NEW YORK LEGAL ASSISTANCE GROUP

EVELYN FRANK LEGAL RESOURCES PROGRAM

MANAGED LONG-TERM CARE: ISSUES IN 2019

APPENDIX

A. MLTC – Current Plans showing Recent Plan Closings & Enrollment Changes

B. Plan Closings – Consumer Rights when MLTC Plan Closes

C. Materials on MLTC Reductions

D. NYS Assembly bill A7578/S5485

a. Bill to (1) improve and simplify Medicaid renewal process for MLTC members and others, to prevent disruption of enrollment and (2) would auto-assign Medicaid recipients to MLTC plans if they cannot manage to join one before the Conflict Free assessment expires 25

b. NYLAG memorandum in support of bill..... 28

E. ICAN

1. **ICAN Brochure** – Independent Consumer Advocacy Network – State Sponsored Ombudsprogram for MLTC, Medicaid Advantage Plus, PACE and FIDA, and Mainstream Managed Care issues regarding long term care services..... 33

F. ONLINE MATERIALS – New York State government

- **MRT 90 – NYS MLTC Website –** Policies, contracts http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/
- http://www.health.ny.gov/health_care/managed_care/mltc/ **NYS MLTC site for consumers-** plan lists, etc.
    - MLTC Policies http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm – look at new ones re notice, task based assessment
- **MRT 1458 – NYS MRT Website –** scroll to end for Nursing Home Transition to MLTC http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm
- **Partnership plan** – State website with CMS approvals of 1115 waiver with "Special Terms & Conditions" on MLTC program http://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm
- **DOH Library of Official Documents** – GIS, ADM, LCM policy directives http://www.health.ny.gov/health_care/medicaid/publications/index.htm
- **NYS OTDA Fair Hearing Requests** http://otda.ny.gov/hearings/request/
- **OTDA Fair Hearing Archive – Fair Hearing decisions https://otda.ny.gov/hearings/search/**
- **DOH Library of Official Documents – ADMs, GIS, LCMs, other directives** https://www.health.ny.gov/health_care/medicaid/publications/
- **New York Medicaid Choice (state's enrollment broker)"**
    - **Request Conflict Free assessments** https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care
    - **Lists of plans by region -** https://nymedicaidchoice.com/choose/find-long-term-care-plan ; https://nymedicaidchoice.com/program-materials
- **ICAN Ombudsprogram for MLTC - 1-844-614-8800,** www.Icannys.org ican@cssny.org
- **Report by NAELA NY and Medicaid Matters: "Mis-Managed Care"** MLTC Hearings on Home care reductions in 2015, available at http://tinyurl.com/nytimes-FairHearing

b. NYHealthAccess articles

- Managed Long Term Care **http://www.wnylc.com/health/entry/114/**
- News Updates on MLTC - http://www.wnylc.com/health/news/78/
- MLTC Appeals – New Requirements in 2018 http://www.wnylc.com/health/entry/184/
- Special Housing Disregard for People Returning Home from Nursing Homes or Adult Homes and Enrolling in or Staying in MLTC Plans http://www.wnylc.com/health/entry/212/
- Spousal Impoverishment Protections http://www.wnylc.com/health/entry/165/
- Fast Track Medicaid App for Immediate Need http://www.wnylc.com/health/entry/203/
- **CDPAP** – Consumer Directed Personal Assistance Program http://www.wnylc.com/health/entry/40
- **Personal Care -** http://www.wnylc.com/health/entry/7/
    - Reimbursement: See http://www.wnylc.com/health/entry/18/
- Community Budgeting or Rent Retention in a Nursing Home – to keep more of income when expect to return home - http://www.wnylc.com/health/entry/117/
- Fact Sheet on Keeping SSI for 3 months when enter a nursing home http://www.wnylc.com/health/download/594/

Managed Long Term Care, Medicaid Advantage Plus, and PACE plans by County in NYS with Enrollment June/2014 – April 2019

Code: Shaded = MAP or PACE plan (includes Medicare) BLACK = CLOSED
Date is when county became Mandatory

County and Date Became Mandatory	Name of plan/ company	June 2014	April 2016	April 2019	Type of plan
ALBANY	FIDELIS MAP	51	41	23	MAP
	EDDY SENIOR CARE	3	4	8	PACE
	FIDELIS	104	233	596	MLTC
	VNS CHOICE	148	209	247	MLTC
	WELLCARE	38	47	48	MLTC
	HOMEFIRST (Elder Plan) Closed in county	6	0	0	MLTC
	UNITED HEALTH-CARE CLOSED	5	35	0	MLTC
	PRIME Health Choice			46	MLTC
	VNA Home Care Opt'ns	39	111	285	MLTC
	TOTAL	**394**	**680**	**1253**	
ALLEGANY (July 2015)	TOTAL SENIOR CARE	18	16	32	PACE
	FIDELIS	0	41	40	MLTC
	VNA Home Care Opt'ns			118	MLTC
	TOTAL	**18**	**57**	**190**	
BROOME (9/2014)	FIDELIS	12	192	501	MLTC
	iCircle Care		35	212	MLTC
	UNITED HEALTH CARE closed	0	112	0	MLTC
	VNA Home Care Opt'ns			225	MLTC
	TOTAL	**12**	**339**	**938**	
CATTARAUGUS (3/2015)	TOTAL SENIOR CARE	80	95	89	PACE
	FIDELIS	1	53	92	MLTC
	VNA HOME CARE OPT'NS			197	MLTC
CAYUGA (6/2014)	FIDELIS	1	43	146	MLTC
	iCircle Care		17	40	MLTC
	VNA Home Care Opt'ns	0	20	105	MLTC
	TOTAL SENIOR CARE			2	PACE
	TOTAL	**1**	**80**	**671**	
CHAUTAUQUA (6/2015)	FIDELIS	1	98	133	MLTC
	KALOS HEALTH			209	MLTC
	VNA Home Care Opt'ns			276	MLTC
CHEMUNG	FIDELIS	0	12	195	MLTC
	ICIRCLE CARE			158	MLTC
	VNA Home Care Opt'ns			78	MLTC

CHENANGO (11/2014)	FIDELIS	1	51	118	MLTC
	ICIRCLE CARE			73	MLTC
	VNA Home Care Opt'ns			84	MLTC
CLINTON	FIDELIS	0	56	130	MLTC
	VNA Home Care Opt'ns			203	MLTC
COLUMBIA (4/2014)	FIDELIS	5	43	131	MLTC
	VNA Home Care Opt'ns			30	MLTC
	VNSNY CHOICE	24	52	52	MLTC
CORTLAND (11/2014)	FIDELIS	2	76	113	MLTC
	ICIRCLE CARE		51	67	MLTC
	VNA Home Care Opt'ns			83	MLTC
DELAWARE (9/22/2014)	FIDELIS	9	61	133	MLTC
	VNA Home Care Opt'ns			49	MLTC
	VNSNY CHOICE	0	8	17	MLTC
DUTCHESS (9/2014)	ELANT	77	187	212	MLTC
	FIDELIS	21	104	231	MLTC
	HAMASPIK CHOICE			292	MLTC
	PRIME HEALTH	--	111	211	MLTC
	VNS CHOICE	14	24	69	MLTC
	ELDERPLAN			129	MLTC
	Total	**112**	**426**	**1144**	
ERIE (1/2014)	Centers Healthy Living	63	78	646	MLTC
	ERIE-NIAGARA MLTC	0	0		MLTC
	ELDERWOOD			394	MLTC
	FALLON HEALTH WEINBERG			802	MLTC
	FIDELIS	178	298	1,012	MLTC
	TOTAL AGING IN PLACE PROGRAM	127	0		MLTC
	WELLCARE	145	198	348	MLTC
	FIRST CHOICE HEALTH	0	0		MLTC
	HOMEFIRST closed in county	3	0	0	MLTC
	KALOS HEALTH			728	MLTC
	UNITED HEALTH CARE CLOSED	3	55	0	MLTC
	VNA Home Care Opt'ns			491	MLTC
	VNSNY CHOICE	103	174	184	MLTC
	Catholic Health CHS BUFFALO LIFE	168	217	257	PACE
	FALLON HEALTH WEINBERG			131	PACE
	TOTAL	**790**	**1020**	**4993**	

ESSEX (6/2015)	FIDELIS	2	21	41	MLTC
	VNA Home Care Opt'ns			39	MLTC
FRANKLIN	FIDELIS	0	74	90	MLTC
	VNA Home Care Opt'ns			114	MLTC
FULTON (9/2014)	FIDELIS	12	73	160	MLTC
	VNA Home Care Opt'ns			173	MLTC
	VNSNY CHOICE	0	11	13	MLTC
GENESEE (12/2014)	FIDELIS	0	40	101	MLTC
	ELDERWOOD			11	MLTC
	VNA Home Care Opt'ns			42	MLTC
	KALOS HEALTH			35	MLTC
	iCircle Care		53	74	MLTC
GREENE (7/2014)	VNA Home Care Opt'ns			31	MLTC
	VNSNY CHOICE	12	45	63	MLTC
HAMILTON (6/2015)	FIDELIS	0	1	9	MLTC
	VNA Home Care Opt'ns			9	MLTC
HERKIMER (6/2014)	FIDELIS	11	84	117	MLTC
	SENIOR NETWORK HEALTH	48	64	79	MLTC
	VNA Home Care Opt'ns			55	MLTC
	VNSNY CHOICE	0	1	2	MLTC
JEFFERSON (7/2015)	FIDELIS			144	MLTC
	VNA Home Care Opt'ns	0	75	144	MLTC
LEWIS	FIDELIS	0	22	66	MLTC
	VNA Home Care Opt'ns			36	MLTC
LIVINGSTON (11/2014)	FIDELIS	24	53	69	MLTC
	iCircle CARE		21	44	MLTC
	VNA Home Care Opt'ns			44	MLTC
MADISON (11/14)	VNA Home Care Opt'ns	21	62	137	MLTC
	FIDELIS	0	13	70	MLTC
	ICIRCLE CARE			13	MLTC
	VNSNY CHOICE	0	4	3	MLTC
	Total	**21**	**79**	**223**	
MONROE (1/2014)	FIDELIS	170	519	1,156	MLTC
	ELDERWOOD			179	MLTC
	Homefirst. (ElderPlan) CLOSED in county	453	0	0	MLTC
	iCircle CARE		418	1,743	MLTC
	UNITED HEALTH CARE CLOSED	3	184	0	MLTC
	Kalos Health			32	MLTC
	VNA Home Care Opt'ns			797	MLTC
	VNSNY Choice	14	67	193	MLTC
	ElderOne Ind liv FOR SRS) (Rochester Gen)	560	668	701	PACE
	TOTAL	**1,200**	**1,856**	**1,803**	

MONTGOMERY (9/2014)	FIDELIS	4	3	2	MAP
	FIDELIS	14	77	178	MLTC
	VNA HOME CARE OP			126	MLTC
	VNSNY CHOICE	0	9	11	MLTC
NASSAU (Jan. 2013)	ELDERPLAN MAP	4	13	32	MAP
	GUILDNET Gold closed	72	85	0	MAP
	HEALTHFIRST COMPLETE CARE	15	30	118	MAP
	Emblem (HIP)closed	75	0	0	MAP
	SENIOR Whole Health			5	MAP
	VNSNY Choice TOTAL	0	0	17	MAP
	AETNA	264	349	843	MLTC
	AGEWELL NEW YORK	363	603	1,336	MLTC
	CENTERLIGHT closed	132	104	0	MLTC
	Centers Healthy Living			1,767	MLTC
	ELDERPL (HomeFirst)	130	219	772	MLTC
	ELDERSERVE	93	98	388	MLTC
	EXTENDED	29	52	295	MLTC
	FIDELIS	583	496	1,016	MLTC
	GUILDNET CLOSED	1,531	1901	0	MLTC
	EMBLEM/HIP closed	253	0	0	MLTC
	INTEGRA	55	103	974	MLTC
	N Shore -LIJ – closed	315	1,004	0	MLTC
	Senior Health Partners	201	217	512	MLTC
	VNSNY CHOICE	345	276	606	MLTC
	WELLCARE	62	77	256	MLTC
	CenterLIGHT PACE	62	59	74	PACE
	TOTAL	**4,584**	**5,775**	**9,328**	
NIAGARA (11/2014)	COMPLETE SR CARE	116	123	128	PACE
	Centers Healthy Living	35	46	66	MLTC
	ELDERWOOD			52	MLTC
	Fallon Health Weinberg			79	MLTC
	FIDELIS	0	45	195	MLTC
	KALOS HEALTH			320	MLTC
	Homefirst (ElderPlan) (dropped out of county)	0	0	0	MLTC
	VNA HOME CARE OP			161	MLTC
	TOTAL	**151**	**214**	**1001**	
ONEIDA (6/2014)	FIDELIS	32	351	655	MLTC
	SENIOR NETWORK HEALTH	433	442	501	MLTC
	UNITED HEALTH CARE closed	0	65	0	MLTC
	VNA HOME CARE OP			325	MLTC
	VNSNY CHOICE	0	0	6	MLTC
	TOTAL	**465**	**858**	**1481**	

ONONDOGA (1/2014)	FIDELIS	45	154	572	MLTC
	iCircle CARE		13	187	MLTC
	VNA HOME CARE OPT'NS	280	350	1,046	MLTC
	UNITED HEALTH CARE closed	12	98	0	MLTC
	Homefirst (ElderPlan) (closed in county)	1	0	0	MLTC
	VNSNY CHOICE	0	2	33	MLTC
	PACE CNY	463	488	625	PACE
	Total	**801**	**1,105**	**2,463**	
ONTARIO (11/2014)	FIDELIS	1	63	121	MLTC
	iCircle CARE		126	195	MLTC
	VNA HOME CARE OP			78	MLTC
	Indep. Living Seniors			23	PACE
ORANGE (9/2013)	ELANT	283	347	361	MLTC
	FIDELIS	417	424	585	MLTC
	HAMASPIK CHOICE	90	275	420	MLTC
	Homefirst (ElderPlan)	1	34	202	MLTC
	UNITED HEALTH CARE closed	0	26	0	MLTC
	PRIME HEALTH CHOICE			46	MLTC
	VNSNY CHOICE	20	20	37	MLTC
	WELLCARE	119	203	274	MLTC
	TOTAL	**930**	**1329**	**1,925**	
ORLEANS (12/2014)	FIDELIS	0	25	47	MLTC
	ELDERWOOD			5	MLTC
	iCircle CARE		41	80	MLTC
	KALOS HEALTH			44	MLTC
	VNA HOME CARE OP			22	MLTC
OSWEGO (11/2014)	FIDELIS	6	86	181	MLTC
	iCircle CARE		5	24	MLTC
	VNA HOME CARE OP	3	58	200	MLTC
OTSEGO (12/2014)	VNA HOME CARE OP			81	MLTC
	VNSNY CHOICE	0	13	11	MLTC
	FIDELIS CARE			103	MLTC
	iCircle CARE		5	61	MLTC
PUTNAM (4/2014)	ARCHCARE	30	49	95	MLTC
	ELDERPLAN			28	MLTC
	FIDELIS	12	67	101	MLTC
	HAMASPIK CHOICE			35	MLTC
	PRIME HEALTH CHOICE			7	
	VNSNY CHOICE	0	8	43	MLTC

RENSSELAER (6/2014)	FIDELIS MAP	26	16	8	MAP
	FIDELIS	14	96	298	MLTC
	Homefirst/ElderPlan-closed in county	6	0	0	MLTC
	VNA HOME CARE OP			224	MLTC
	VNSNY CHOICE	52	111	152	MLTC
	TOTAL	**98**	**223**	**682**	
ROCKLAND (9/13)	CENTERLIGHT closed	231	103	0	MLTC
	Centers Healthy Living	23	24	76	MLTC
	ELANT	251	346	373	MLTC
	ELDERPLAN	13	52	152	MLTC
	FIDELIS	392	480	706	MLTC
	HAMASPIK CHOICE	96	457	690	MLTC
	HOMEFIRST ElderPlan	13	52	152	MLTC
	PRIME Health Choice			127	MLTC
	UnitedHealth closed	1	32	0	MLTC
	VNSNY CHOICE	16	21	111	MLTC
	WELLCARE	133	198	183	MLTC
	TOTAL	**1,169**	**1,765**	**2,124**	
St. LAWRENCE	VNA HOME CARE OP			251	MLTC
	FIDELIS CARE			290	MLTC
SARATOGA (7/2014)	VNSNY CHOICE	14	83	130	MLTC
	VNA HOMECARE OP	0	69	294	MLTC
	FIDELIS CARE			224	MLTC
SCHENECTADY (7/2014)	HomeFirst (ElderPlan -	2	0	0	MLTC
	VNSNY CHOICE	0	21	90	MLTC
	FIDELIS	28	150	421	MLTC
	VNA HOME CARE OP			182	MLTC
	EDDY SENIOR CARE	137	172	212	PACE
	FIDELIS MAP	25	18	12	MAP
SCHOHARIE (9/2014)	FIDELIS	0	60	78	MLTC
	VNA HOME CARE OP			74	MLTC
	VNSNY CHOICE	0	17	31	MLTC
SCHUYLER	VNA HOME CARE OP			12	MLTC
	FIDELIS CARE			38	MLTC
	ICIRCLE CARE			35	MLTC
SENECA (6/2015)	iCircle CARE		25	45	MLTC
	VNA HOME CARE OP			32	MLTC
STEUBEN (11/2014)	FIDELIS	1	60	138	MLTC
	iCircle CARE		36	97	MLTC
	VNA HOME CARE OP			158	MLTC

SUFFOLK (Jan. 2013)	Guildnet Gold- closed	83	88	0	MAP
	HIP/Emblem closed	26	0	0	MAP
	VNSNY CHOICE TOTL	0	0	26	MAP
	CENTERLIGHT	85	92	100	PACE
	AETNA BETTER HLTH	256	410	1,106	MLTC
	AGEWELL NEW YORK	148	384	1,637	MLTC
	CENTERLIGHT closed	170	207	0	MLTC
	Elderplan/(HomeFirst)	41	166	44	MLTC
	ELDERSERVE	124	226	420	MLTC
	EXTENDED	3	17	203	MLTC
	FIDELIS	397	523	1,346	MLTC
	GUILDNET	1,394	2,307	0	MLTC
	HIP/Emblem (closed)	66	0	0	MLTC
	INTEGRA	24	41	615	MLTC
	VNSNY CHOICE	105	91	111	MLTC
	N Shore LIJ closed	35	294	0	MLTC
	WELLCARE	15	41	183	MLTC
	TOTAL	**2,972**	**4,887**	**5,791**	
SULLIVAN (4/2014)	FIDELIS	18	99	216	MLTC
	ELDERPLAN			28	MLTC
	HAMASPIK CHIOCE	89	302	354	MLTC
	VNSNY CHOICE	1	7	9	MLTC
TIOGA (11/2014)	FIDELIS	4	15	78	MLTC
	ICIRCLE CARE			20	MLTC
	VNA HOME CARE OP			47	MLTC
TOMPKINS (11/2014)	FIDELIS	2	91	138	MLTC
	iCircle CARE		38	111	MLTC
	VNA HOME CARE OP			54	MLTC
ULSTER (4/2014)	FIDELIS	082	228	363	MLTC
	ELDERPLAN			35	MLTC
	HAMASPIK CHOICE	26	355	508	MLTC
	VNS CHOICE	1	31	62	MLTC
	WELLCARE	41	110	151	MLTC
WARREN (9/22/2014)	FIDELIS	1	58	116	MLTC
	PRIME Health Choice			19	MLTC
	VNA HOME CARE OP			82	MLTC
	VNSNY CHOICE	0	9	28	MLTC
WASHINGTON (7/2014)	FIDELIS	4	43	75	MLTC
	Prime Health Choice			12	MLTC
	VNA HOME CARE OP			63	MLTC
	VNSNY CHOICE	0	7	13	MLTC
WAYNE (11/2014)	FIDELIS	1	50	90	MLTC
	iCircle CARE		92	194	MLTC
	Ind Living for Sen'rs			35	PACE
	VNA HOME CARE OP			89	MLTC

WESTCHESTER (Jan. 2013)	AGEWELL NEW YORK	293	497	701	MLTC
	Alphacare – merged w/ Senior Whole Health	9	138	0	MLTC
	ARCHCARE	430	473	1,237	MLTC
	CENTERLIGHT closed	369	239	0	MLTC
	Centers Healthy Living			328	MLTC
	ElderPlan (HomeFirst)	329	537	890	MLTC
	ELDERSERVE	143	197	402	MLTC
	FIDELIS	252	372	853	MLTC
	GUILDNET closed	209	463	0	MLTC
	HIP / EMBLEM Closed	41	0	0	MLTC
	HHH Choices Closed	89	0	0	MLTC
	INTEGRA	33	105	527	MLTC
	MONTEFIORE	49	144	344	MLTC
	Senior Whole Health			246	MLTC
	Senior Health Partners	162	323	335	MLTC
	VNSNY CHOICE	254	263	443	MLTC
	WELLCARE	30	69	122	MLTC
	ARCHCARE SENIOR			65	PACE
	CENTERLIGHT	223	206	198	PACE
	ELDERPLAN	0	21	35	MAP
	HEALTHFIRST			42	MAP
	HIP/EMBLEM closed	5	0		MAP
	VNSNY CH. TOTAL	0	0	19	MAP
	TOTAL	**2,920**	**4,047**	**7,932**	
WYOMING (12/2014)	FIDELIS	0	33	52	MLTC
	ELDERWOOD			3	MLTC
	ICIRCLE CARE			25	MLTC
	VNA HOME CARE OP			61	MLTC
YATES (6/2015)	iCircle CARE		23	48	MLTC
	VNA HOME CARE OP			18	MLTC
	FIDELIS CARE			52	MLTC

April 2019	**NYC**	**Rest of State**	**Total statewide**
PACE	3,122	2,680	5,802
MAP	15,006	339	15,345
MLTC	172,776	56,935	229,711
FIDA (NYC, Nassau, Westch)*	2,675	215	2,890
TOTAL	**193,579**	**60,169**	**253,748**

Data from http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/
Compiled by NYLAG EFLRP eflrp@nylag.org

Contact information for plans at **http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm and at**

http://nymedicaidchoice.com/program-materials (Long Term Care Plans by region)

NOTE MAP and PACE are options but these plans combine Medicare Advantage with MLTC and Medicaid, and all primary and acute care paid for by Medicare AND Medicaid must be access from in-network providers. In order to keep your own doctor and pay with Original Medicare, join an MLTC plan.

MLTC Plans in NYC with Enrollment Figures 2013 – April 2019, in order of Highest Enrollment in NYC

plan	Apr-13	Mar-18	Dec-18	April-19	Notes re closed plans
1. Centers Plan for Healthy Living	149	14,345	27,827	29,400	
2. INTEGRA (Personal Touch)		4,830	13,269	15,769	
3. VNS CHOICE	19,360	11,376	10,166	15,115	
4. Senior Whole Health	278	7,373	14,133	14,473	
5. Senior Health Partners (HealthFirst)	8,088	12,743	13,933	14,247	
6. ELDERSERVE	8,282	10,532	12,520	13,364	
7. ELDERPLAN (HomeFirst)	7,572	10,609	11,585	11,762	
8. VillageCareMAX	1,687	7,466	11,745	11,269	
9. Fidelis	4,224	7,577	8,347	8,451	
10. AgeWell New York (Parker Jewish)	363	5,963	6,958	7,681	
11. AMERIGROUP/HealthPlus	2,726	4,176	5,856	6,335	
12. EXTENDED MLTC		1,867	5,203	5,994	
13. Aetna	390	3,145	5,170	5,556	
14. WELLCARE	4,166	4,887	3,905	3,849	
15. Archcare MLTC	217	1,714	3,110	3,272	
16. United Health Care	211	1,899	2,900	2,969	
17. MetroPlus	100	1,460	1,901	1,958	
18. MONTEFIORE HMO		1,069	1,254	1,312	
CLOSED PLANS as of 4/2019					
19. INDEPENDENCE CARE SYSTEMS	4,382	6,504	5,825	0	→VNS Choice 4/2019 unless picked other plan
20. GUILDNET	10,602	10,594	2,734		Closed Jan. 2019
21. HIP	649	0		0	→ Guildnet 12/2015
22. ALPHACARE (Magellan)		3,414			→ Senior Whole Health
23. CenterLight	7,566	42			→ Centers Plan 11/2016
24. HHH CHOICES	1,973	0			closed
25. North Shore LIJ		2,604			→Centers Plan 9/2017
Total NYC - MLTC	**82,985**	**136,189**	**168,341**	**172,776**	
rest of state	4,810	39,465	55,227	56,935	
Total NYS	**87,795**	**175,654**	**223,568**	**229,711**	

Data from NYS DOH Monthly Medicaid Managed Care Enrollment Report, at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

Compiled by Evelyn Frank Legal Resources Program, NYLAG
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NYC MLTC plans with Enrollment 2013 to April 2019, **Sorted Alphabetically** (with closed plans)

plan	Apr-13	Mar-18	Dec-18	April-19	Notes re closed plans
Aetna	390	3,145	5,170	5,556	
AgeWell New York (Parker Jewish)	363	5,963	6,958	7,681	
ALPHACARE (Magellan)		3,414			transferred to Senior Whole Health
Archcare MLTC	217	1,714	3,110	3,272	
CenterLight	7,566	42			transferred to Centers Plan 11/2016
Centers Plan for Healthy Living	149	14,345	27,827	29,400	
ELDERPLAN (HomeFirst)	7,572	10,609	11,585	11,762	
ELDERSERVE	8,282	10,532	12,520	13,364	
EXTENDED MLTC		1,867	5,203	5,994	
Fidelis	4,224	7,577	8,347	8,451	
GUILDNET	10,602	10,594	2,734		Closed Jan. 2019 ↓9% Sept to Oct "18
HealthPlus/ AMERIGROUP	2,726	4,176	5,856	6,335	
HHH CHOICES	1,973	0			closed
HIP	649	0		0	transferred to Guildnet 12/2015
INDEPENDENCE CARE SYSTEMS	4,382	6,504	5,825	0	txferred to VNS Choice if not select other plan
INTEGRA (Personal Touch)		4,830	13,269	15,769	↑ 25% Sept to Dec 18 from 7th to 4th largest
MetroPlus	100	1,460	1,901	1,958	
MONTEFIORE HMO		1,069	1,254	1,312	
North Shore LIJ		2,604			transferred to Centers Plan 9/2017
SENIOR HEALTH PARTNERS (HealthFirst)	8,088	12,743	13,933	14,247	
Senior Whole Health	278	7,373	14,133	14,473	
United Health Care	211	1,899	2,900	2,969	
VillageCareMAX	1,687	7,466	11,745	11,269	
VNS CHOICE	19,360	11,376	10,166	15,115	
WELLCARE	4,166	4,887	3,905	3,849	
Total NYC - MLTC	**82,985**	**136,189**	**168,341**	**172,776**	
rest of state	4,810	39,465	55,227	56,935	
Total NYS	**87,795**	**175,654**	**223,568**	**229,711**	

Data from NYS DOH Monthly Medicaid Managed Care Enrollment Report, available at

https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

Compiled by Evelyn Frank Legal Resources Program, NYLAG

Office of Health Insurance Programs

Division of Long Term Care

Managed Long Term Care Policy 17.02: MLTC Plan Transition Process – MLTC Market Alteration

Date of Issuance: September 22, 2017

Effective immediately, the Department is establishing a process applicable to Managed Long Term Care (MLTC) enrollees in Partially Capitated, Programs of the All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus (MAP) plans who are required to involuntarily transition from one MLTC plan to another MLTC plan, as the result of (a) plan closure, (b) a plan's service area reduction or withdrawal, or (c) merger, acquisition or other arrangement approved by the Department.

A. Plan Closures

1. Requests. Requests to withdraw from the market through plan closure must be formally submitted to the Department, and receive specific approval, prior to any action on the part of the plan. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. Alternatively, an MLTC plan may submit a notice of intent, and the Department will work with the interested party(s) to identify milestones and deliverables for a transition plan to accomplish the expressed outcome. The Department must approve any request to withdraw.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through plan closure. Notices shall include a listing of available plans and direction to select a new plan within sixty (60) days of the date of the letter, and shall clearly state that enrollees who do not select a plan within sixty (60) days, will be auto-assigned to a new MLTC plan. Members will be provided with information on all available product types, but any necessary auto-assignment will be to a Partially Capitated MLTC Plan. The Department will take steps to preserve enrollee – provider relationships with any necessary auto assignment. Notices will be issued by the State's Enrollment Broker, New York Medicaid Choice (NYMC) and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for plan closure and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process the transfer to the new plan of choice via a 'warm transfer' process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will

subsequently process the enrollment transaction to the receiving plan. The plan that is closing must provide the new plan of choice with detailed information on the enrollee's plan of care and network provider relationships within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select or are auto-assigned to the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.

Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

B. Service Area Reduction

1. Requests. Requests to withdraw from the market by reducing a plan's service area must be formally submitted to the Department, and receive specific endorsement, prior to any action on the part of the plan. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. Alternatively, an MLTC plan may submit a notice of intent, and the Department will work with the interested party(s) to identify milestones and deliverables for a transition plan to accomplish the expressed outcome. The Department must approve any request to reduce a service area.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through reduction of a plan's service area. Notices shall include a listing of available plans and direction to select a new plan within sixty (60) days of the date of the letter and shall clearly state that enrollees who do not select a plan within sixty (60) days, will be auto-assigned to a new MLTC plan. Members will be provided with information on all available product types, but any necessary auto-assignment will be to a Partially Capitated MLTC Plan. The Department will take steps to preserve enrollee – provider relationships with any necessary auto assignment. Notices will be issued by NYMC and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for reduction in service area and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process

the transfer to the new plan of choice via a 'warm transfer' process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will subsequently process the enrollment transaction to the receiving plan. The plan that is withdrawing must provide the new plan of choice with detailed information on the enrollee's plan of care within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.

Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

C. Mergers, Acquisitions, and Other Arrangements Approved by the Department

1. Requests. Requests to withdraw from the market by merging with, or being acquired by, another MLTC plan must be formally submitted to the Department, and receive specific endorsement, prior to any action on the part of either plan. The Department will consider for approval, and reserves the right to approve, other proposed arrangements. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. The Department must approve any request for a merger, acquisition, or other proposed arrangement with another MLTC plan.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through merger, acquisition, or other proposed arrangement with another MLTC plan. Notices shall contain an announcement notice of the upcoming change, written information on plan choice and contact information for NYMC for education on other available options. Notices will be issued by NYMC and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for merger, acquisition, or other acceptable arrangement and all member notifications have been approved by the Department. Enrollees will be provided with information on plan choice and may elect to transfer to any other MLTC, within a sixty (60) day selection period. Market reduction that relates to an approved acquisition, merger, or other acceptable arrangement will result in

transfer of remaining enrollees to the designated receiving plan.

The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.
Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

PLEASE NOTE: MLTC enrollees will continue to have the opportunity to pursue a voluntary plan-to-plan transfer at any time.

D. Rate Adjustments

1. Plan Closures. No immediate premium rate adjustment will be made, because members are dispersed throughout the entire network area and will be accounted for in the next rate cycle. The Department will track the membership and dispersion and adjust rates prior to the next rate cycle if necessary.

2. Service Area Reduction. No immediate premium rate adjustment will be made, because members are dispersed throughout the entire network area and will be accounted for in the next rate cycle. The Department will track the membership and dispersion and adjust rates prior to the next rate cycle if necessary.

3. Mergers, Acquisitions, and Other Arrangements Approved by the Department. The Department will blend the most recent premium rates (draft or approved) of the consolidating plans. The blend will occur in the development process utilizing the community portion of the rate. The blend will utilize the most recent projected community enrollment to develop the blended community rate.

   Additionally, the Nursing Home Transition (NHT) add-on will also be recalculated based on the combined projected nursing home and community enrollment of both plans.

   The new blended rate must be actuarially sound as determined by the Department's actuary.

   Note: Different financing arrangements other than those specified above may be required for any of the member transition scenarios.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services

Date of Issuance: November 17, 2016

On December 30, 2015, the Department notified all managed long term care ("MLTC") plans of recent changes to the Department's regulations governing personal care services ("PCS") and consumer directed personal assistance ("CDPAS"), including revised regulatory provisions governing notices that deny PCS or CDPAS or propose to reduce or discontinue PCS or CDPAS. (See MLTC Policy 15.09 at http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm.).

The purpose of this directive is to provide further guidance to MLTC plans concerning appropriate reasons and notice language to be used when proposing to reduce or discontinue PCS or CDPAS. In particular, it addresses notices that propose to reduce or discontinue PCS or CDPAS for either of the following reasons: a change in the enrollee's medical or mental condition or social circumstances; or a mistake that occurred in the previous authorization or reauthorization.

A MLTC plan may not reduce or discontinue an enrollee's PCS or CDPAS unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi), for PCS, and 18 NYCRR §§ 505.28(h)(5)(ii)(a) through (f), for CDPAS. Two such examples are discussed in greater detail below. The MLTC plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering the facts of the individual enrollee's circumstances and thus cannot reduce services as part of an "across-the-board" action that does not consider each individual enrollee's particular circumstances and need for assistance.

The general purpose of these requirements is to assure that the plan's notice accurately advises the enrollee, in plain comprehensible language, ***what*** the plan is proposing to change with regard to the enrollee's PCS or CDPAS and ***why*** the plan is proposing to make that change. The more specificity the plan's notice provides with regard to the specific change in the enrollee's services, the reason for the change, and why the prior services are no longer needed, the better able the plan will be to defend its proposed reduction or discontinuance at any fair hearing, at which the plan bears the burden of proof to support its proposed action (i.e. the plan must establish that its proposed reduction or discontinuance is correct).

A. Change in Enrollee's Medical or Mental Condition or Social Circumstances

In such a case, the Plan's notice must indicate:

- The enrollee's medical or mental condition or social circumstances have changed and the plan determines that the services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. If the reason for the proposed reduction or discontinuance is a change in one or more such conditions or circumstances, the plan's notice must not simply recite the underlined language in the previous sentence, which would impermissibly make it the enrollee's responsibility to figure out which particular condition or circumstance had changed. Such boilerplate recitations are inadequate. Instead, the plan's notice must:

  1) state the enrollee's particular condition or circumstance - whether medical condition, mental condition, or social circumstance – that has changed since the last assessment or authorization;

  2) identify the specific change that has occurred in that particular medical or mental condition or social circumstance since the last assessment or authorization; and

  3) state why the services should be reduced or discontinued as a result of that change in the enrollee's medical or mental condition or social circumstances.

  Example of a change in medical condition: The plan authorized an enrollee for personal care services. At the time of the assessment, the enrollee was recuperating from hip replacement surgery. As the enrollee recovered from her surgery, her medical condition improved. Specifically, the enrollee's hip has now healed sufficiently that she is now able to walk 30 feet alone. The physician's order documented this improvement in her medical condition. Due to the improvement in her medical condition, she no longer needs the previously authorized level and amount of assistance with personal care services. Accordingly, the enrollee no longer needs help ambulating inside her apartment.

  Example of a change in social circumstances: The plan had authorized an enrollee for Level II personal care services, support with dressing. At the time of the initial authorization, the enrollee lived in her longtime residence with no family or friends who could help dress and undress. Her sister then moved next door and agreed to help with this task. Due to the change in the enrollee's social supports, she no longer needs the previously authorized amount of assistance for dressing and undressing.

B. Mistake

In such a case, the Plan's notice must indicate:

- A mistake occurred in the previous PCS or CDPAS authorization or reauthorization. The plan's notice must identify the specific mistake that occurred in the previous assessment or reauthorization and explain why the prior services are not needed as a result of the mistake.

  Plans must adhere to the following guidelines when proposing to reduce or discontinue services based on a mistake that occurred in the previous assessment or reassessment:

  1) A mistake in a prior authorization or reauthorization is a material error that occurred when the prior authorization was made. An error is a material error when it affected the PCS or CDPAS that were authorized at that time.

     Example of a mistake: The plan authorized, among other services, assistance with the Level I task of doing the enrollee's laundry. This authorization, however, was based on an erroneous understanding that the enrollee's apartment building did not have laundry facilities and that the aide would need to go off-site to do the enrollee's laundry. During a subsequent assessment, it was determined that the aide did, in fact, have access to a washer and dryer in the basement of the enrollee's apartment building. The plan thus proposed to reduce the time needed for the aide to perform the enrollee's laundry to correct the prior mistake and reflect that less time is needed to complete this task than was previously thought.

  2) This particular reason for reducing or discontinuing services is intended to allow an MLTC to rectify a material error made in a previous authorization for a particular enrollee. It must not be expanded beyond that narrow application or otherwise used as a reason to reduce services across-the-board or reduce services for a particular enrollee without a legitimate reason as described in this policy directive. For example:

     - A MLTC plan must not implement a new task-based assessment tool that contains time or frequency guidelines for tasks that are lower than the time or frequency guidelines that were contained in the plan's previous task-based assessment tool, and then reduce services to an individual or across-the-board on the basis that a "mistake" occurred in the previous authorization.

- A MLTC plan must not reduce services when implementing a new task-based assessment tool, if those services were properly contained in the former task-based assessment tool, on the basis that a "mistake" occurred in the previous authorization.

3) A prior authorization for PCS or CDPAS is ***not*** a mistake if it was based on the UAS-NY assessment that was conducted at that time but, based on the subsequent UAS-NY assessment, the enrollee is determined to need fewer hours of PCS or CDPAS than were previously authorized.

In such a case, a subsequent assessment might support the plan's determination to reduce or discontinue services for one of the reasons enumerated in NYCRR §§ 505.14(b)(5)(v)(c)(2)(i)-(vi) for PCS and 18 NYCRR §§ 505.28(h)(5)(ii)(a)-(f) for CDPAS. For example:

- There has been an improvement in the enrollee's medical condition since the prior authorization. In such a case, the MLTC plan's notice must identify the specific improvement in the enrollee's medical condition and explain why the prior services should be reduced as a result of that change, as set forth above.

Plans are reminded that enrollees are entitled to timely (i.e. 10 day prior notice) and adequate notice whenever plans propose to reduce or discontinue PCS or CDPAS or other services. All partially capitated plans must also use the State-mandated fair hearing notices. In additions, plans must comply promptly with all aid-continuing directives issued by the NYS Office of Temporary and Disability Assistance.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services

Date of Issuance: November 17, 2016

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.

If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring,

supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates.

NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night**.** A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link:

http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at mltcworkgroup@health.ny.gov.

NYLAG
NEW YORK LEGAL ASSISTANCE GROUP

Important Change for Medicaid Managed Care and MLTC Enrollees
Appeals and Fair Hearing Rights

1. What is changing on May 1, 2018?

New rules change how and when you can ask the State for a Fair Hearing to appeal a decision by your Medicaid managed care plan, HARP plan, or Managed Long Term Care (MLTC) plan. Starting May 1, 2018, if your plan denies, reduces or stops a service, and you think the decision is wrong, **you must first ask your plan to look at your case again. This is called a Plan Appeal**. You must then wait for the plan's decision **before** asking for a Fair Hearing.

This is a big change. Before May 1, 2018, you could request a Fair Hearing right away if you thought your plan's decision about your services was wrong. **Now you must first request a Plan Appeal before you can ask for a Fair Hearing.**

2. What happens if the plan decides to reduce or stop a service I am getting now?

The plan must send you a written notice called an "Initial Adverse Determination" at least 10 days before the date the plan says that it will reduce or stop any of your services. You have 60 days from the date of the plan's notice to ask for a Plan Appeal, **but if you want to keep your services the same while your case is appealed, you must ask for a Plan Appeal within 10 days** of the date of the plan's notice or by the date the notice says the change will take effect, whichever is later. If you request the Plan Appeal within 60 days but after the effective date of the reduction, you can ask the plan to "fast track" your Plan Appeal. If you lose your Plan Appeal, you may ask for a Fair Hearing. If you don't request a Fair Hearing, or if you don't win your Fair Hearing, and you received your services unchanged while waiting for the decision, you may have to pay for those services.

3. What happens if the plan denies my request to approve a new service or more services?

For some services, you have to ask the plan for approval before you get them. If the plan denies approval, it has 14 days to send you a notice of its decision. If your health is at risk, you or your provider may request that approval be "fast tracked." This requires the plan to decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information, and why the delay needed to obtain this information is in your interest. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If the plan denies your request for approval, the decision is called an "Initial Adverse Determination." If you think your plan's decision is wrong, you can ask for a Plan Appeal. After May 1, 2018, **you must first ask for a Plan Appeal and wait for a plan appeal decision before you may ask for a Fair Hearing.** You have 60 days to ask for a Plan Appeal. If you disagree with the Plan Appeal decision, you may ask for a Fair Hearing.

4. How do I request a Plan Appeal?

You can request a Plan Appeal by completing and faxing or mailing the Appeal Request Form that came with the plan's Initial Adverse Determination Notice. Some plans allow you to e-mail the request. The plan's contact information for requesting the appeal should be printed on the Appeal Request Form. You can also call the plan to request the appeal, but you will then also need to mail or fax confirmation of the request, unless you ask your Plan Appeal to be "fast tracked."

5. Can someone ask for a Plan Appeal for me?

If you want someone, like your medical provider, a family member, or a representative to ask for the Plan Appeal for you, you and that person must both sign and date the appeal request. Or you must give written permission to that person to request an appeal for you, unless you gave them permission in the past.

6. What happens in a Plan Appeal and How Long Does it Take?

After you ask for a Plan Appeal, the plan will send you and your representative your case file, with all the information they have about your request. You may submit new evidence for the plan to consider in its review. The plan will send you its decision about your appeal within 30 days. If your health is at risk and you or your provider request a "fast track" appeal, your plan must decide it within 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information to decide, and why the delay needed to obtain this information is in your interest. If the plan's appeal decision denies you all or some of the services you are seeking, the plan must send you a "Final Adverse Determination."

7. What if the Plan does not decide my Plan Appeal on time?

If you do not receive a "Final Adverse Determination" – a decision for your Plan Appeal -- by the time limits in the question above, you can ask for a Fair Hearing without waiting for the plan's decision.

8. What if I think the Plan Appeal decision is wrong?

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for a Fair Hearing, but if the plan is reducing or stopping a service you are getting right now, and you want your services to stay the same and not be reduced during the appeal, **you must ask for a Fair Hearing within 10 calendar days** from the date of the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same as they were before, until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

If the plan said the service is not medically necessary, you can ask the State for an External Appeal. You will have four months to ask for an External Appeal. Your services may be reduced while awaiting an External Appeal, unless you also requested a Fair Hearing in time to prevent a reduction.

You can ask for a Fair Hearing or an External Appeal or both. If you ask for both, the Fair Hearing decision will always be the final answer.

9. Where can I get more information?

For advice or assistance with a plan appeal or fair hearing with an MLTC plan, a HARP plan, or for Long Term Services and Supports such as home care with a Mainstream Medicaid Managed Care Plan, call **ICAN –Independent Consumer Advocacy Network** Phone: **844-614-8800**

TTY Relay Service: 711 Website: icannys.org E-Mail: ican@cssny.org

Call **NYLAG – EFLRP** contact eflrp@nylag.org **212-613-7310**

See http://www.wnylc.com/health/entry/184/ for more information.

A07578 Summary:

BILL NO	A07578
SAME AS	SAME AS S05485
SPONSOR	Gottfried
COSPNSR	
MLTSPNSR	

Amd §4403-f, Pub Health L; amd §366-a, Soc Serv L

Provides for automatic enrollment and recertification simplification for Medicaid managed care plans and long term care plans.

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A07578 Memo:

Memo not available

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A07578 Text:

STATE OF NEW YORK

7578

2019-2020 Regular Sessions

IN ASSEMBLY

May 9, 2019

Introduced by M. of A. GOTTFRIED -- read once and referred to the Committee on Health

AN ACT to amend the public health law and the social services law, in relation to automatic enrollment and recertification simplification for Medicaid eligible recipients

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Paragraph (b) of subdivision 7 of section 4403-f of the public health law is amended by adding a new subparagraph (iii) to read as follows:

(iii) Where a person determined eligible for Medicaid ("Medicaid

recipient") has been determined by the commissioner or his or her designee to require community-based long term care services for more than one hundred twenty days, and the Medicaid recipient has not selected and enrolled in a managed long term care plan prior to any expiration date of such determination of need for long term care, after being provided with information to make an informed choice, the commissioner shall assign the recipient to a managed long term care plan, taking into account consistency with any prior community-based direct care workers having recently served the recipient, quality performance criteria, capacity, and geographic accessibility. The commissioner may assign participants pursuant to such criteria on a weighted basis. A recipient assigned to a managed long term care plan under this subparagraph shall be deemed to have been determined to be in need for long term care services for more than one hundred twenty days and eligible to be enrolled in a managed long term care plan.

§ 2. Paragraph (b) of subdivision 2 of section 366-a of the social services law, as added by section 51 of part A of chapter 1 of the laws of 2002, is amended to read as follows:

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, an applicant or recipient may attest to the amount of his or her

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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accumulated resources, unless such applicant or recipient is seeking medical assistance payment for long term care services for the first time. A recipient who has already provided documentation of resources may attest to the amount of accumulated resources if it has remained the same or is less than the amount originally documented. For purposes of this paragraph, long term care services shall mean care, treatment, maintenance, and services described in paragraph (b) of subdivision [~~1~~] one of section three hundred sixty-seven-f of this title, with the exception of short term rehabilitation, as defined by the commissioner of health.

§ 3. Paragraph (d) of subdivision 5 of section 366-a of the social services law, as amended by section 12 of part D of chapter 56 of the laws of 2013, is relettered paragraph (e) and three new paragraphs (f), (g) and (h) are added to read as follows:

(f) Notwithstanding paragraph (b) of subdivision two of this section and paragraphs (a), (b), (c) and (d) of this subdivision, the following recipients will be recertified automatically, unless there has been a finding of lack of eligibility for Medicaid:

(i) enrollees in Medicaid managed long term care plans as defined in section forty-four hundred three-f of the public health law;

(ii) enrollees in Medicaid managed care plans as defined in section three hundred sixty-four-j of this title who receive personal care services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or consumer directed personal assistance services pursuant to section three hundred sixty-five-f of this title;

(iii) enrollees receiving Medicaid in the Aged, Blind and Disabled category who receive fixed income from the Social Security Administration (SSA); and

(iv) Medicare Savings Program (MSP) recipients who have a fixed income from the Social Security Administration (SSA).

(g) Nothing in paragraph (e) of this subdivision should be construed to alter a Medicaid recipient's obligation to inform the public welfare district of changes in income or other factors that might impact eligibility pursuant to subdivision four of this section.

(h) Upon a finding of lack of eligibility, recipients identified in paragraph (e) of this subdivision will be entitled to notice and hearing

rights as provided in section twenty-two of this chapter.

§ 4. This act shall take effect on the one hundred eightieth day after it shall have become a law; provided that the amendments to paragraph (b) of subdivision 7 of section 4403-f of the public health law made by section one of this act shall be subject to the expiration and reversion of such paragraph and shall expire and be deemed repealed therewith and provided further that such amendments shall not affect the repeal of such section and shall expire and be deemed repealed therewith. Effective immediately, the commissioner of health shall make regulations and take other actions reasonably necessary to implement this act on that date.

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NEW YORK LEGAL ASSISTANCE GROUP

MEMORANDUM IN SUPPORT

A07578 (Gottfried)/ S05485 (Rivera)

AN ACT to amend the public health law and social services law, providing for automatic enrollment into Managed Long Term Care plans and recertification simplification for Medicaid and Medicare Savings Program recipients who are aged, blind, or disabled or who rely on continuity of Medicaid eligibility in order to receive Medicaid home care services.

The New York Legal Assistance Group (NYLAG) supports this legislation.

NYLAG uses the power of the law to help New Yorkers in need combat social and economic injustice. We address emerging and urgent legal needs with comprehensive, free civil legal services, impact litigation, policy advocacy, and community education. Among the array of free legal services we provide to low-income New Yorkers is representation of the elderly and people with serious illness or disabilities in retaining Medicaid eligibility and accessing Medicaid home care services through Managed Long Term Care (MLTC) plans.

This bill will improve two burdensome and error-prone Medicaid procedures which now cause seniors and people with disabilities to lose Medicaid, Medicare Savings Programs, and/or home care coverage, despite being eligible. First, by automating the annual Medicaid "renewal" process, which now is burdensome and error-prone, it will prevent the erroneous termination of Medicaid eligibility for several vulnerable populations. When Medicaid is cut off because of a glitch in the renewal process, the individual is automatically disenrolled from their Managed Long Term Care (MLTC) plan, resulting in the loss of life-saving home care benefits.

Second, the bill would automatically enroll consumers into a MLTC plan after they have been approved for Medicaid and for MLTC enrollment and after they have been given the opportunity to choose their own plan but have been unable to do so. Currently, those who cannot manage to navigate the many hurdles to timely enroll in an MLTC plan lose their eligibility for MLTC, and they must begin the entire process again. The delay in accessing home care services places them at risk of harm. This bill would align the MLTC program with mainstream Medicaid managed care, in which individuals approved for Medicaid have always been auto-enrolled in a plan after a choice period.

1. Automatic Recertifications for MLTC, Medicare Savings Program & Others Aged, Blind and Disabled:

Over the last fifteen years, advances in technology have enabled the state and local Medicaid programs to verify many types of income and financial resources of applicants and recipients electronically, without requiring documentation from the applicant or recipient. With these advances, applicants and recipients could "attest" to the amount of their income or resources, without the burden of submitting documentation. See NYS DOH 04 ADM-06 - *Attestation of Resources*; 05/OMM-INF-2, 11 OHIP/ADM-9 - *Automated Medicaid Renewal for Individuals with Fixed Incomes in the Aged, Blind and Disabled Category*. Federal law at 42 U.S.C. § 1396w requires states to implement a program for verifying assets for purposes of determining and re-determining Medicaid eligibility for aged (age 65 or over), certified blind and certified disabled applicants and recipients. NYS DOH has done this through 2017 Administrative Directive 17 OHIP/ADM-02 *Asset Verification System*, which is implemented statewide except not fully in New York City.

Despite these advances in technology, and despite the fact that most seniors and people with disabilities who receive Medicaid have fixed incomes and assets, New York has continued to require enrollees who are Aged, Blind or Disabled to undergo a burdensome and error-prone mail renewal process annually to prove they are still eligible for Medicaid or the Medicare Savings Program. The renewal packages are mailed to recipients who, due to disability, age, and/or language, are unable to understand and respond on a timely basis. Stories are legion of consumers who never receive these mailings, or who submitted the required response, only to have Medicaid discontinued for an alleged "failure to recertify."

The Medicaid mail renewal process is a shameful example of the old "churning" process in welfare systems. Recipients are cut off Medicaid not because they are not eligible, but because they fall victim to the bureaucratic barriers of an archaic mail renewal system. If the local district fails to process the renewal in time, or finds the recipient did not sufficiently document eligibility, the district should then send a Notice of Intent to Discontinue Medicaid, with the right to request a hearing and Aid Continuing. However, the consumer often does not receive the discontinuance notice at all, or may not have the wherewithal to request a fair hearing in the short 10 days from the date of the discontinuance Notice to obtain "Aid Continuing." Navigating the hearing process is difficult, and most consumers do not find their way to a legal services advocate.

The consequences of being "churned" off of Medicaid or Medicare Savings Program eligibility are severe. If a Fair Hearing isn't requested in time for Aid Continuing, the consumer is automatically *disenrolled* from an MLTC plan – leading to cut-off of home care services. Even if

they manage to request a fair hearing quickly, an Aid Continuing directive does not automatically re-enroll them in their MLTC plan – this requires extensive advocacy. Even the constitutional due process protection of Aid Continuing, then, is not enough to ensure continuity of vital home care services in the complex MLTC system. Although some MLTC plans continue services after discontinuance with the assumption that the case will be fixed, in many cases the plan does not actually help their member to recertify during that time and ultimately stop services without notice.

Similarly, when an individual is "churned" off of the Medicare Savings Program, if they do not manage to get Aid Continuing with a fair hearing request, their Social Security check is reduced by $135.50/month – the cost of the Medicare Part B premium. For someone whose income is under $1406/month, this reduction can be catastrophic.

This bill seeks to stop the cycle of "churning" eligible people off of Medicaid by automating the Medicaid recertification process for these four groups:

1. Managed Long Term Care (MLTC) enrollees,
2. Mainstream managed care members receiving personal care or consumer-directed personal assistance (CDPAP) services,
3. Medicaid enrollees in the Aged, Blind, and Disabled Category without excess income,
4. and Medicare Savings Program (MSP recipients).

According to a 2011 Administrative Directive, 11 OHIP/ADM-9 - *Automated Medicaid Renewal for Individuals with Fixed Incomes in the Aged, Blind and Disabled Category*, the latter two groups should already receive automatic renewals, but this bill codifies that requirement in statute.

The annual recertification process for MLTC enrollees is a waste of resources for plans, local districts, the State Department of Health, enrollees, and their families. The majority of MLTC enrollees are on fixed incomes, which increases only incrementally through cost of living increases. Each year they must undergo a recertification process which is so prone to errors that seniors and people with disabilities routinely have Medicaid cut off erroneously.

Allowing deemed resource eligibility and attestation for these groups would not put the State at risk of reauthorizing Medicaid for people who are ineligible. Attestation of resources is already used in many parts of Medicaid, with no reported downside. The Medicaid program already conducts investigations for potential ineligibility and would continue to do so. This would not change enrollees' obligation to report changes in income or resources and would not change excess income liability to the plans.

2. Auto-Enrollment of Eligible Medicaid Recipients Into MLTC Plans

People who have successfully applied for Medicaid in order to enroll in a MLTC plan face many hurdles and delays before they can actually enroll in a plan.

First, under the Special Terms & Conditions of the 1115 waiver authorizing the MLTC program,[i] they must first schedule an in-home assessment by a nurse from the Conflict Free Eligibility and Enrollment Center (CFEEC), which the State has contracted with Maximus to run through NY Medicaid Choice. It can take several weeks to schedule that half-day assessment, the purpose of which is to ensure that the individual requires community-based long term care services for more than one hundred and twenty days. Over 90% of people assessed are determined eligible. Not until that assessment is completed may the Medicaid recipient schedule in-home assessments with prospective MLTC plans. At that assessment an MLTC plan nurse assesses the individual, and if they agree, processes the enrollment, which is effective either the 1st of the following month, or, if it is already too late in the month (after the 18th), effective the 1st of the month after the following month. It can take an MLTC plan several weeks to schedule those assessment visits. Meanwhile, the clock is ticking as the CFEEC determination is only good for 75 days – if the individual is not enrolled by then, the CFEEC expires and must be redone, requiring scheduling a new visit a few weeks down the road. See DOH MLTC Policy 16.08: *Conflict Free Evaluation and Enrollment Center (CFEEC) Update to Expiration of Evaluations (available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-08.htm*)*.

Second, MLTC plans often discourage enrollment of members who may be perceived as having high needs, since the plan wants to avoid providing high-cost care with the fixed capitation rate. For example, an individual who is bedbound, living alone, may need 24-hour/day care. The plan representative, however, might say they would authorize fewer than eight hours/day. The consumer is then incentivized to shop around for another plan that might approve the number of hours needed. Plans also have been known to say that the individual cannot be safely cared for in the community, and requires nursing home placement, even though the CFEEC has found them eligible for community-based long term care services; this is another common pretext for avoiding a high-need consumer. With the closing of Independence Care Systems (ICS) and Guildnet MLTC plans, which had reputations for providing adequate care to higher needs members, there are fewer options for the consumer.

Third, MLTC plans will be even less incentivized to authorize high hours of care when needed if and when CMS approves the carve-out of permanent nursing home care from the MLTC package. People in nursing homes, though determined to be eligible for community based services through a CFEEC, will not find an MLTC plan willing to provide the services they need to

return home to the community. People in the community with high needs will be avoided by the MLTC plans, as they are now, and will end up in nursing homes.

In contrast, consumers who do not have Medicare have long been auto-assigned to managed care plans if they do not select a plan within 30 days of being approved for Medicaid. Soc. Serv. L. §364-j, subd. 4(f). The law provides that this auto-assignment may be on a weighted basis, "…taking into account capacity and geographic accessibility. The commissioner may … assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants." Id.

This bill would establish an auto-assignment protocol for MLTC similar to that used in mainstream managed care be required. Auto-assignment would prevent delays in enrollment and curtail the cherry-picking that plans engage in to avoid high-need consumers. Auto-assignment would ensure that a consumer who has been screened by the CFEEC enrolls in an MLTC plan before the CFEEC expires after 75 days. The bill additionally provides that the CFEEC will be deemed to be in effect – and does not expire – if the auto-assignment is not completed by the 75th day after the CFEEC determination.

For the reasons stated above, the New York Legal Assistance Group supports this legislation.

[i] CMS Special Terms and Conditions, dated 1/19/17 available here, https://www.health.ny.gov/health_care/managed_care/appextension/docs/2017-01-19_renewal_stc.pdf ; see page 37.

What do we do?

Toll-Free Helpline

Anyone can call our toll-free telephone number to reach a live, expert health counselor. You can get accurate, in-depth guidance on your first call.

One-on-One Assistance

Through our helpline or our network of agencies, we provide direct assistance to hundreds of people each month. Our cases range from quick advice calls to formal appeals.

Community Presentations

We educate consumers, advocates and health care providers about Managed Long Term Care and FIDA.

Our Services Are Free

Get help today.

- Call: **(844) 614-8800**
  - Our helpline is open Monday through Friday, 8am to 8pm.
  - If you are hearing or speech impaired, you can use the NY Relay service by dialing 711
- Email: **ican@cssny.org**
- Website: **icannys.org**

ICAN is a program of the **Community Service Society**, and is funded by the State of New York.

Community Service Society | Fighting Poverty Strengthening New York

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cssny.org

ICAN Brochure, 8/2015

Get help with Managed Long Term Care

ICAN is an independent, free, and confidential resource to help you make the health insurance decisions that are right for you.

ICAN
Independent Consumer Advocacy Network

What is ICAN?

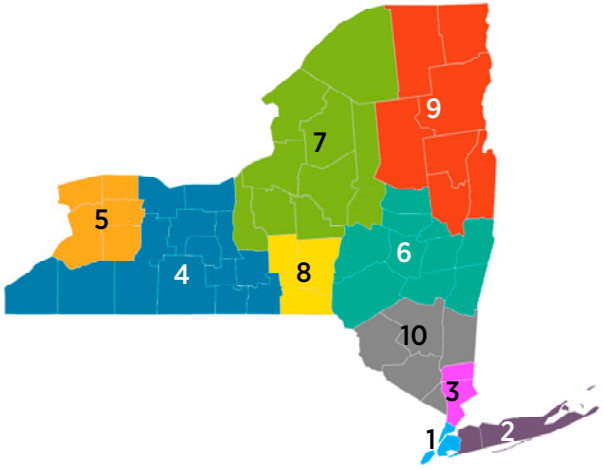
ICAN is the New York State Ombudsprogram for people with Medicaid who need long term care services.

We assist New Yorkers with enrolling in and using managed care plans that cover long term care services, such as home attendant services or nursing home care.

We can help you by:

- Answering questions about Medicaid, Medicare, long term care, and managed care plans
- Giving you information about your health insurance options, like the new FIDA program, and helping you decide what is right for you
- Solving problems with your managed care plan or providers, using negotiation or formal appeal processes

ICAN is a statewide network of organizations



1. CSS
   Center for Independence of the Disabled, NY
   The Legal Aid Society
   Medicare Rights Center
   NY Legal Assistance Group
2. Nassau/Suffolk Law Services Comm.
3. Westchester Disabled On the Move
4. Legal Assistance of Western NY
5. Neighborhood Legal Services
6. Empire Justice Center
7. ACR Health
8. Action for Older Persons
9. Southern Adirondack Independent Living Center
10. Legal Services of the Hudson Valley

Who Does ICAN Help?

- We help anyone in a Medicaid managed care plan who needs long term care services (like a home attendant or nursing home).
- We also help people who are applying for Medicaid and need help enrolling in a Managed Long Term Care (MLTC), Medicaid Managed Care (MMC), or Fully Integrated Duals Advantage (FIDA) plan.
- We can talk with you, your family member, or anyone who is helping you with your health insurance or care decisions.

Call ICAN at (844) 614-8800 or visit icannys.org