Managed Long Term Care Frequently Asked Questions

Overview

- What is Managed Long Term Care (MLTC)?
- Are there different types of MLTC?

Eligibility/ Enrollment

- Am I eligible for MLTC?
- How do new 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?
- Why must I enroll in a MLTC?
- Must I enroll in MLTC if I live in NYC and need community-based long term care service such as personal care, home health services, therapies, private duty nursing, and adult day health care?
- If I am a dual eligible consumer, must I enroll in a MLTC?
- How long do new enrollees have to choose a plan before they are auto assigned to one?
- Is there a lock-in period after MLTC enrollment?
- Will spend-down patients be dis-enrolled from any MLTC if they do not pay their spend-down to the plan?

Coverage/ Coordination/ Billing

- How does MLTC affect my Medicaid and/or Medicare coverage?
- Is the care coordinator responsible for Medicare transportation? Will they identify and assist with the maintenance of housing?
- Will the number of Care Coordination Model's per county be capped?
- How will I benefit from participating in MLTC?
- 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?
- Will home modifications be a part of the benefit package or be separately billed to Medicaid or not be available?
- In mandatory enrollment zip codes, if a consumer contacts a plan to discuss their enrollment options during the 60 day period, and the plan conducts a visit, is the consumer entitled to a written plan of care before the enrollment?
- Will the plan cover the care and pay the coinsurance when the Medicare coverage ends?
- If the nursing home is not in the network, may the plan simply disenroll the member in the middle of the month with no advance notice?

- If a non-mandatory dual between the ages of 18 and 21 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 a consumer chooses a plan within the 60 day timeframe, do they have to choose a plan upon receiving the mandatory enrollment packet and does the plan still have 30 days to do an assessment? The Department verbally stated that continuity of care begins during the patient's effective enrollment date.
- Are members considered voluntary when they transfer from one MLTC to another and are they still covered under this transition? Also, does this hold true for PCS members in an MCO who wish to voluntarily transfer to an MLTC?
- Are MLTC plans responsible for paying a member's Medicare co-pay for skilled rehabilitation services provided in a skilled nursing facility?

Preventing Abuse/ Appeals

- How will you identify care coordinators that aren't doing what they need to do?
- What appeal rights are available in MAP and PACE?
- What is the state doing in terms of oversight to ensure that plans authorize necessary personal care and other necessary community-based services?

Communication/ Education

- My mother isn't fluent in English. Will this be a problem?
- When, where, and how was stakeholder input obtained from the developmental disabilities community?
- How will consumer education work and how is DOH preparing for a population that has various levels of cognitive impairment?

Policy

- Where can I find the Management Contract Guidelines?

Overview

Q. What is managed long-term care (MLTC)?

A. Managed long-term care (MLTC) is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen.

Q. Are there different types of managed long-term care?

A. There are three products of managed long-term care in New York State: Programs of All-Inclusive Care for the Elderly (PACE) Managed Long-Term Care Partial Capitated Plans; and Medicaid Advantage Plan.

PACE Organizations

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis). PACE members are required to use PACE physicians and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member. The PACE is approved by the U.S. Centers for Medicare and Medicaid Services.

Managed Long-Term Care Plans

Managed long-term care plans provide long-term care services (like home health and nursing home care) and ancillary and ambulatory services (including dentistry, and medical equipment), and receive Medicaid payment. Members get services from their primary care physicians and inpatient hospital services using their Medicaid and/or Medicare cards. Members must be eligible for nursing home admission. While several plans in New York State enroll younger members, most managed long-term care plan enrollees must be at least age 65.

Eligibility/ Enrollment

Q. Am I eligible for managed long-term care?

A. You are eligible to enroll in managed long-term care if you:

- are age 21 and older and in need of community-based long term care Services for more than 120 days
- a dual (those in need of Medicare and Medicaid) between 18 and 21 remain voluntary
- a dual eligible, 18-21 in need of community based long term care services for over 120 days.
- a non-dual eligible, age 18 and older assessed as nursing home eligible.
- are able to stay safely at home at the time you join the plan;
- meet the age requirement of the plan (the age requirement for a PACE organization is 55 years old; for most other plans, the age requirement is 65 years old);
- live in the area served by the plan;
- have or are willing to change to a doctor who is willing to work with the plan; and
- have a way of paying that is accepted by the plan. All plans accept Medicaid. Some plans also accept Medicare and private pay.
  See the Managed Long-Term Care Plan Directory to find out which plans accept Medicaid, Medicare or private pay enrollees.

Q. 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?

A. 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.

Q. **Why must I enroll in a MLTC?**

A. 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.

Q. Must I enroll in MLTC if I live in NYC and need community-based long term care services such as personal care, home health services, therapies, private duty nursing and Adult Day Health Care?

A. On August 31, 2012, the Department received written approval from CMS to move forward with Medicaid Redesign Team Initiative #90 and to fully implement the transition and enrollment of recipients requiring community-based long term care into Managed Long Term Care Plans or Care Coordination Models (CCM) beginning in New York City (NYC). This initiative amends the Partnership Plan Medicaid Section 1115 Demonstration waiver to require all dual-eligible individuals (persons in receipt of both Medicare and Medicaid) who are aged 21 or older and are in need of community-based long term care services for more than 120 days to be enrolled into Partial MLTCPs or CCMs. If you are a Medicaid recipient in NYC, Nassau, Suffolk, and Westchester who meets the criteria above you must receive those services through a MLTC plan. Individuals who are presently receiving Medicaid community-based care services will be transitioned into MLTC over time. These individuals will receive information from Medicaid Choices, the Department's Enrollment Broker about what consumers need to do and how to select a Plan. This mandatory enrollment for will continue throughout the State as Plan capacity is developed.

Q. If I am a dual eligible consumer, must I enroll in a MLTC?

A. If you are a dual eligible consumer over 21, require CBLTC for more than 120 days and reside in a county that has been approved by CMS for mandatory enrollment, you are required to join a Managed Long Term Care plan to continue receiving community based long term care services per state law

Q. How long do new enrollees have to choose a plan before they are auto assigned to one?

A. New consumers seeking community based long term care services will be provided with information on plan choices and will not be auto assigned.

Q. Is there a lock-in period after MLTC enrollment?

A. There is no lock-in period.

Q. Will spend-down patients be disenrolled from any MLTC if they do not pay their spend-down to the plan?

A. Yes, a patient may be disenrolled if they do not pay their spend-down to the plan.

Coverage/ Coordination/ Billing

Q. How does MLTC affect my Medicaid and/or Medicare coverage?

A. If you are currently receiving Medicaid and/or Medicare services, you still receive the same types of services usually paid for by Medicaid and Medicare. You do not lose any of your regular Medicaid or Medicare benefits. If the Medicare or Medicaid service is not covered by the plan, you may still receive the service outside the plan using your Medicare or Medicaid card.

Q. Is the care coordinator responsible for Medicare transportation? Will they identify and assist with the maintenance of housing?

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

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

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

Q. How will I benefit from participation in MLTC?

A. 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.

Q. 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?

A. 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.

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

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

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

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

Q. Will the plan cover the care and pay the coinsurance when the Medicare coverage ends?

A. 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.

Q. If the nursing home is not in the network, may the plan simply disenroll the member in the middle of the month with no advance notice?

A. If it is determined that a 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.

Q. If a non-mandatory dual between the ages of 18 and 21 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?

A. Yes.

Q. If a county is mandatory, a consumer chooses a plan within the 60 day timeframe, do they have to choose a plan upon receiving the mandatory enrollment packet and does the plan still have 30 days to do an assessment? The Department verbally stated that continuity of care begins during the patient's effective enrollment date.

A: The effective date of enrollment is the first day of the month.

b. Does that mean the plan's assessed hours are effective on the patient's enrollment date?
A. Yes, the Continuity of Care policy applies. Receiving plans must honor the pre-existing service plan for at least 60 days after enrollment, or until a care assessment is completed whichever is later.

c. How will new users and plan to plan transfers be treated?
A. New users will be assessed by the plan and develop a plan of care. If the new user agrees with the care plan an enrollment agreement is signed. For plan to plan transfers the policy is the same.

d. How will plan to plan transfers be treated for involuntary disenrollment?
A. For plan to plan transfers, no assessment prior to enrollment is required and the continuity of care policy applies. The receiving plan must assess within 30 days of enrollment. The receiving

plans must honor the pre-existing service plan for at least 60 days after enrollment, or until a care assessment whichever is longer.

e. Does the transition policy apply to people who received the mandatory enrollment packet?
A. Yes.

f. Does the transition policy apply to consumers who are auto-assigned?
A. Yes.

Q. Are members considered voluntary when they transfer from one MLTC to another and are they still covered under this transition? Also, does this hold true for PCS members in an MCO who wish to voluntarily transfer to an MLTC?

A. For plan to plan transfers, no assessment prior to enrollment is needed and continuity of care policy applies or until a care assessment is completed. Medicaid only MCO members consumers must be assessed by a MLTCP prior to enrollment and must need more than one hundred twenty (120) days of community based long term care services and meet the nursing home level of care.

Q. Are MLTC plans responsible for paying a member's Medicare co-pay for skilled rehabilitation services provided in a skilled nursing facility?

A. Yes.

Preventing Abuse

Q. 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?

A. 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.

Q. What appeal rights are available in MAP and PACE?

A. 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.

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

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

Communication/ Education

Q. My mother is not fluent in English. Will this be a problem?

A. No. Language is not a barrier to receiving managed long-term care services. Most plans have bi-lingual staff and written materials are prepared in several languages. Oral translation services are available from each managed long-term care plan free of charge. Each plan has the names, locations and telephone numbers of providers who speak languages other than English. Contact the plan in your area to get this information.

Q. When, where and how was stakeholder input obtained from the developmental disabilities community?

A. The 1115 waiver exempts individuals with developmental disabilities for mandatory managed long term care.

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

A. 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.

Policy

Q. Where can I find the Management Contract Guidelines?

A. 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, under the heading of Long Term Home Health Program from the following website: http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm