SDOH and the CMS Regional Office.

## **MCO Participation Policies, Contracting Requirements**

To participate in Medicaid Advantage, MCOs must: 1) be approved by CMS as a Medicare Advantage Plan; 2) participate in the Medicaid managed care program or be qualified as a Medicaid Advantage Plan by SDOH, and 3) offer the standardized Medicare Advantage benefit package to dual eligibles enrolled in the program.

Proposals for Medicaid Advantage Premiums must be deemed acceptable by DMC's Bureau of Managed Care Financing and approved by the State's Division of Budget. Networks for Medicaid only service to be offered by the MCO's Medicaid Advantage product must be approved by the DMC's Bureau of Managed Care Certification and Surveillance. Marketing plans, marketing materials and sales check lists, enrollment forms, and member handbooks must follow SDOH and CMS approved models and be approved by DMC's Bureau of Program Planning and Implementation and the CMS Regional Office prior to use. Model Medicaid Advantage contracts must be executed by participating MCOs and approved by CMS prior to marketing and the processing of enrollments.

## **Qualification Process for New Plans**

A plan certified in the State as a managed care plan under Article 44 of the State's Public Health Law and which participates in Medicare Advantage, will be allowed to qualify to participate in offering the Medicaid Advantage product for the dual eligible population only, if the plan agrees to explore the feasibility of serving additional aid categories at a later date. SDOH will require such plans to go through a similar qualification process as other plans that wish to participate in

Medicaid managed care. Plans will be required to respond to qualification provisions that relate to Medicaid Advantage and the dual eligible population.

With respect to network review, the SDOH will defer to Medicare approved networks for Medicare benefits and will only review provider networks for benefits related to Medicaid Only Covered Services such as private duty nursing, dental, and non-emergency transportation services (when included in the plan's Medicaid Advantage product).

### **Plan Reporting Requirements**

MCOs participating in the dual eligible initiative will be held to the same reporting requirements as mainstream Medicaid managed care plans with respect to annual financial statements, quarterly financial statements, other financial reports, additional reports as requested by SDOH, ownership and related information disclosure, revision of certificate of authority, public access to reports, certification regarding individuals who have been debarred or suspended by the federal or State government, conflict of interest disclosures, and physician incentive plan reporting.

In addition, participating MCOs will be required to submit quality of care performance measure reports to SDOH, as specified by CMS for the Medicare Advantage Program including Medicare HEDIS results and Medicare CAHPS. Reports may be duplicative of reports submitted to CMS and separate reports for the dual eligible population are not required.

MCOs are also required to submit reports to SDOH on all quality management and performance improvement projects, including the Chronic Care Improvement Program as directed by CMS for the Medicare Advantage Program.

MCOs will be required to submit encounter data on a monthly basis to SDOH's Fiscal Agent. Submissions will be comprised of encounter records, or adjustments to previously submitted records which the MCO has received and processed from provider encounter or claim records of any contracted services rendered to the enrollee in the current or any preceding months, including both Medicare and Medicaid covered services.

MCOs must submit electronically to the HPN, updated provider network reports on a quarterly basis for providers of Medicaid Only Covered Services. Networks must be reported separately for each county in which the Contractor operates.

MCOs must also submit a summary of all complaints received during the preceding quarter related to Medicaid Only Services and services determined by the MCO to be a benefit under both Medicare and Medicaid, and the total number of complaints that have been unresolved for more than 45 days. In addition, MCOs must submit quarterly, complaints of fraud and abuse related to Medicaid Only Covered Services warranting investigation as well as confirmed cases of fraud and abuse related to Medicaid Only Covered Services.

Appointment Availability/24 hour /Access and Availability Surveys, Independent QARR audits, new enrollee screening completion reports, no contact reports and LDSS specific reports will not be required.

## **Organization Determinations, Actions and Grievance Systems**

Processes for organization determinations, actions and grievance systems will follow the Special Terms and Conditions of the State's 1115 waiver demonstration as amended by CMS in its December 15, 2004 letter of approval allowing Medicare/Medicaid dual eligibles to voluntarily enroll in one managed care plan for both Medicare and Medicaid benefits.

- If the MCO determines that the service is a Medicare-only benefit, the plan must provide a Medicare notice in accordance with 42 CFR Section 422.568. The Medicare Advantage plan and enrollee will follow the Medicare appeal procedures outlined in section 422.560 et. seq. and Chapter 13 of CMS' Medicare Managed Care Manual.
- If the MCO determines that the service is a Medicaid-only benefit, the plan must provide a Medicaid notice in accordance with Sections 438.210 and 438.404. The plan, State and enrollee will follow the Medicaid Action and Grievance System procedures outlined in Section 438.400 et seq.
- If an MCO determines that the service is a benefit under both Medicare and Medicaid, the enrollee may choose to pursue either the Medicare appeals procedures or the Medicaid Advantage Action Appeal and Grievance system. If the enrollee chooses to pursue the Medicare appeal procedures to challenge the denial, then the enrollee is precluded from pursuing the Medicaid grievance system. The plan must provide a notice that informs the enrollee of his or her rights under both programs. The notice must explain the extent to which the enrollee may be precluded from filing an appeal under the alternate process, once the enrollee has made a selection. (Since the Medicare appeal procedures under Section 1852(g) of the Act cannot be waived, if an enrollee chooses to pursue an appeal under the Medicaid grievance system to challenge the denial, then the enrollee has up to 60 days from the day of the notice of denial of coverage to pursue a Medicare appeal, regardless of the status of the Medicaid Action Appeal.)

Additionally, participating health plans agree through the Medicaid Advantage model contract to utilize the Medicaid definition of "medically necessary" when making decisions regarding Medicaid only covered services and services determine by the MCO to be a benefit under both Medicare and Medicaid.

## **Budget Neutrality**

Medicare/Medicaid dual eligibles are excluded from the budget neutrality provision in that these individuals are not subject to mandatory enrollment.

## **Capitation Payments Financial Tracking and Reporting to CMS**

To participate in the Medicaid Advantage Program each plan must submit a premium proposal to SDOH for the Medicaid portion of the dual eligible program. Premium proposals must be submitted in the standard format prescribed by SDOH. Proposals will be reviewed for reasonableness and consistency with the plan's Medicare submission to CMS. The rates must reflect the uniform Medicaid benefit package described herein, and reflect the regions and premium groups indicated in the Medicaid standard premium proposal format.

Plans will be required to submit quarterly financial reports (Medicaid Managed Care Operating Reports, or MMCOR) of actual cost and utilization for the dual eligible program. Summary data will be reported to CMS consistent with what is reported for the mainstream program.

### **Administrative and Management Data System**

Unless otherwise specified, the same administrative and management systems in place for Medicaid managed care are applicable to Medicaid Advantage. Automatic assignment is not a feature of the Medicaid Advantage Program, as participation in the program is voluntary.

### **County Qualification and Readiness**

Since Medicaid Advantage builds on the established Medicare and Medicaid managed care delivery system throughout the State, the program will only exist in counties that already have the operational capacity to implement Medicaid Advantage. Additional readiness reviews will not be required. All counties will be provided with training and technical assistance on Medicaid Advantage from the SDOH, as needed.

The SDOH prepared LDSSs for Medicaid Advantage implementation through the provision of regional training in the fall of 2004. As new plans join the program, LDSSs are provided with copies of materials developed for Medicaid Advantage implementation including the model handbook, sales script, model enrollment form and the model Medicaid Advantage contract.

Regional training is used to educate LDSSs about Medicaid Advantage program features, and the local districts' role with respect to educating beneficiaries about the availability of Medicaid Advantage, processing enrollments and disenrollments, and overseeing the implementation of the Medicaid Advantage marketing guidelines by participating health plans. Specific training is also provided to the enrollment broker.