



Managed Long Term Care Frequently Asked Questions and Answers

- Q1. How can I get a copy of the webinar powerpoint slides?**
A1. A copy of the webinar power point slides can be found at:
<http://www.health.ny.gov/healthcare/medicaid/redesign/managedltcworkgroup.htm>
- Q2. Will the CCM Guidelines webinar be available on the agencies website?**
A2. A copy of the webinar power point slides can be found at:
<http://www.health.ny.gov/healthcare/medicaid/redesign/managedltcworkgroup.htm>
- Q3. Can you confirm the email address for sending questions?**
A3. The e-mail address for sending questions is: mltcworkgroup@health.state.ny.us
- Q4. Is the application for the Care Coordination Model posted and, if yes, where can I find it?**
A4. The application can be found on the Medicaid Redesign Team Website, by clicking on the following link:
http://www.health.ny.gov/health_care/medicaid/redesign/managed_ltc_workgroup.htm
- Q5. Where can I find the Management Contract Guidelines?**
A5. The Management Contract Guidelines can be found on the Medicaid Redesign Team Website by clicking on the Supplemental Information link and selecting Management Contract Guidelines from the following website:
http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm
- Q6. Could you please let me know where I could find the HRA rates?**
A6. HRA rates can be found on the Medicaid Redesign Team website by clicking on the “MRT: 90 Mandatory Managed Long Term Care Enrollment” link on the following webpage:
http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm
- Q7. The MLTC transitional care policy does not appear on the website – will it be posted there soon?**
A7. The policy statement is posted on the Medicaid Redesign Team website under supplemental information in the advisory April 26, 2012 link.

- Q8. The policy cites a subsection of the Public Health Law that doesn't exist (sec. 4403-f(7)(i)) – will a new policy be distributed that clarifies this?**
- A8. Yes, PHL 4403-f 11d is now available at the following website:
http://www.health.ny.gov/health_care/managed_care/docs/phlart44.pdf
The link leads to a PDF document. The subsection cited is on page 24 of the document. Please refer to the Table of Contents for ease in navigating the policy.
- Q9. How do we begin the process of contracting?**
- A9. Providers interested in contracting with Managed Long Term Care plans should contact the plan directly. Plans are listed on the DOH website at the following link:
http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm
- Q10. DOH said on a recent MLTC call that letters went out and Maximus already has received about 35 calls/questions/complaints from consumers. Could we have an update on what Maximus is doing/telling these clients to prepare them for the rollout and helping them “choose” a plan?**
- A10. Maximus provides information regarding Managed Long Term Care plans, including information on provider networks to facilitate the choice of the individual and will facilitate linking the consumer with their selected plan upon request. (A consumer brochure is provided – please see new post on MRT website:
http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm
- Q11. Will Maximus make their presentation on their role and function in mandatory MLTC publically available?**
- A11. A copy of the presentation can be found at:
<http://www.health.ny.gov/healthcare/medicaid/redesign/managedltcworkgroup.htm>
- Q12. When is the Department going to update the MLTC webpage http://www.health.ny.gov/health_care/managed_care/mltc/ --and post the GUIDE and LISTS there?**
- A12. The Department is working to update the website.
- Q13. Are members referred by Local Department of Social Services (LDSS)? If not, does the LDSS have to approve each enrollment?**
- A13. Members can be referred by the LDSS, however, the LDSS does not have to approve each enrollment, this applies to NYC at this time.

Q14. What happens to the current Long Term Home Health Care Provider (LTHHCP) do they just cease to exist?

A14. One option for entities such as the LTHHCPs is to establish a corporate entity to apply to be a Managed Long Term Care Provider (MLTCP) or Care Coordination Model (CCM).

Another option is that LTHHCPs, consistent with any arrangement or agreement with their sponsoring agency, may make contractual arrangements with Managed Care Organizations (MCOs), MLTCPs or CCMs to provide home care services.

With regard to delineation of care management responsibilities in cases of LTHHCP contracts with MLTCs, MCOs or CCMs, it should be noted that currently LTHHCPs, MCOs, MLTCPs and CCMs all have broad care management responsibilities.

Accordingly, contractual arrangements must clearly articulate case management responsibilities between the entities to ensure no duplication of case management services.

It should be noted that once a LTHHCP consumer is transferred to a MLTCP or a CCM, the payment from the state will take the form of a “per member per month” payment to the plan for both services and care coordination. MLTCPs and CCMs may contract with providers for reimbursement, services and care coordination but the provider will no longer bill the state. All payment will be pursuant to the contractual relationship between the plan and the provider.

Q15. What is the status of the UAS-NY assessment tool and will it be used for Medicaid patients?

A15. At this time, the assessment tools have not changed. Ultimately, the Uniform Assessment System-New York (UAS-NY) will be incorporated into managed long term care. The beta testing of the UAS-NY was completed in August, pilot and implementation are planned for 2012 and 2013.

Q16. Will DSS have any oversight any longer with the LTHHCP?

A16. Yes however, during transition of services in mandatory counties Maximus will communicate with the consumer, their family or other responsible person regarding the transition. LDSS will continue existing oversight of LTHHCP, as providers will continue to provide services to consumers who are not required to enroll in Managed Long Term Care in mandatory counties. LTHHCP will remain an option for community based long term care (CBLTC) in non-mandatory counties with current oversight in place.

Q17. Will home modifications be a part of the benefit package or be separately billed to Medicaid or not be available?

A17. Social and environmental supports are a benefit of all managed long term care products.

Q18. Currently eligibility for MLTCPs are based on the SAAM score. How will the Department of Health measure eligible for MLTCP when the eligibility criteria changes to need for more than 120 days of long term care in the community. Stated otherwise, will eligibility be tied to a SAAM score that picks up the need for LTC services or will it be based on the medical judgment of the MLTCP?

A18. The Semi Annual Assessment of Members (SAAM) tool will continue to be used to functionally assess enrollees. Eligibility for Managed Long Term Care will not be tied to

the SAAM score for partial managed long term care plans. Nursing home level of care remains a requirement for both PACE and MAP eligibility.

Q19. Will the DOH still require OASIS submission for those patients who are not receiving skilled care (as defined by Medicare) when they are in a MLTC program in addition to the SAAM tool?

A19. Managed Long Term Care requires the SAAM. For any patient requiring CHHA service, the CHHA must adhere to the Conditions of Participation (COP) requirements.

Q20. How will you identify care coordinators that are not doing what they need to do? How will you handle these issues and prevent them in general?

A20. Care provided by plans is tracked through surveys and complaints raised by consumers and/or informal supports. The Department is enhancing its existing systems for complaints, surveys and surveillance.

Q21. If the care coordinator is responsible for all needs- will they coordinate Medicaid transportation? Will they identify and assist with the maintenance of housing?

A21. The care manager provides care management, including arrangements for transportation and other necessary services to support the individual in their own home.

Q22. If a Long Term Home Health Care Provider or CHHA applies to become a Care Coordination Model can they apply to cover a region larger than their original Long Term Home Health Care Provider or CHHA approval, or are approvals not to be limited in geographic areas as currently configured?

A22. The Article 36 license does not have to replicate the Article 44 application. Additional geographic areas can be served via contractual arrangement.

Q23. How will consumer education work and how is DOH preparing for a population that has various levels of cognitive impairment?

A23. The Department of Health has worked extensively with the enrollment broker to develop effective as well as user friendly consumer and provider education mechanisms. Maximus is required under contract to meet standards for continuation to disabled individuals. In addition LDSS is engaged to continue support to these populations.

Q24. Will the number of Care Coordination Model's per county be capped?

A24. The Department does not anticipate placing a cap on the number of Care Coordination Model's per county.

Q25. Why must I enroll in a MLTC?

A25. If a consumer resides in a county that has been approved by CMS for mandatory enrollment, the consumer is required to join a Managed Long Term Care plan to continue receiving home care or other community based long term care services per state law.

Q26. How will I benefit from participation in MLTC?

A26. Consumers will continue to receive home care or other community based long term care services once they join a Managed Long Term Care Plan. The Plan will also provide case management, and arrange all long-term care services.

- Q27. I am reviewing the posted Care Coordination Model materials. Is there a deadline for organizations to submit the application?**
- A27. There is no deadline for organizations to submit an application for Care Coordination Models.
- Q28. I was just wondering about clients with Medicaid spend-downs and if DOH is developing a plan for those folks.**
- A28. The MLTC Plans enroll people with a spenddown.
- Q29. When, where and how was stakeholder input obtained from the developmental disabilities community?**
- A29. The 1115 waiver exempts individuals with developmental disabilities for mandatory managed long term care.
- Q30. As we go towards mandatory enrollment on July 2, new enrollees can still choose Lombardi as an option for July and August. Would ADHCP admits follow a similar timeline, or when will ADHCPs no longer be able to admit new patients?**
- A30. Until the state receives federal approval of the amendments of the 1115 and 1915-c waivers, consumers may still utilize LTHHCP and Adult Day Health Care (ADHC) as service options. LTHHCP will remain an option until the 1915c waiver amendment is approved.
- Q31. Those who are *currently* receiving Medicaid services and fit the mandatory population definition will be given 60 days to choose a plan until they are auto assigned. But how about for *new* enrollees? Do they have 60 days as well or do they have 30 days to pick a plan until they are auto assigned to one?**
- A31. New consumers seeking community based long term care services will be provided with information on plan choices and will not be auto assigned.
- Q32. As new enrollees can still choose Lombardi as an option for July and August, does this change the Jan. 2013 anticipated date for mandatory enrollment of Lombardi members? If so, is it for new and/or current Lombardi members or both?**
- A32. The current transition plan calls for Long Term Home Health Care members to transition into Managed Long Term Care in January 2013. At this time, this date has not been adjusted. When 1915c amendments are approved enrollment of new consumers will end in New York City.
- Q33. Do MAP and PACE currently use the SAAM to evaluate Nursing home eligibility? Will they use the uniform assessment tool in the future?**
- A33. Yes, MAP and PACE currently use the SAAM to evaluate nursing home eligibility, and will use the uniform assessment tool when it is implemented.
- Q34. What appeal rights are available in MAP and PACE?**
- A34. MAP has the same appeal rights as partial plans, which are outlined in 42 CFR Part 438. PACE has very similar appeal rights which are outlined in 42 CFR Part 460. Both also have fair hearing rights under Medicaid, as well as external appeal rights through the Department of Financial Services.

- Q35. Are PACE enrollees prohibited from going outside of the “network” clinic or provider location, for example, for urgent care or specialty care not available in the PACE setting?**
- A35. PACE participants are not prohibited from going out of network for urgent care. Specialty care that is not available at the PACE centers is provided through network providers at applicable locations.
- Q36. Is there a lock-in period after MLTC enrollment?**
- A36. There is no lock-in period.
- Q37. Will spend-down patients be disenrolled from any MLTC if they do not pay their spend-down to the plan?**
- A37. Yes, a patient may be disenrolled if they do not pay their spend-down to the plan spend-down to the plan, as makes them ineligible for Medicaid.
- Q38. In 2013 do Medicaid Advantage enrollees receiving personal care services get auto enrolled in the corresponding MAP or do they have to choose and only get auto-enrolled into MLTC?**
- A38. This is under review by the State Department of Health at this time and a decision will be made shortly.
- Q39. How do new Medicaid applicants enroll into MLTC? Can they be assessed by multiple plans prior to enrolling or must they enroll in order to get assessed for services?**
- A39. Consumers new to service must be assessed prior to enrollment. Consumers may contact multiple plans and request assessment, however, services will not be provided until they are enrolled in a plan.
- Q40. What information will Maximus have to counsel new mandatory populations, will they transfer recipients to plans for the actual enrollment process?**
- A40. Maximus will supply a mandatory packet consisting of a informational brochure (available in multiple languages), that reviews all types of Managed Long Term Care products, a list of plans available to consumers, and some quick tips to help consumers with the process. Depending on consumer interest, Maximus can warm transfer to plans.
- Q41. What does the plan transfer and disenrollment process look like?**
- A41. All plan transfers and disenrollments will be coordinated by Maximus. These activities will be tracked and reported to the Department of Health.

Q42. As discussed on the MLTC weekly call, can you please confirm that the following assertions are true, and if not, please clarify the policy on the following:
(1) MLTC plans must pay the member's Medicare coinsurance for skilled in-patient rehabilitation services provided in an SNF, regardless of whether the facility is in the MLTC plan's nursing home network.

A42. Yes, Managed Long Term Care plans must pay the member's Medicare coinsurance for nursing facilities.

(1) CASA offices will continue to process new applications and renewal authorizations for personal care, including housekeeping, home attendant, and CDPAP services after July 1, 2012, or whatever date MLTC becomes mandatory, for:

a. Applicants who are under 21 years of age.

A: Yes, all Medicaid applications remain with CASA

b. Applicants for or recipients of TBI or NHTDW waiver services, for whom personal care services continue to be authorized by the CASA,

A: Yes, the access to these waivers does not change.

c. People with Medicaid but not Medicare who are not enrolled in a mainstream Medicaid managed care plan.

A: Yes.

d. People with Medicaid but not Medicare who are enrolled in a mainstream Medicaid managed care plan, but who want CDPAP services before 9/1/2012, when the managed care plans are required to provide such services as part of the service package.

A: Yes, however the requirement for CDPAP has been moved back to 10/1/2012.

e. Dual eligibles who would otherwise be subject to mandatory enrollment in MLTC, who want to apply for CDPAP services before 9/1/2012, when the MLTC are plans that are required to provide such services as part of the service package.

A: Yes, however the date for plan coverage is now 10/1/2012.

(2) If a fair hearing is pending challenging an adverse action by HRA, with an aid continuing directive, on the date that enrollment in an MLTC is effective under mandatory enrollment (whether the individual chooses the plan or is auto-assigned), the MLTC plan must comply with the aid continuing directive until the hearing is held and decided, regardless of whether the so-called authorization period for the personal care services expires before the hearing is decided.

A: Yes, if a hearing is pending challenging an adverse action, the Managed Long Term Care plan must comply with the aid continuing directive until a hearing is held and decided.

Q43. Re: Hospice – we understand hospice is not a covered service in MLTC plans, but we fail to understand why MLTC plans can't wrap around Medicare or Medicaid hospice benefits. We have heard people being required to disenroll when they need hospice. For many years, recipients have relied on Medicaid personal care or CHHA home health aide services to supplement the limited aide services provided as part of hospice care. Since personal care will be available solely through MLTC in mandatory counties, this will deprive needy terminally ill people of necessary aide services they need to die at home as they wish.

A43. PACE can provide hospice like services. The Department is currently reviewing the Hospice/Partial/MAP relationship.

Q44. In mandatory enrollment zip codes, if a consumer contacts a plan to see options during the 60 day period, if a plan conducts a visit, is the consumer entitled to a written plan of care before the enrollment?

A44. The plan is responsible for issuing a written plan of care.

Q45. What is the state doing in terms of oversight to ensure that plans authorize necessary personal care and other necessary community-based services?

A45. Staff has been designated to provide oversight, handle complaints and conduct surveillance.

Q46. Department of Health policy states that the plan must cover the care during the Medicare-covered rehab period, and pay the coinsurance. What is the policy/procedure when Medicare coverage ends?

A46. Plans will not be responsible for covering care, however they are responsible for paying for coinsurance when in a Medicare-covered rehab period. When Medicare coverage ends the Plan is responsible for care management service planning to meet members assessed needs.

Q47. May the plan simply disenroll the member in the middle of a month, with no advance notice, because the nursing is not in the network?

A47. If it is determined that long term custodial nursing home is needed at the end of short term rehab, plans will work with consumers to utilize a network nursing home. The consumer may voluntarily disenroll from the plan and select another plan. Plans have been encouraged to increase their nursing home network to allow greater choice for consumers.

Q48. Should a plan's case management include working with the hospital, member and family to ensure that the member is discharged to an in-network facility, in case the stay extends past the Medicare-covered period?

A48. Yes.

- Q49. Should a plan be required to assist the member to transfer to an in-network facility once the Medicare-covered period ends, and to cover the cost of care pending a reasonable period to transfer?**
- A49. Yes.
- Q50. The state's policy for managed care payment for personal care in NYC is payment at the HRA rate, in effect until March 1, 2013. It has been reported that one or more plans have told providers that the requirement for payment at the HRA rate is only in force from the time of the patient's enrollment until the patient is assessed by the plan. Can you confirm that this is an invalid interpretation?**
- A50. The intent of the policy is that HRA rates apply through 3/1/13.
- Q51. When the dually eligible CASA/ (personal care) cases are in the Managed Long Term Care Programs (MLTCPs) will MLTC clients be able to receive Hospice services which are billed to Medicare?**
- A51. Consumers can be in a partial MLTCP and receive Hospice, but must disenroll from the plan by the end of the month of admission if their services are paid by Medicare. Consumers whose hospice services will be paid by Medicaid must disenroll from MLTC before being admitted to hospice. This policy is currently under review by the Department
- Q52. Maximus has indicated that they will only consider persons who have received a mandatory letter to be mandatory. If a person in the mandatory population calls Maximus prior to their receiving a mandatory letter they will be treated as voluntary. If we need to qualify this group for enrollment and develop a POC, then will this population not have a continuity of care period? Would voluntary PCS recipients for all intents and purpose be treated the same way as a mandatory for the purpose of the transition?**
- A52. Until final written CMS approval is received by SDOH, people who have not received mandatory letters to transition to MLTC will be considered voluntary. These individuals will be treated like any new MLTC enrollee and will have the ability to refuse to enroll in any MLTC plan if they are not in agreement with the plan of care. However, once final written approval has been received, mandatory rules, including continuity of care provisions, will apply to all enrollments.
- Q53. For a non-mandatory dual between the ages of 18 and 21 who wants to disenroll from a MLTC and is in need of continued service but doesn't want to go to another plan, can they get fee for service personal care service? If so, does the plan submit a conversion to Maximus or HRA?**
- A53. Yes, the plan would follow the conversion process through HRA.