ICAN

Independent
Consumer Advocacy
Network

Introduction to Long Term Care Services through Medicaid Managed Care

Community Service Society | Fighting Poverty Strengthening New York

HEALTHY CAPITAL DISTRICT INITIATIVE

Agenda

- Introduction to ICAN
- Medicaid Long Term Care services
- What is MLTC?
- How do I join MLTC?
- How do I use my plan?
- How to get help from ICAN

Introduction to ICAN

What is ICAN?

ICAN stands for **Independent Consumer Advocacy Network**.

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

We assist New Yorkers with understanding how to enroll in and use managed care plans that cover long term care or behavioral health services.

What do we do?

- **Answer your questions** about managed care plans.
- **Give you advice** about your plan options.
- **Help you enroll** in a managed care plan.
- Identify and **solve problems** with your plan.
- Help you **understand your rights**.
- Help you **file complaints** and/or grievances if you are upset with a plan's action.
- Help you **appeal** an action you disagree with.

Who do we help?

We help anyone enrolled in a **Medicaid managed care plan** who needs:

- **long term care services** (like home attendant, adult day care, or nursing home); or
- **behavioral health services** (help recovering from and living with mental illness or substance use disorder.)

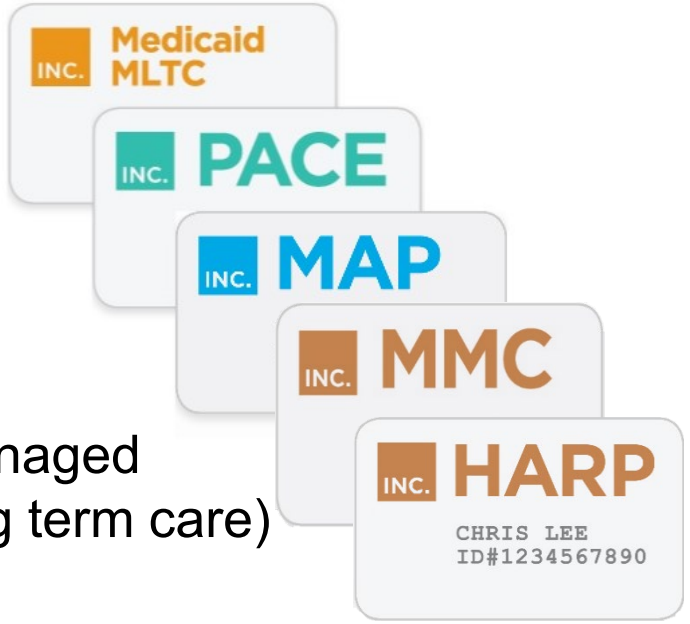
We also help educate people who are newly eligible for enrollment in a Medicaid managed care plan.

We can talk to friends, family members, social workers, providers, and anyone else who is helping people with their healthcare decisions.

What kinds of plans does ICAN work with?

The plans we work with are:

- MLTC (partially capitated MLTC)
- **PACE** (Programs of All-inclusive Care for the **Elderly**)
- **MAP** (Medicaid Advantage Plus)
- **MMC-LTSS** (Mainstream Medicaid Managed Care for those enrollees who need long term care)
- **HARP** (Health And Recovery Plans)

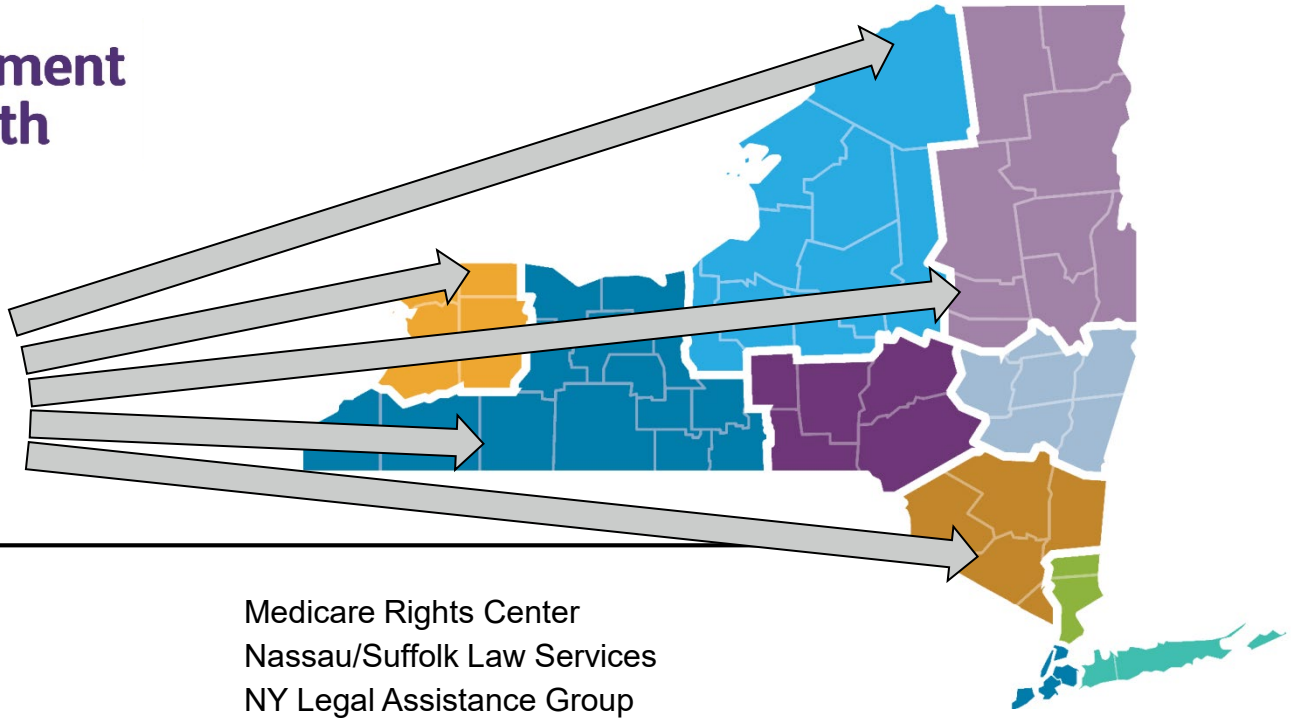


* FIDA is no longer available after 2019.

Who is ICAN?

NEW YORK STATE | Department of Health

Community Service Society | Fighting Poverty Strengthening New York



Our Network of Agencies:

ACR Health
Action for Older Persons
BronxWorks
Center for Independence of the Disabled NY
Healthy Capital District Initiative
Korean Community Services
Legal Assistance of Western New York
Legal Services of the Hudson Valley
Medicare Rights Center
Nassau/Suffolk Law Services
NY Legal Assistance Group
South Asian Council for Social Services
Southern Adirondack Independent Living
Urban Justice Center
Westchester Disabled On the Move
Western NY Independent Living

How we help

We'll meet you **in person** at our offices or at your home.

Our services are completely **free and confidential**.

We give **educational presentations** to consumers, caregivers, and professionals.

We monitor our cases for **potential trends** and report them to the state.

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HEALTHY CAPITAL DISTRICT INITIATIVE

* Interpreters are available for all other languages.

Medicaid Long Term Care Services

What is “long term care?”

Health insurance (like Medicare or Medicaid) pays for **medical care** like doctors, hospitals and drugs.

But most health insurance doesn’t pay for **long term care,** such as home care, adult day care, or nursing home.

Home care

Some older adults or people with disabilities need another person to help them safely perform their **activities of daily living (ADLs)**.

Medicaid can pay for a **Personal Care Attendant** or **Home Health Aide** to provide this help **in your own home**.

Here are some examples of ADLs:

- Bathing
- Dressing
- Grooming
- Using the toilet
- Walking
- Preparing meals
- Reminding to take medication
- Grocery shopping
- Laundry

Medicaid pays for long term care

Many New Yorkers who need long term care get it through **Medicaid**.

And most people with Medicaid must get their long term care through a **managed care plan**.

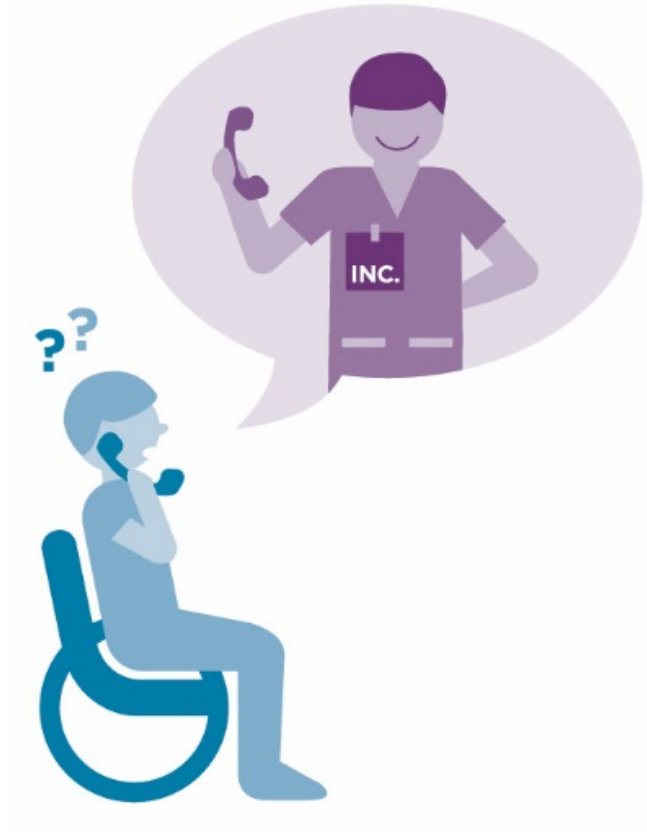
You must join a plan offered by a private health insurance company to get Medicaid to pay for your long term care. Medicaid pays these companies to provide long term care to their members.

What is MLTC?

MLTC is managed care

- There are **different types of plans** that cover long term care.
- All of them cover services like home care, adult day care, nursing home care, medical supplies, and transportation services.
- All of them must **follow the same rules** as the Medicaid program.
- Each type of plan may cover different services.
- But all plans of the same type must cover the same services.

Care Manager



When you join an MLTC plan, you will get a **Care Manager**.

Your care manager will visit you at least twice a year and help you get the care you need.

You can call your care manager whenever you have questions or problems.

Does this section apply to you?

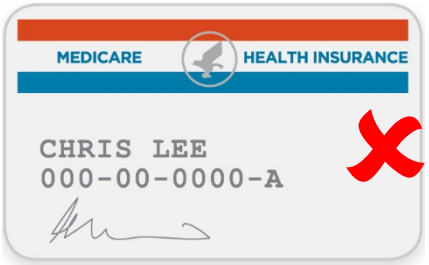
First question:

- **Do you have Medicaid?**
  - If the answer is **NO**, then first you need to apply for and be approved for **Community Medicaid with Community-Based Long Term Care (CBLTC)**.
  - There are Facilitated Enrollers throughout the state who can help you apply for Medicaid.
  - You are not eligible to enroll in MLTC or receive ICAN services until you are approved for Medicaid.

Does this section apply to you?

Second question:

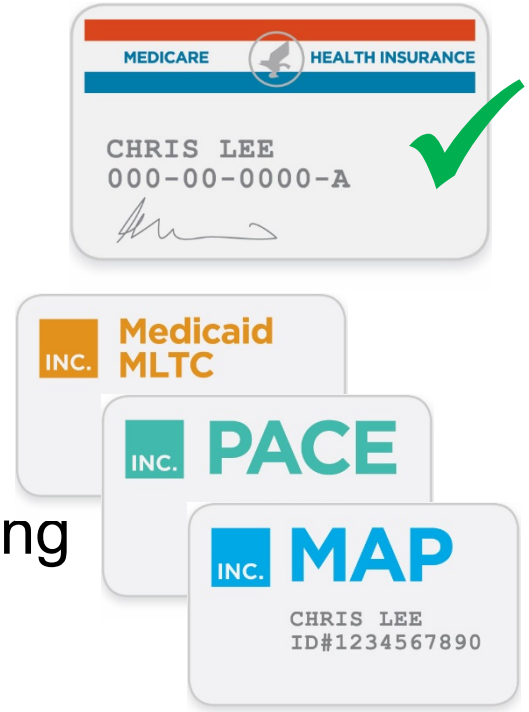
- **Do you have Medicare?**
  - If the answer is **NO**, then most likely you get all of your health care through a Medicaid Managed Care (MMC) plan (or “mainstream” plan) or a Health And Recovery Plan (or HARP).
  - These plans cover all of your doctors, hospitals, medications, and also your long term care services. You generally do not need a separate MLTC plan to get long term care services.



Does this section apply to you?

Second question:

- **Do you have Medicare?**
  - If the answer is **YES**, then that makes you a **dual eligible.**
  - There are three different kinds of MLTC plans you can choose from in this area to get your Medicaid long term care services.



What kind of plan is right for you?

- **Do you want your Medicare and Medicaid to be combined into one plan?**
  - If the answer is **YES**, then you should choose:
    - PACE
    - MAP
  - If the answer is **NO**, then you should choose:
    - Medicaid MLTC

Medicaid MLTC

- Medicaid MLTC is a separate health insurance plan that **adds onto** your existing Medicare and Medicaid coverage.
- You would be able to **keep your current Original Medicare or Medicare Advantage** plan for doctors, hospitals, and other medical care.
- Medicaid MLTC plans **just cover long term care** and a few other services.
- Because they do not cover doctors, **you can continue to see the same doctors** you see now.

What long term care services are covered?

- Home care
  - (including personal care, home health aide, and Consumer Directed Personal Assistance)
- Adult day care
- Private duty nursing
- Physical/Occupational/ Speech therapy
- Transportation to medical appointments
- Home delivered meals
- Medical equipment and supplies
- Hearing aids and audiology
- Eyeglasses and vision care
- Dental care
- Podiatry
- Nursing home

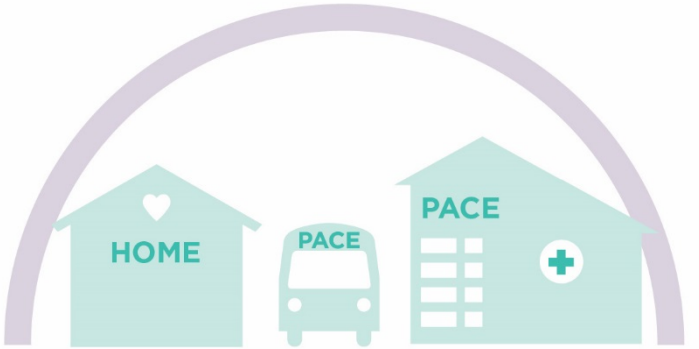
Note: this is not a complete list of covered services.

Combined Plans

- There are two kinds of MLTC plans in this area that **combine your Medicare and Medicaid into one plan**: PACE & MAP
- With these plans, **you would no longer use your Medicare card** to get medical care. Everything would be through your plan.
- These plans are **more convenient** because you have only one insurance plan to worry about.
- However, you need to make sure your doctors take the plan before you join.

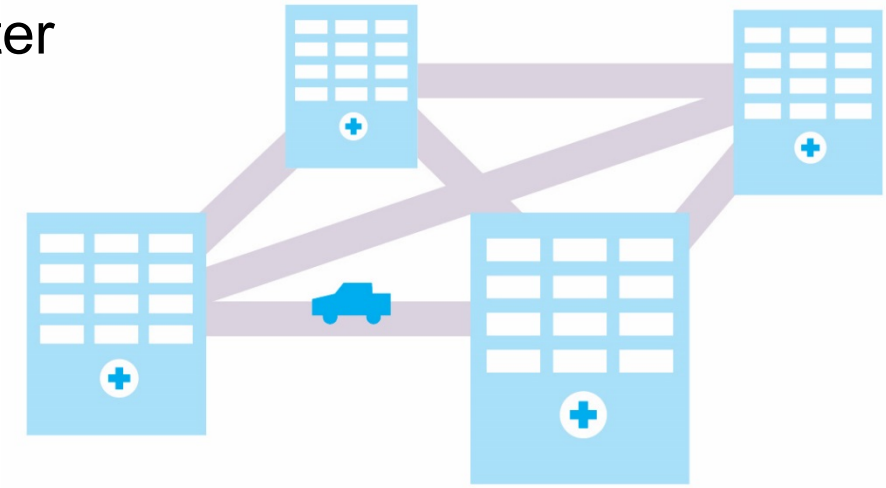
PACE: Program of All-inclusive Care for the Elderly

- PACE combines Medicare, Medicaid and long term care services under one plan.
- You have to be **at least 55 years old** to join PACE.
- If you join a PACE, **you must go to a center** in your neighborhood to get most of your care.
- The PACE center includes doctors and nurses who coordinate your care, as well as adult day care, meals, and other services.
- PACE is not available everywhere in the State. But it is a great option for people who live near a PACE center.



MAP: Medicaid Advantage Plus

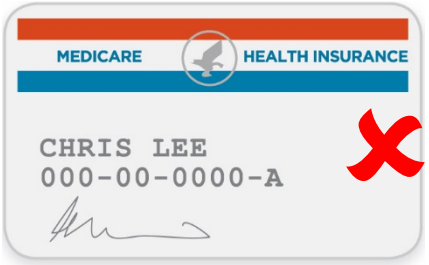
- Medicaid Advantage Plus is **like a Medicare Advantage plan combined with a Medicaid MLTC plan**.
- MAP includes all Medicare, Medicaid and long term care services.
- Age requirements vary among plans from 18+ to 65+.
- Unlike PACE, there is no center you need to go to for your doctors and other care.



How do I join MLTC?

A note for people without Medicare

- The following process is only for people with Medicare and Medicaid ("dual eligibles") who want to enroll in MLTC.
- If you have Medicaid but **not Medicare**, then you generally do not need to enroll in MLTC.
- You would simply contact your **Medicaid Managed Care or HARP** plan to request long term care services.



Steps to MLTC Enrollment

1. Apply for Medicaid
2. Conflict-Free Evaluation
3. What type of plan?
4. Choose your plan
5. Enroll

1 Apply for Medicaid

- Most people seeking long term care need to apply for Medicaid through the Local Department of Social Services (LDSS).
- There are Facilitated Enrollers throughout the state who can help you apply for Medicaid.
- If you are age 65 or older, or certified disabled or blind, your income and resources must be under the following limits to qualify:*



Income	$875	$1,284
Resources	$15,750	$23,100

* These limits are as of 2020; they may change each year. There are also some deductions from income and resources; consult with a Medicaid expert to find out if you're eligible.

1 Spend-Down

- If you are over the Medicaid income limit, you can still get Medicaid and MLTC with a **spend-down.**
- Spend-down means that your excess income becomes like a premium you must pay to your MLTC plan each month in order to keep your coverage.

1 Other options for excess income

- **Spousal Impoverishment Budgeting**
  - Married couples where one spouse joins MLTC can keep more income.
- **Special Income Standard**
  - People returning home from a nursing home or adult home can deduct a rent allowance from their income.
- **Supplemental Needs Trust** ("pooled income trust")
- **Informal bargaining with the plan** (pay what you can)
  - But you could still be disenrolled for non-payment.

2 Conflict-Free Evaluation

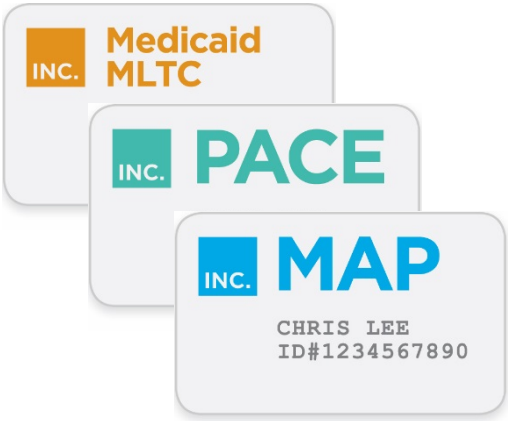
- The next step is to ask Medicaid whether you need enough help to join an MLTC plan.
- **MLTC is not for everyone.** Even if you already have Medicaid, you can only join MLTC if you need help with your daily activities.
- Medicaid decides if you can join MLTC by sending a nurse to your home to meet with you. This is called an **evaluation**.
- You can schedule this by calling **855-222-8350**. This nurse will come from the **Conflict Free Evaluation and Enrollment Center (CFEEC)**, which is run by New York State.

2 Conflict-Free Evaluation

- The CFEEC **nurse will tell you right away** if you are approved to join MLTC.
- The CFEEC evaluation only tells you **whether or not you can enroll** in MLTC. It does not tell you which services you receive, or how many hours of home care.
- Your CFEEC evaluation **expires after 75 days**, so make sure you move to step 3 quickly!
- The Conflict Free Center will also **send you a letter** stating whether you have been approved.
- If you are denied, you will have the **right to appeal**.

3 What type of plan?

- See slides 17-28 to review the different kinds of MLTC plans.
- **Call ICAN** to learn more about the different kinds of plans.
- Call **NY Medicaid Choice**, New York State's Enrollment Broker for managed care, at **888-401-6582** to get help deciding which plan is right for you.



4 Choose your plan

- Get a **list of plans** available in your county.
  - http://nymedicaidchoice.com
- Find out which plans have **good quality** measures.
  - http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/
- Find out which plans contract with **preferred providers** (dentist, podiatrist, home care agency).
  - For **combined plans**, also make sure doctors are in network and drugs are on formulary.
- Call your first-choice plan to **schedule assessment**.
- **Ask questions** during the assessment.

4 Assessment by plan

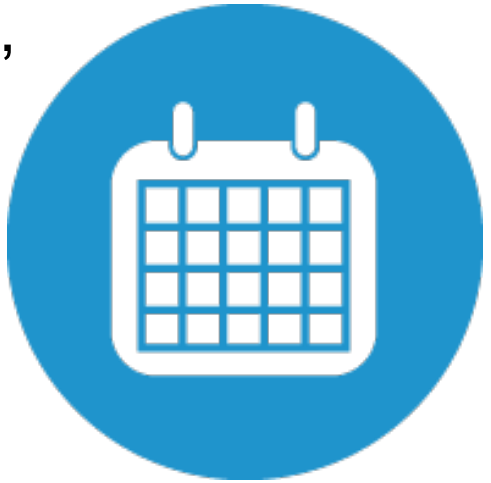
- The plan must conduct your assessment **within 30 days** of your call.
- This assessment is how the plan decides **which services** to provide and **how many hours** of home care.
- You should have a **family member or friend** present for the assessment.
- The plan should give you a **written plan of care** after your assessment.
- If you do not like the plan of care proposed by the first plan, **you can ask other plans** to assess you.

5 Enroll

- Once you have found a plan that you like and that offers to provide you the care you need, that plan can help you enroll.
- **Medicaid MLTC**
  - Call NY Medicaid Choice at **888-401-6582.**
  - The plan can call with you.
- **MAP or PACE**
  - Enroll through the plan.

5 Enroll

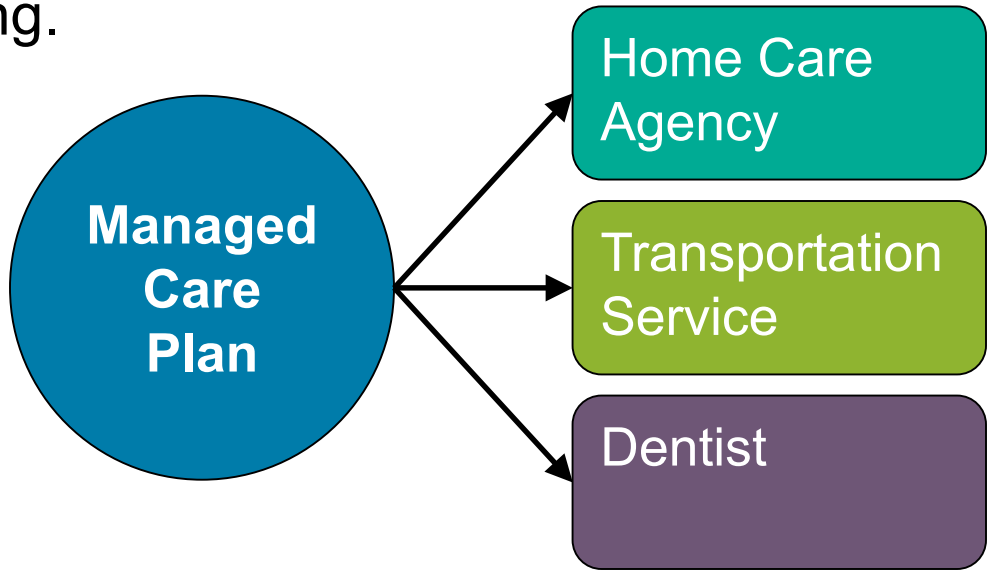
- If you enroll **before the 20th** of the month, your services will begin on the **1st of the next month**.
- If you enroll **after the 20th**, your services will not start until **the following month**.
- The entire process, from applying for Medicaid to enrolling in a plan, may take approximately one to three months.



How do I use my plan?

How plans are structured

- Your Medicaid managed care plan is an insurance company.
- This means that they do not provide healthcare to you directly. Instead, they pay providers to provide care to you.
- Usually, they also decide whether you should receive care, and how much for how long.
- Once the plan has approved services through one of their participating providers, they coordinate your care.



Working with your care manager

- Your first point of contact for any issue with your plan is your **care manager**.
- Your care manager:
  - Visits you **at least twice a year**
  - Works with you to **develop your care plan**
  - Helps you receive covered services
  - **Coordinates** any other services that support your needs (even if not covered by the plan)
  - **Makes changes** to your care plan if your needs change
  - Helps you **transition between care settings** (e.g., discharge from hospital back to your home)

N.Y. Dep't of Health, MLTC Model Contract, Art. V(J).

Communicating with your plan

- You can do most things over the phone with your care manager.
- However, it is best to also **submit important requests in writing**.
  - Service authorizations
  - Appeals
  - Grievances
- Call your care manager and ask for a fax number; fax your request in writing.

Service Authorizations

Most long term care services require prior authorization by the plan before your plan will pay for them.

- **Prior Authorization** – When you ask your plan for a new service
- **Concurrent Review** – When you ask your plan for more of a service you are already receiving
- The plan must give you a written decision within 14 days (or as short as 72 hours if fast-tracked)
- The plan's decision on a service authorization is an **action.** If you disagree with an action, you can appeal it.

N.Y. Dep't of Health, MLTC Model Contract, Appendix K.

Actions by your plan

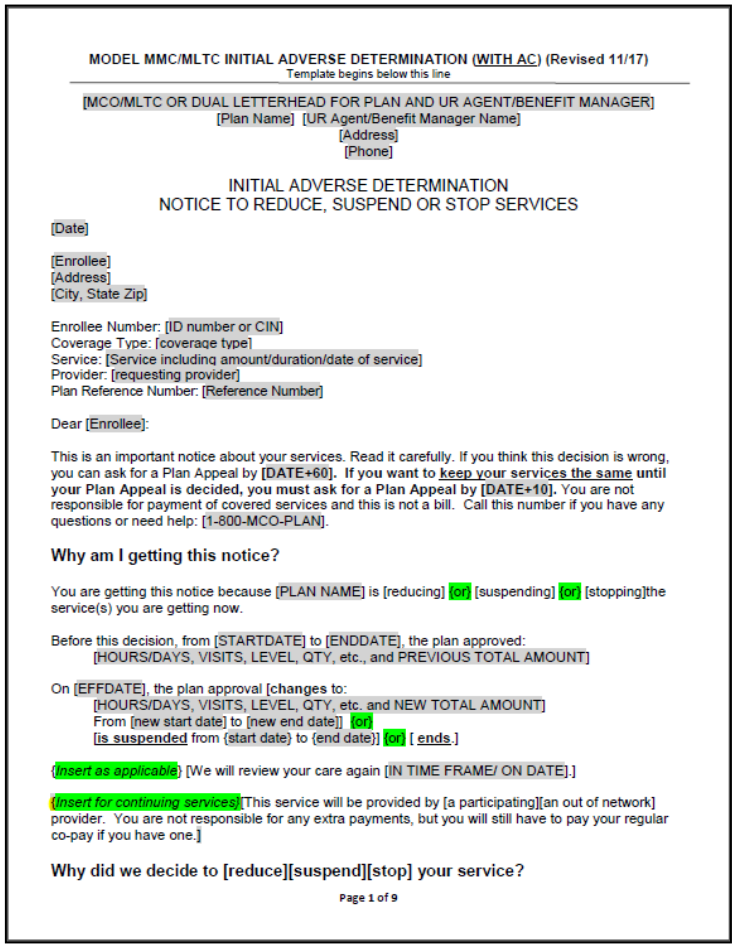
Action – When a plan:

- **denies** or limits services requested by you or your provider;
- denies a request for a **referral**;
- decides that a service is **not a covered benefit**;
- **reduces, suspends or terminates** services that were already authorized;
- **denies payment** for services;
- doesn't provide **timely services**;
- doesn't make grievance or appeal determinations within the **required timeframes**; or
- denies a request to go **out-of-network.**

42 C.F.R. § 438.400(b); N.Y. Dep't of Health, MLTC Model Contract Appendix K.

You have the right to written notice

- Whenever your plan takes an **action** regarding your services, they must send you an **adequate, written notice**
  - Among other things, this notice must state the action being taken, the **reason for the action**, and the effective date of the action
- If the plan proposes to **reduce or discontinue** a service you are already receiving, the notice must also be **mailed to you 10 days before the effective date**



MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) (Revised 11/17)
Template begins below this line

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

INITIAL ADVERSE DETERMINATION
NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [Service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **[DATE+60]. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by [DATE+10].** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

Why am I getting this notice?

You are getting this notice because [PLAN NAME] is [reducing] {or} [suspending] {or} [stopping]the service(s) you are getting now.

Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [EFFDATE], the plan approval [changes to:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT]
From [new start date] to [new end date]] {or}
[is suspended from {start date} to {end date}] {or} [ends.]

{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for continuing services*}[This service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

Why did we decide to [reduce][suspend][stop] your service?

Page 1 of 9

42 C.F.R. § 438.404; 18 NYCRR § § 358-2.2, 358-2.23 & 358-3.3.

You have the right to appeal

- If you disagree with your plan's action, you have the right to request a **plan appeal**.
  - This means you are asking your plan to take another look at their decision, and if they agree with you that they made a mistake, change it.

- **Requesting a plan appeal**
  - Use the plan appeal form included with the notice.
  - You can request an appeal over the phone, but (unless it is fast-tracked; see next slide) you must also confirm it in writing.
  - You can have another person request the appeal for you by signing a letter giving them permission.

42 C.F.R. § 438.402; 18 NYCRR § 358-3.1.

Plan appeal timelines

- **Aid Continuing**
  - If the proposed action is to reduce or discontinue your services, you can keep your services the same until your appeal is decided. This is called **aid continuing**.
  - If you want aid continuing, you must **request a plan appeal within 10 days** of the notice date, or by the date the change is supposed to start, whichever is later.
- For other kinds of actions (or if you don't want aid continuing), you must request the plan appeal within **60 days of the notice date**.
- The plan must give you a written decision within **30 days** of your request.
  - **Fast Track** – You may be eligible for a decision within **72 hours** if a delay will seriously risk your health, life, or ability to function; and certain other situations.
  - **Extension** – The plan may take up to **14 days** longer if they can show that they need additional information and it would be in your interest.

42 C.F.R. § 438.402; 18 NYCRR § 358-3.1.

Fair Hearings

- If you lose your plan appeal, you have the right to request a **Medicaid fair hearing**.
  - A fair hearing is where you can have an impartial hearing officer listen to you and the plan and decide who is right.
- If you want to keep your services the same until the fair hearing is decided, **you must request the fair hearing within 10 days of getting the plan appeal decision** notice, or by the date the change is supposed to start, whichever is later.
  - You can get aid continuing at this stage even if you did not get it during the plan appeal stage.
- You must complete the plan appeal before you can request a fair hearing.
  - Since 5/1/18, you can no longer request a fair hearing until ***after*** you've received a decision from the plan appeal.

42 C.F.R. § 438.402; 18 NYCRR § 358-3.1.

External Appeals

- If you lose your plan appeal, you may also be able to request an **external appeal** (in addition to a fair hearing).
  - This means asking the N.Y. State Department of Financial Services to review the record to decide who is right.
  - You must have a plan appeal before you can request an external appeal.
  - Not all issues can be brought to an external appeal.

N.Y. Dep't of Health, MLTC Model Contract Appendix K.

Complaints

If you are unhappy with something that your plan did (or didn't do) that wasn't an **action**, you can file a **complaint** with the plan. Here are some examples of things that would be appropriate for a complaint, not an appeal:

- The plan provided you with medical supplies that were poor quality.
- Your care manager doesn't call you back.
- Your personal care aide was rude to you.

42 C.F.R. § 438.400; N.Y. Dep't of Health, MLTC Model Contract Appendix K.

Your rights in MLTC

You have the right to:

- receive **medically necessary care**.
- **timely access** to care and services.
- **privacy** about your medical record and when you get treatment.
- get information on **available treatment options** and alternatives presented in a manner and language you understand.
- get information in a **language you understand**; you can get oral translation services free of charge.
- get information necessary to **give informed consent** before the start of treatment.
- be treated with **respect and dignity**.
- **get a copy of your medical records** and ask that the records be amended or corrected.

Your rights in MLTC (cont'd)

- **take part in decisions** about your health care, including the right to refuse treatment.
- **be free from any form of restraint or seclusion** used as a means of coercion, discipline, convenience or retaliation.
- get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- be told where, when and how to get the services you need from your MLTC plan, including how you can get covered benefits from **out-of-network providers** if they are not available in the plan network.
- **complain** to the N.Y.S. Dep't of Health or your LDSS; and, the Right to use the N.Y.S. **Fair Hearing** System and/or a N.Y.S. **External Appeal**, where appropriate.
- **appoint someone to speak for you** about your care and treatment.

How to get help from ICAN

Get help

Krista Harbacz – ICAN Coordinator

(518)462-7040 ext. 421

kharbacz@hcdiny.org

icannys.org

Questions?

Community Service Society | Fighting Poverty Strengthening New York

ICAN Independent Consumer Advocacy Network

HEALTHY CAPITAL DISTRICT INITIATIVE