

Office of Health Insurance Programs

Policy and Proposed Contract Changes to Transition Long Term Home Health Care Program  
Non-dually eligible participants into Medicaid Managed Care

April 2013

## **ISSUE/BACKGROUND**

Resulting from recommendations of the Medicaid Redesign Team, New York State's enacted 2011-12 budget includes a number of changes to the Medicaid program that are intended to contain costs, create efficiencies and improve the quality and coordination of care provided to over 4 million State residents.

The NYS Department of Health (SDOH) will begin mandatory Mainstream Medicaid Managed Care (MMMC) enrollment of the approximately 3,100 Medicaid, non-dually eligible, Long Term Home Health Care Program (LTHHCP) participants who are not otherwise exempt or excluded, beginning in April 2013. The non-dually eligible population identified for this transition is comprised of 2,700 adults (aged 18 and older) and 400 children (under 18 years old). 62 percent of the non-dual LTHHCP participants live in New York City and 38 percent reside in the rest of state. Previously, non-dually eligible LTHHCP enrollees were excluded from MMMC enrollment.

The Department has held several stakeholder workgroup meetings with Medicaid managed care plans, LTHHCP provider agencies, State agencies and local departments of social services (LDSS) to identify obstacles and opportunities that will affect the enrollment of this population. The main issues have been broken into three major areas: Transition/Enrollment of Population, Transitional Care Policy, and Access to Waiver Services. This document reflects the policy decisions that have been developed to respond to the issues raised.

### **I. Transition/Enrollment of Population**

A statewide mailing was conducted the week of April 8, 2013 to notify all non-dually eligible LTHHCP participants that they will soon be required to join a Medicaid managed care plan. The mailing identifies local departments of social services staff, LTHHCP agencies, and the enrollment broker, New York Medicaid Choice, as resources for additional information and assistance with choosing a health plan.

Mandatory mailings in counties with an enrollment broker

- A second mailing (mandatory enrollment packet) will be sent to inform consumers that they have 60 days to select a health plan in which to enroll. The packet will include the MMMC brochure, a list of plans serving the individual's county, and NY Medicaid Choice or LDSS contact information for enrollment inquiries and assistance.
- During the 60 day plan selection period, New York Medicaid Choice staff will have information necessary to assist persons in choosing the right plan. If the consumer

does not choose a plan within the designated time frame, one will be auto-assigned (AA) for them using the State's approved algorithm.

Mandatory mailings in counties without an enrollment broker

- The LDSS have received a full list of those non-dually eligible individuals that are targeted for enrollment into a managed care plan. The LDSS will work with the LTHHCP agency and each consumer to choose and enroll in a plan within the 60 day period to be tracked manually by the LDSS.

LTHHCP (non-dually eligible) participants who are in receipt of only the waiver services of Medical Social Services and/or Home Delivered Meals must enroll in a mainstream Medicaid managed care plan. The needs of these individuals can be met under the mainstream managed care benefit package, which has been expanded to include both of these waiver services exclusively for LTHHCP participants in receipt of these waiver services at the time of transition.

Individuals who are enrolled in Medicaid and meet NYS Mental Hygiene Law criteria for a developmental disability are identified by restriction/exception code 95 in eMedNY and remain exempt from mandatory enrollment in mainstream Medicaid managed care programs.

In cases where the non-dually eligible LTHHCP participant is in receipt of waiver services that are not included in the mainstream Medicaid managed care plan, the individual has the option to remain in the LTHHCP, apply for enrollment in another home and community based Medicaid waiver program, such as Care at Home, Nursing Home Transition and Diversion, or the Traumatic Brain Injury, if eligible, or managed long term care if available.

## **II. Transitional Care Policy**

Coordination of a safe transition is a responsibility shared by the LTHHCP agency and the local department of social services. The LTHHCP participant, family or other chosen representatives, the primary care physician, the LTHHCP agency, and the LDSS must all be aware of the Effective Date of Enrollment in the Medicaid managed care plan. The LTHHCP agency must submit the current service plan care to the selected plan prior to the enrollment date to promote continuity of care and obtain necessary authorization.

Upon plan enrollment, the existing service plan will continue for 90 days after the effective date of MMMC enrollment or until the plan's assessment, whichever is later. The LTHHCP will continue to provide all services utilizing the existing service providers throughout the transition period, with no changes in service or frequency. Medicaid managed care plans will be required to reimburse the LTHHCP for these services at the fee for service (FFS) rate for the duration of the transition period. Once the transitional period has ended, the plan will assume full responsibility for care management and provision of services.

Once the plan conducts its assessment for continued care, any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal, either expedited, if warranted, or standard appeal, the right to have authorized services continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination, either in whole or in part, on the appeal. Further, if there is an appeal or fair hearing as a result of any proposed plan reduction, suspension, denial or termination of previously authorized services, the plan must comply with the aid to continue requirement identified above. In particular, if the enrollee requests a State fair hearing to review a plan adverse determination, aid to continue is to be provided until the fair hearing decision is issued.

After enrollment in a managed care plan, these individuals will be subject to a twelve (12) month Lock-In Period following the Effective Date of Enrollment, with an initial ninety (90) day grace period in which to disenroll without cause and enroll in another health plan, if available.

- An enrollee with HIV infection or AIDS may request transfer from a managed care plan to a HIV SNP, or from a HIV SNP to another HIV SNP at any time.
- Once enrolled in a managed care plan, disenrollment to return to the LTHHCP will not be permitted and will be enforced through a restriction/exception code system edit.

Additional information on disenrollment policy is found in the Medicaid Managed Care Model Contract which can be accessed on the NYS DOH web site at:

[http://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf)

### **III. Access to Waiver Services**

The LTHHCP is a coordinated plan of care and services for individuals who would otherwise be medically eligible for placement in a nursing facility. The LTHHCP enables the State to provide participants with a number of supportive services not available under New York's State Plan for Medicaid services because the provision of waiver services is effective in preventing premature institutionalization of program participants and allows those who are at risk for institutionalization to remain in the community.

Individuals enrolled in a Medicaid managed care plan must receive, from the managed care program, all medically necessary benefits identified in the Prepaid Benefit Package, as appropriate. For all enrollees transitioned from the LTHHCP and in receipt of long term services and supports, each plan must coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but are carved out.

In preparation for the transition of non-dually eligible Long Term Home Health Care Program participants to Medicaid managed care, DOH identified two highly utilized waiver services that are not included in the MMMC Prepaid Benefit Package. Due to concern that without access to these services, individuals may be at risk for failure to remain in the community, the services of

Medical Social Services (MSS) and Home Delivered Meals (HDM) will be available to those LTHHCP participants in receipt of these services immediately prior to managed care enrollment. These services must be continued under the plan as long as there is an assessed need for the service to ensure ongoing access to these waiver services.

Service descriptions:

**Medical Social Services (MSS)** are individually designed services intended to assist members who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability, integrating into the community, and on-going life in the community. They are a counseling service provided to the member who is coping with altered abilities and skills, a revision of long term expectations or changes in roles in relation to significant others. The MSS are available to members and/or anyone involved in an ongoing significant relationship with the member when the issue to be discussed relates directly to the waiver participant. There are times when it is appropriate to provide this service to the member in a family counseling or group counseling setting.

**Home Delivered Meals (HDM)** is an individually designed service which provides meals to individuals who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. These meals assist the participants to maintain a nutritious diet. They do not, however, constitute a full nutritional regimen.

In event that an individual's needs cannot be met by the managed care plan, and the consumer does not qualify for enrollment in another waiver to access the required services, LTHHCP enrollment may be continued. The LTHHCP waiver will remain an option at least until the current LTHHCP waiver expires in 2015.