NYSBA Elder Law Section Fall Meeting 2018: MLTC Update

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Introduction

Since Governor Cuomo's Medicaid Redesign initiative began in 2011, the majority of New Yorkers needing Medicaid home care must enroll in Managed Long Term Care (MLTC) plans.[1] MLTC plans are but one variety of Medicaid Managed Care plan offered in New York State. There have been several significant changes to the MLTC program in the last year. To fully understand these changes, it is important to have a basic background on Medicaid Managed Care.

Background on Medicaid Managed Care

In New York state, the majority of Medicaid recipients are required to receive their Medicaid benefits through privately owned and operated managed care organizations (MCOs).[2]

Under fee-for-service (FFS) Medicaid, an enrolled provider submits claims directly to the Medicaid program for each service provided, sometimes subject to prior authorization by the Medicaid program. In Medicaid Managed Care, the State pays each MCO a fixed capitation payment per-member, per-month (PMPM) for each enrollee. The capitation is generally the same for all enrollees in a given plan, but varies from plan to plan. This variation is due to differences in the acuity of each plan's enrolleed population. For example, if a plan's enrollees have medical conditions that would tend to make them costlier to care for on average than the overall population, then that plan would get a higher monthly capitation. This is called "risk adjustment." Plans are expected to comply with all rules governing the Medicaid program, but have flexibility to determine their own networks of contracted medical providers and employ utilization management (e.g., prior authorization) to reduce costs.

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1 https://www.health.ny.gov/health_care/medicaid/redesign/

2 N.Y. Social Services Law § 364-j(3)(a) [Mainstream Medicaid Managed Care]; N.Y. Public Health Law § 4403-f [Managed Long Term Care].

There are about nine different varieties of MCO providing Medicaid benefits in New York. By far the most common is the Medicaid Managed Care, or "mainstream," plan, which covers 71% of all Medicaid recipients in the state.[3] The remaining managed care products are tailored for particular subsets of the Medicaid population with special healthcare needs (e.g., people living with HIV/AIDS, dual eligibles, long term care consumers, people with behavioral health needs, or people with intellectual or developmental disabilities). All together, these special Medicaid managed care products account for only around 7% of the Medicaid population.

However, there has been tremendous growth in the MLTC product, with enrollment more than doubling in the last five years (MMC enrollment grew by 25% in that same period).[4]

Medicaid Managed Care Enrollment Summary[5]

Managed Care Product	Abbrev-iation	Covers Long-Term Home Care?	Number of Enrollees	% of Recipients
Mainstream Medicaid Managed Care	MMC	Yes	4,368,967	71
Partial-Capitation Managed Long Term Care	MLTC	Yes	212,736	3
Health And Recovery Plans	HARP	Yes	129,499	2
Medicaid Advantage Plus	MAP	Yes	11,459	0
Medicaid Advantage	MA	No	6,237	0
Programs of All-inclusive Care for the Elderly	PACE	Yes	5,663	0
Fully Integrated Duals Advantage	FIDA	Yes	3,797	0
FIDA for Individuals with Intellectual or Developmental Disabilities	FIDA-IDD	Yes	1,048	0
Managed Care Total			**4,739,406**	**78**
Fee-For-Service Total			**1,371,393**	**22**
Total			**6,110,799**	

[3] N.Y. Social Services Law § 364-j(1)(b).

[4] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018 and August 2013), *at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm.

[5] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018), *at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm; N.Y. Dep't of Health, MEDICAID PROGRAM ENROLLMENT BY MONTH: BEGINNING 2009 (January 2018), *at* https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3 (Managed Care enrollment data as of August 2018; fee-for-service data as of January 2018; most current available).

"Mainstream" Medicaid managed care plans are Health Maintenance Organizations (HMOs) or Prepaid Health Service Plans (PHSPs), licensed under Article 44 of the Public Health Law or Article 43 of the Insurance Law, to provide comprehensive health services on a full capitation basis to Medicaid recipients.[6] These entities are regulated by the NY Department of Financial Services (formerly the Department of Insurance) in the same manner as MCOs provided through employer-sponsored, marketplace, or other commercial venues.[7]

However, because they provide Medicaid benefits, Medicaid managed care plans are also subject to several other layers of regulation, from both the Federal and State governments.

The U.S. Centers for Medicare and Medicaid Services (CMS) promulgated regulations governing any state that uses managed care plans to deliver Medicaid benefits.[8] These regulations were amended in 2016, introducing several significant changes to New York's program which are only going into effect this year.

Each Medicaid Managed Care plan has a contract with the State, which is based off of a Model Contract posted on the Department of Health website.[9] These contracts obligate MCOs to comply with a number of different laws and regulatory regimes, including: 42 C.F.R. Part 438; the N.Y. Public Health Law; the N.Y. Social Services Law; and the Americans with Disabilities Act.[10]

In general, the rule is that "what's good for FFS is good for managed care." However, there are three specific applications of that rule that are worth highlighting:

- The State must require that covered services "be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid."[11]
- When the state delegates prior authorizations for Medicaid services to private entities, Medicaid recipients may challenge such determinations as if they were made by the Medicaid program.[12]
- The Model Contracts include a glossary of covered services, incorporating by reference the eMedNY Provider Manuals that define clinical criteria and medical necessity for FFS Medicaid.[13]

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6 Id. However, the variety of managed care plan providing the majority of home care services, MLTC, is partially capitated. This means that its benefit package only includes a subset of the services otherwise covered by Medicaid.

7 N.Y. Public Health Law § 4402(1); N.Y. Insurance Law § 4301.

8 42 C.F.R. Part 438.

9 See https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm#model and https://www.health.ny.gov/health_care/managed_care/providers/#model_contracts.

10 See e.g., N.Y. Dep't of Health, MLTC PARTIAL CAPITATION CONTRACT, Art. II (May 24, 2017) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

11 42 C.F.R. § 438.210.

12 N.Y. Social Services Law § 365-a(8).

From these authorities we can conclude that if a particular service were deemed medically necessary for a particular individual under FFS Medicaid, it should remain so under managed care, absent some change in the individual's condition.

In addition to the Provider Manuals, there are N.Y. State regulations defining the medical necessity criteria and assessment processes for most Medicaid-covered healthcare services.[14] Of particular importance to home care practitioners are those regulations governing the personal care,[15] consumer-directed personal assistance program,[16] certified home health agency, [17] and private duty nursing benefits.[18]

The above authorities require that the MCOs' processes for authorizing those services can be no stricter than these regulations. So while the financing and delivery systems may have changed, the underlying rules regarding covered services have not. This remains true in spite of the following recent changes.

2016 Amendments to Federal Medicaid Managed Care Regulations

In 2016, the U.S. Centers for Medicare and Medicaid Services (CMS) finalized amendments to the regulations governing Medicaid Managed Care.[19] These amendments included many changes intended to modernize the regulations in light of changes in managed care. Several of these changes relate to the process for appealing adverse determinations by managed care plans, and are therefore of particular relevence for elder law practitioners.

Exhaustion of Internal Appeals Now Mandatory

All types of Medicaid Managed Care plans have always been required to have an internal grievance and appeal system.[20] This system was required to enable enrollees to appeal certain actions by the plan and receive a written decision. However, because these plans administer Medicaid benefits, enrollees are also entitled to a Medicaid Fair Hearing.[21] Under the previous regulation, states were given flexibility to decide whether to require enrollees to exhaust the

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13 N.Y. Dep't of Health, MLTC PARTIAL CAPITATION CONTRACT, Appendix J (May 24, 2017) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf; N.Y. Dep't of Health, EMEDNY PROVIDER MANUALS at https://www.emedny.org/ProviderManuals/index.aspx.

14 See e.g., 18 N.Y.C.R.R. Chap. II, Subch. E, Art. 3.

15 18 N.Y.C.R.R. § 505.14.

16 18 N.Y.C.R.R. § 505.28.

17 18 N.Y.C.R.R. § 505.23.

18 18 N.Y.C.R.R. § 505.8.

19 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27497 (May 6, 2016)(codified at 42 CFR Part 438), available at https://www.federalregister.gov/d/2016-09581.

20 42 C.F.R. Part 438, Subpart F.

21 18 NYCRR Part 358.

internal plan-level appeal before they could request a Fair Hearing. Under these amendments, states no longer have that option. Exhaustion of internal appeals is now required for all kinds of Medicaid Managed Care plan, in all states.[22]

When Medicaid Managed Care was first implemented in New York, advocates successfully argued that exhaustion should not be required, because Medicaid recipients were accustomed to requesting fair hearings, and this was a new system that was likely to result in many disputes about services. As a result, exhaustion had never been required for enrollees in Mainstream MMC plans in New York (this includes HIV SNP and HARP).

However, New York *did* require exhaustion of internal appeals in MLTC plans until July 2015.[23] All other varieties of Medicaid Managed Care in New York have always required exhaustion of internal appeals (i.e., PACE, Medicaid Advantage, Medicaid Advantage Plus, FIDA, and FIDA-IDD).

From July 2015 through April 2018, MLTC enrollees were not required to exhaust internal appeals before requesting a Fair Hearing. Beginning May 1, 2018, they are.[24] This change has several important ramifications for enrollees and their advocates.

Consumers can no longer request a Fair Hearing to challenge a plan action

From July 2015 through April 2018, enrollees in MLTC and MMC plans had two non-exclusive options when challenging a plan action with which they disagreed: internal appeal and/or fair hearing. They could request an internal appeal, wait for a decision, and then request a fair hearing; or they could request both simultaneously; or they could just request a fair hearing. As a practical matter, going straight to a fair hearing usually made the most sense, because they had a more favorable reversal rate (over 70%); the decisionmaker was independent and impartial; and legal precedent was more likely to be honored. However, because fair hearings take many months and are difficult for consumers to navigate, some people would request an internal appeal concurrently and withdraw their hearing if they got a favorable decision.

Starting May 1, 2018, enrollees cannot request a fair hearing to challenge a plan action until they have received a Final Adverse Decision (FAD) after a requesting an internal plan appeal.[25] This means that enrollees no longer have a choice at their first step of the appeals process: the first

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22 42 C.F.R. § 438.408(f)(1).

23 N.Y. Department of Health, MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees (July 2, 2015), at https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-03.htm.

24 Email from Hope Goldhaber, Deputy Director, Division of Health Plan Contracting and Oversight, N.Y. Dep't of Health, to Service Authorizations and Appeals Stakeholder Workgroup (February 27, 2018, 3:59 pm) (on file with author).

25 42 CFR §§ 438.402(c)(1)(i) & 438.420(b); NY Dep't of Health, NYS MMC Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations at 2 (12/15/2017).

step is always to request an internal appeal. If the plan does not issue a FAD within the timeline, or if the FAD or extension notice is defective, then the enrollee can proceed to a fair hearing under "deemed exhaustion."[26]

Practice Note: The exhaustion requirement only applies to "adverse benefit determinations" by Medicaid managed care plans.[27] There are still certain issues which an enrollee can take directly to a fair hearing without needing to request an internal appeal first. For example, involuntary disenrollments are technically not actions of the plan; they are actions of NY Medicaid Choice, the enrollment broker designated by the State. As a result, NY Medicaid Choice must send a timely and adequate notice and the individual has the right to a fair hearing and aid continuing, without needing to exhaust the internal plan appeal.

Requesting a fair hearing no longer ensures aid continuing; must request an internal appeal

Under Federal and State welfare regulations, the Medicaid program must continue services without change during the pendency of the appeal while a recipient is appealing a reduction or discontinuance of services.[28] Prior to May 1, 2018, the enrollee could only get aid continuing by requesting a fair hearing, not an internal appeal. Starting May 1, 2018, this is reversed: the enrollee must request an internal appeal by the deadline in order to get aid continuing.

If the enrollee makes a mistake and requests a fair hearing, the state agency may issue an aid continuing directive, which the managed care plan must honor.[29]

The deadline to obtain aid continuing remains the same: by the effective date of the proposed action, or within 10 calendar days of the date of the notice, whichever is later.[30] When the plan receives an enrollee's request for an internal appeal of a reduction or discontinuance, they must assume that the enrollee wants aid continuing, unless the enrollee checks the box on the appeal form indicating, or states orally, that they do not want it.[31] This "opt-out" aid continuing is an advantage for consumers who may not have known to say the "magic words" when requesting

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26 42 CFR §§ 438.402(c)(1)(i)(A) & 438.408(c)(3), (f)(1)(i).

27 42 CFR § 438.400(b).

28 42 CFR §§ 431.230, 438.420; 18 NYCRR § 358-3.6.

29 N.Y. Dep't of Health, PowerPoint Presentation: 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS MLTC: PARTIAL CAP, MAP, MEDICAID ADVANTAGE at slide 11 (December 7, 2017), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf; N.Y. Dep't of Health, MANAGED LONG TERM CARE PARTIAL CAPITATION CONTRACT ("MLTC Model Contract"), Art. V(R) at pp.39-40 (May 24, 2017), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

30 42 CFR § 438.420.

31 N.Y. Dep't of Health, MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) ("Model IAD Notice"), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf.

their appeal. However, it is still true that consumers may be held liable for the cost of services they receive as aid continuing if they lose their appeal.[32]

Second opportunity to get/lose aid continuing after FAD

Now that the fair hearing is the second level of appeal, the question arises of whether/when aid continue persists after receiving an unfavorable decision at the first level of appeal. Regardless of whether aid continuing was granted at the plan appeal level, the enrollee must request a fair hearing within 10 calendar days of the date the FAD was mailed (which should be the same as the notice date) in order to obtain aid continuing during the pendency of the fair hearing.[33]

If the enrollee already had aid continuing at the plan appeal level, then the plan must automatically maintain the aid continuing for 10 calendar days after the FAD in case the enrollee requests a fair hearing during that time.[34] However, the enrollee can lose their aid continuing (even though they had it during the plan appeal) if they don't request their fair hearing within 10 days of the FAD.

Even if the enrollee did not get aid continuing during the plan appeal, they have a second chance once they receive the FAD, by requesting a fair hearing within 10 days.

Adjusted timelines for service authorizations, appeals, and fair hearings

The amended Federal regulations made some adjustments to the timelines for requesting service authorizations, appeals, and fair hearings, and for managed care plans to issue decisions.[35] The modified timelines are indicated in *italics* below.

Service Authorizations

	Old Timeline	New Timeline
Prior Authorization (standard)	3 business days after all info but not > 14 days*	3 business days after all info but not > 14 days*
Prior Authorization (expedited)	3 business days*	*72 hours**
Concurrent Review (standard)	1 business day after all info but not > 14 days*	1 business day after all info but not > 14 days*

[32] 18 NYCRR § 358-3.6(d); 42 CFR § 438.420(d).

[33] 42 CFR § 438.420(c)(2); N.Y. Dep't of Health, PowerPoint Presentation: 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS MLTC: PARTIAL CAP, MAP, MEDICAID ADVANTAGE at slide 10 (December 7, 2017), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf

[34] Id.

[35] NY Dep't of Health, NEW YORK STATE MEDICAID MANAGED CARE SERVICE AUTHORIZATION AND APPEALS TIMEFRAME COMPARISON (February 2, 2018), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-2-2_timeframe_comparison.pdf.

	Old Timeline	New Timeline
Concurrent Review (expedited)	1 business day after all info but not > 3 business days*	1 business day after all info but not > *72 hours**
Concurrent Review (homecare post-discharge)	1 business day after all info but not > 3 business days*	1 business day after all info but not > *72 hours**

* Subject to extension of up to 14 calendar days.

Internal Appeals

	Old Timeline	New Timeline
Filing Deadline (MLTC)	60 calendar days	60 calendar days
Filing Deadline (MMC & Medicaid Advantage)	60-90 business days	*60 calendar days*
Filing Deadline (Medicaid Advantage Plus)	At least 45 business days	*60 calendar days*
Decision Deadline (standard)	30 calendar days*	30 calendar days*
Decision Deadline (expedited)	2 business days after all info but not > 3 business days*	2 business days after all info but not > *72 hours**

* Subject to extension of up to 14 calendar days.

Fair Hearings

	Old Timeline	New Timeline
Filing Deadline (aid continuing)	10 days from notice date of IAD, or by effective date	*10 days from mailing of FAD*
Filing Deadline (no aid continuing)	60 calendar days from notice date of IAD	*120 calendar days from mailing of FAD*

There have been no changes to the filing or decision timelines for external appeals to the N.Y. State Department of Financial Services.[36] The filing deadline for these remains four months from the FAD.[37] The enrollee must exhaust the plan appeal before requesting an external appeal.[38] If the enrollee requests both an external appeal and a fair hearing, the fair hearing decision will control.[39]

[36] N.Y. Insurance Law § 4910.
[37] Id. at § 4914(2)(a).
[38] Id. at § 4910(2)(a)(ii).
[39] Id. at § 4910(4).

Expedited Appeals

The regulations have long provided for a "fast-track" process in certain cases. As noted above, the regulations shortened the decision timeline for expedited appeals from 3 business days to 72 hours. However, the model notice provided by New York State contains additional grounds for expedited appeals which may make this process more accessible to enrollees.

> Your Plan Appeal will be fast tracked if:
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> - Delay will seriously risk your health, life, or ability to function;
> - Your provider says the appeal needs to be faster;
> - You are asking for more of a service you are getting right now;
> - You are asking for home care services after you leave the hospital;
> - You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
> - You are asking for mental health or substance abuse services that may be related to a court appearance.[40]

The second reason ("your provider says the appeal needs to be faster") suggests that the doctor's request for an expedited appeal cannot be overruled by the plan. In the past, plans had complete discretion to deny requests for expedited appeals, regardless of whether a letter from the treating physician was provided in support of the request. Any request for an expedited appeal under this (or the first) prong should include a doctor's note explaining in detail how "taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."[41]

The third reason ("you are asking for more of a service you are getting right now") suggests that appeals of *all* concurrent reviews must be expedited. In other words, every time a plan denies an enrollee's request for increased home care hours, the appeal must be expedited. This has always been true for one subset of concurrent reviews: requesting increased homecare hours upon discharge from a hospital or nursing home. In either case, this provision has the potential to be of great benefit for enrollees who otherwise must go without medically necessary care for many weeks while awaiting a decision on their appeal.

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[40] Model IAD Notice, supra at note 31.
[41] 42 CFR § 438.410(a).

Practice Note: Advocates are encouraged to invoke these grounds when appropriate to get a faster decision on appeals. However, one downside of expedited appeals is that 72 hours leaves very little time to obtain the case file from the plan, supplement the record with additional medical evidence, and submit any written arguments in support of the appeal. As a result, the plan will likely decide based on no better a record than they had for the initial determination, with the likely result that it will still be denied. Perhaps the best thing about an expedited appeal is that you can "get to no" faster, and proceed quickly to a fair hearing.

Changes to the process for requesting internal appeals

The amendments still preserve multiple means of requesting an internal plan appeal. However, they added the requirement that an orally-requested appeal must be confirmed in writing (unless it is expedited).[42] Furthermore, the enrollee's representative cannot request the internal appeal on their behalf unless they provide written consent of the enrollee.[43] However, if the enrollee has previously designated an authorized representative for the plan, the plan must honor that designation for subsequent appeals.[44]

All plans must include with their IAD notice a standard form that can be used to request an internal appeal.[45] The plans are expected to provide multiple means of requesting an internal appeal, including by phone, fax, email, and mail.[46]

Practice Note: The best practice is to request internal appeals by fax. This ensures that there is a paper trail and proof of delivery, to resolve any potential disputes regarding timeliness. This also means that you can use the appeal form provided by the plan, so they will be most likely to accept it and have all of the information they need to properly process it. Phone appeals are not recommended, as plan staff are sometimes unfamiliar with the appeals process and may give misinformation or process the appeal incorrectly. The one exception is to make a protective filing when the deadline to receive aid continuing is fast approaching, and there is no way to request it by fax or email. Even in that case, it is necessary to follow up in writing to confirm.

New model notices

In response to the amended regulations, the Department of Health has issued new model notices that plans must use for all Initial Adverse Determinations (IAD) and Final Adverse Determinations (FAD), effective May 1, 2018.[47]

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42 42 CFR §§ 438.402(c)(3)(ii), 438.406(b)(3).

43 42 CFR § 438.402(c)(1)(ii).

44 N.Y. Dep't of Health, 2016 FINAL RULE 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS FREQUENTLY ASKED QUESTIONS FOR MANAGED LONG TERM CARE PLANS: PARTIAL CAPITATION, BENEFIT DETERMINATIONS FOR MAP AND MEDICAID ADVANTAGE PLANS ("Part 438 FAQ") #7 at p.8 (March 14, 2018) *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_faqs.pdf.

45 N.Y. Dep't of Health, MODEL APPEAL REQUEST FORM FOR DENIAL OF SERVICES at p.8 of PDF (February 1, 2018), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

46 Model IAD Notice, supra at note 31.

Previously, plans were required to use two separate notices for most IADs: one to comply with the Federal managed care regs, and a separate one to comply with State fair hearing regs. Thankfully, these are now combined into a single notice. The Department incorporated feedback from both plans and consumer advocates in designing these notices. They are structured as a series of questions that recipients might ask about the notices, along with responses in plain language. Much of the content is determined by computerized algorithms that fill in blanks or select from alternative blocks of language. All legal precedent regarding the required content of these notices remains in effect (e.g., Mayer v. Wing).

Case files must be provided automatically

Before the amendment, consumer representatives were accustomed to requesting the evidence packet from the plan after requesting a fair hearing. Now, the plan is required to automatically send a copy of the case file to the enrollee and their representative once an internal appeal is requested.[48]

Practice Note: An enrollee has a legal right to obtain a copy of their case file or any other health information from their plan at any time under HIPAA.[49] However, the HIPAA rules give the covered entity up to 30 days to provide the requested records. If the enrollee requests an internal appeal, the plan must provide them automatically and "sufficiently in advance of the resolution timeframe for appeals," which one might expect to be less than 30 days as that is the standard resolution timeframe for internal appeals.[50] It might make sense to make an immediate internal appeal request as soon as the IAD is received, along with a request for the case file, and a request to leave the record open to permit an opportunity to review the case file and supplement with additional evidence and arguments.

The next three changes to be discussed derive from the legislation passed in April 2018 as part of New York State's budget process.[51]

Nursing Home Carve-Out

This change regards the fate of Medicaid Managed Care plan enrollees who require permanent placement in a nursing home. Prior to 2015, MMC enrollees would be involuntarily disenrolled and return to fee-for-service Medicaid after 60 days in a nursing home. While MLTC enrollees

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47 N.Y. Dep't of Health, WEBSITE: SERVICE AUTHORIZATION AND APPEALS at https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm.

48 42 CFR § 438.406(b)(5) ("Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the [plan] in connection with the appeal of the adverse benefit determination."); Part 438 FAQ at #2-4 (p.7), supra at note 44.

49 45 CFR § 164.524.

50 42 CFR § 438.406(b)(5).

51 N.Y. Budget Appropriations Bill, S.7507 / A.9507, *available at* https://www.nysenate.gov/legislation/bills/2017/s7507.

were not involuntarily disenrolled, they were permitted to voluntarily disenroll, and indeed most did. Starting in 2015, the long-term nursing home benefit was carved into both MMC and MLTC.[52] As a result, plans were no longer able to shift enrollees to fee-for-service upon nursing home placement. In addition, long-term nursing home residents on fee-for-service Medicaid were auto-assigned to MLTC and MMC plans. Now New York plans to request permission from the Federal government to partially reverse this policy.[53]

Upon CMS approval, MLTC enrollees who are permanently placed in nursing homes must be involuntarily disenrolled from their MLTC plans after three calendar months. Individuals will be allowed to remain in the same nursing home throughout this transition. "The permanent placement designation is recognized as a mutual agreement between the enrollee, his or her physician, the nursing home, and the plan."[54] This change also means that nursing home residents on fee-for-service Medicaid will no longer be required to enroll in MLTC.

This change only impacts enrollees of partial-capitation MLTC plans; it does not impact enrollees of MAP, PACE, FIDA or MMC plans.

In addition, individuals who are disenrolled from their MLTC plan under this rule will be deemed eligible for Community-Based Long Term Care (CBLTC) services for six months, meaning that they can re-enroll in MLTC to return to the community without needing a Conflict-Free Evaluation and Enrollment Center (CFEEC) evaluation. However, they will require a pre-enrollment assessment by the MLTC plan of their choice.

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52 N.Y. Dep't of Health, TRANSITION OF NURSING HOME BENEFIT AND POPULATION INTO MANAGED CARE (February 2015), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf.

53 N.Y. Dep't of Health, DEAR HEALTH PLAN ADMINISTRATOR LETTER ("Dear HPA Letter") (May 23, 2018), *available at* https://hca-nys.org/wp-content/uploads/2018/04/Dear-Health-Plan-letter-budget.pdf.

54 Id.

Practice Note: This policy was intended to relieve the financial burden on MLTC plans of paying for expensive nursing home care, the monthly cost of which exceeds their monthly capitation from the state. Advocates are concerned that this creates a financial incentive to institutionalize enrollees who would otherwise need costly, high-hour home care services. MLTC plans are prohibited from disenrolling a member due to the cost of their care or the nature of their medical condition(s).[55] However, an MLTC plan can now once again use nursing home placement as a loophole to allow them to disenroll high-cost enrollees and shift their costs onto fee-for-service Medicaid. In response to concerns from the NY State Assembly, the Department gave assurances that it would "provide guidance highlighting information about an individual's rights as a nursing home resident in New York State and nursing home and Plan responsibilities per the discussion around permanent placement. In addition, the guidance will address supports for individuals who wish to return to the community at any time to deliver services, facilitate MLTC plan enrollment and coordinate housing and transitional supports."[56]

Enrollment Lock-In

Another change arising from the NY Budget process this year is a provision restricting MLTC enrollees' ability to change plans. Beginning December 1, 2018, individuals enrolling in an MLTC plan (either because they are new to care or due to a plan-to-plan transfer) will have a 90-day grace period to change plans, followed by a 9-month lock-in period during which they may not switch plans unless they can show good cause.[57] "While not an exhaustive list, the following circumstances are examples of good cause: the enrollee is moving from the plan's service area, the plan fails to furnish services, or it is determined the enrollment was non-consensual."[58]

After the 9-month lock-in period, the enrollee may once again switch plans at will. However, any subsequent enrollment starts a new 90-day grace period, followed by a new 9-month lock-in period. This policy only applies to partial-capitation MLTC plans; there is no lock-in for MAP, PACE, or FIDA. There has always been a lock-in period for MMC; that has not changed.

Cap on Number of Home Care Agencies in MLTC Network

As with the prior two changes, this one attempts to address the growth of cost in the MLTC program. It caps the number of Licensed Home Care Services Agencies (LHCSAs) with which a

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55 42 CFR § 438.56(b)(2).

56 N.Y. Dep't of Health, SIDE LETTER TO N.Y. STATE ASSEMBLY HEALTH COMMITTEE CHAIR, HON. RICHARD N. GOTTFRIED (March 30, 2018), on file with author.

57 N.Y. Dep't of Health, MEDICAID UPDATE: JUNE 2018, VOLUME 34, NUMBER 6, *available at* https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-06.htm#mltc.

58 Id.

partial-capitation MLTC plan may have contracts.[59] Beginning October 1, 2018, all MLTC plans must limit the number of LHCSAs in their networks based on the following ratios:

For Downstate: 1 LHCSA per each 75 enrollees (1:75)

For ROS: 1 LHCSA per each 45 enrollees (1:45)

These ratios will be further constricted starting October 1, 2019:

For Downstate, the ratio is 1 LHCSA per each 100 enrollees (1:100)

For ROS, the ratio is 1 LHCSA per each 60 enrollees (1:60)

The Department provided for two exceptions to this policy:

- **Continuity of Service** – A plan may request a three-month extension of its contract with a LHCSA in order to ensure continuity of service to an enrollee who would otherwise lose their aide due to termination of the LHCSA's contract. During the three-month period, the contract with that LHCSA does not count against the plan's total.
- **Adequate Access to Services** – A plan may also request an exception if they can demonstrate that additional LHCSA contracts are required to ensure adequate access to services in a geographic area. This includes "special needs services" and services that are culturally or linguistically appropriate.

Plans must email LHCSAExceptions@health.ny.gov in order to request either of the foregoing exceptions. There is no indication that enrollees have any right to challenge plans' denials of their requests for exceptions.

Practice Note: The majority of home care services covered by MLTC plans are provided by LHCSAs in the plans' provider networks. With this change, many enrollees will be presented with a difficult choice: switch to a different LHCSA (and therefore lose your current aides), or switch to a different MLTC plan (and possibly lose your hours). Many MLTC enrollees have struggled to find aides with whom they are compatible, which becomes even more important for those enrollees with dementia and other cognitive impairments, for whom stability of caregivers is critical. Because there is no legal entitlement to keep a certain aide, a change of agencies/aides is not amenable to legal remedies.

One possible solution is trying to persuade the aides to move to a different agency (one that is in-network). However, this raises the possibility that the aides may lose wage enhancements based on seniority, and other employment benefits.

[59] N.Y. Dep't of Health, LIMITATION ON NUMBER OF CONTRACTED LHCSAS IN A PARTIAL CAPITATION PLAN NETWORK (August 21, 2018), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/lhsca_contract_guidance.pdf.

In theory, there is no reason why an individual shouldn't be able to switch MLTC plans to one with whom the preferred agency remains in-network. However, for an enrollee receiving high hours of home care, it is quite common for other plans to deliberately assess the enrollee for fewer hours than they have been receiving in order to deter them from transferring. Furthermore, any such plan-to-plan transfer is treated as a voluntary one, and therefore any resulting reduction in hours is treated as a new application for services. As a result, any appeal of such a change is not eligible for aid continuing, and the enrollee (not the plan) bears the burden of proof to establish the authorization was not correct.

Increased Medicaid Cap on Physical/Occupational/Speech Therapy Visits

For many years there has been a cap on the number of rehabilitation therapy visits per year that Medicaid will pay for. One bright spot in this year's budget was to increase this cap from 20 visits per year to 40.[60]

Market Alterations

One of the oldest and largest MLTC plans in the state, Guildnet, recently announced their plans to terminate all of their health insurance products effective December 1, 2018.[61] Another large and long-time MLTC plan, Independence Care System, has been reported to be in danger of closing as well.[62] Any such plan closures are now governed by a transition process set out in state guidance.[63] This also includes any changes to a plan's service area (as happened when Guildnet pulled out of Long Island last summer) or acquisition of a plan by another company (as happened when Centerlight's and NorthShore-LIJ's members were acquired by Centers Plan for Healthy Living).

MLTC Policy 17.02 provides that the closing plan must provide written notice to all enrollees 60 days in advance of the closing date. The enrollees are given the option to choose a new plan within that 60-day period, or be autoassigned to a new plan if they take no action. If an affected enrollee wishes to choose a new plan (rather than be auto-assigned), they may contact New York

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60 Dear HPA Letter, supra at note 53.

61 Crain's New York Business, MAJOR MANHATTAN NONPROFIT'S INSURANCE ARM SHUTTING DOWN HEALTH PLAN (August 28, 2018), *available at* http://www.crainsnewyork.com/article/20180828/HEALTH_CARE/180829882/major-manhattan-nonprofit-s-insurance-arm-shutting-down-health-plan.

62 Crain's New York Business, DISABILITY ADVOCATES FEAR CLOSURE OF SPECIALIZED PLAN (July 5, 2018), *available at* http://www.crainsnewyork.com/article/20180705/HEALTH_CARE/180709962/disability-advocates-fear-closure-of-specialized-plan.

63 N.Y. Dep't of Health, MLTC POLICY 17.02: MLTC PLAN TRANSITION PROCESS – MLTC MARKET ALTERATION (September 22, 2017), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/17-02.pdf.

Medicaid Choice within the 60 days to effectuate the transfer, and no pre-enrollment assessment by the new plan is required. Most importantly, regardless of whether the enrollee selects a new plan or allows themselves to be auto-assigned, the new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for 120 days after enrollment. The only exception to the 120-day transition requirement is that the plan may change the enrollee's services earlier after conducting a new assessment, but only if the enrollee agrees to the new plan of care. Any reduction or discontinuance of services after the 120-day period is subject to timely and adequate notice (on the state-mandated IAD form), the right to an internal plan appeal, aid continuing, and plan burden of proof.

Practice Note: MLTC enrollees may be contacted by plan staff or others informing them of their plan's impending closure and urging them to start looking for a new plan. In general, the safest advice is for them to wait until they receive their 60-day written notice. The reason is that if an enrollee switches to a new plan before the 60-day notice, they will not be protected by the 120-day transition rights, because it will be considered a voluntary plan-to-plan transfer.

Furthermore, the 120-day transition rights only apply to the first plan enrollment after plan closure. So if an enrollee of terminating Plan A enrolls in Plan B at the end of the 60-day period, Plan B must continue the services they were receiving from Plan A. But if the enrollee subsequently decides they don't like Plan B and switches to Plan C (even within the 120-day period), that is considered a voluntary plan-to-plan transfer, so transition rights do not apply.

The following tables provide a snapshot of enrollment in the various types of MLTC plan.

Partial-Capitation MLTC Plans by Enrollment and Region[64]

Plan Name	NYC	Long Island	RoS	Total
Centers Plan for Healthy Living	25,718	2,832	877	29,427
Fidelis/Centene	7,942	2,259	11,425	21,626
Healthfirst	13,544	505	348	14,397
Senior Whole Health	13,653		221	13,874
Elderplan/Homefirst	10,772	793	1,378	12,943
VNSNY CHOICE	9,755	1,183	1,713	12,651
Riverspring/Elderserve	11,323	688	369	12,380
Integra	10,647	1,185	394	12,226
VillageCare	10,716			10,716
Agewell	6,318	2,711	659	9,688
Guildnet	7,316			7,316

[64] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018), *available at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

VNA Homecare Options			6,811	6,811
Aetna	4,556	1,774		6,330
Independence Care System	6,182			6,182
Wellcare	3,954	558	989	5,501
Empire BCBS Healthplus/Amerigroup	5,080			5,080
Extended	4,441	433		4,874
United Healthcare	2,748		1,463	4,211
Archcare	2,758		1,176	3,934
iCircle Care			2,691	2,691
Hamaspik Choice			2,196	2,196
Metroplus	1,857			1,857
Montefiore	1,189		331	1,520
Kalos Health			1,309	1,309
Elant			995	995
Fallon Health Weinberg			742	742
Senior Network Health			548	548
Prime Health Choice			383	383
Elderwood			328	328
Grand Total	**160,469**	**14,921**	**37,346**	**212,736**

FIDA Plans by Enrollment and Region[65]

Plan Name	NYC	Long Island	RoS	Total
VNSNY CHOICE	1,233	45		1,278
Healthfirst	912	74	12	998
Partners Health Plan (FIDA-IDD)	359	380	124	863
Elderplan/Homefirst	387	62		449
Guildnet	417			417
Agewell	35	204	10	249
Metroplus	209			209
Senior Whole Health	131			131
Centers Plan for Healthy Living	25			25
VillageCare	23			23
Riverspring/Elderserve	14	3	1	18
Total	**3,386**	**388**	**23**	**3,797**

[65] Id.

Medicaid Advantage Plus Plans by Enrollment and Region[66]

Plan Name	NYC	Long Island	RoS	Total
Healthfirst	7,193	92		7,285
VNSNY CHOICE	1,394	16	12	1,422
Elderplan/Homefirst	1,330	29	41	1,400
VillageCare	688			688
Guildnet	478			478
Fidelis/Centene	43		53	96
Senior Whole Health	86	3		89
Empire BCBS Healthplus/Amerigroup	1			1
Total	**11,213**	**140**	**106**	**11,459**

PACE Plans by Enrollment and Region[67]

Plan Name	NYC	Long Island	RoS	Total
Centerlight	2,400	178	210	2,788
Independent Living for Seniors			771	771
Archcare	709		22	731
PACE CNY			566	566
CHS Buffalo Life			240	240
Eddy Senior Care			215	215
Complete Senior Care			120	120
Fallon Health Weinberg			118	118
Total Senior Care			114	114
Grand Total	**3,109**	**178**	**2,376**	**5,663**

[66] Id.
[67] Id.

Glossary

ABD	**Adverse Benefit Determination** – "1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." 42 CFR § 438.400(b).
CBLTC	**Community-Based Long Term Care** – In order to be eligible to enroll in MLTC, MAP, PACE or FIDA, a Medicaid recipient must be found in need of CBLTC for a continuous period of 120 days within a calendar year. CBLTC consists of personal care services (but not merely Level 1, aka housekeeping), home health aide (i.e., CHHA) services, private duty nursing, consumer directed personal assistance services (CDPAS), or medical-model adult day health care (ADHC). Social adult day care alone does not constitute CBLTC.
CFEEC	**Conflict-Free Evaluation and Enrollment Center** (pronounced "see-fic") – In 2013, CMS required New York State to stop allowing MLTC plans to determine whether prospective enrollees met the clinical eligibility standard for MLTC enrollment (see CBLTC above), because plans were caught (and sanctioned for) fraudulently enrolling ineligible, low-needs individuals. They also refused to enroll eligible, high-needs individuals. Since 2013, prospective MLTC enrollees must obtain an independent, conflict-free evaluation from a nurse employed by MAXIMUS (who also operates the enrollment broker, NY Medicaid Choice). The CFEEC nurse conducts a UAS-NY assessment in the individual's home, and then immediately informs them whether they have met the eligibility standard (97% do). After getting the green light from CFEEC, the individual may contact any MLTC plan to enroll. Plans may still try to dispute CFEEC's determination of eligibility, but the individual is at least entitled to notice and appeal rights.
Dual Eligible	Someone eligible for both Medicare and Medicaid.

FAD **Final Adverse Determination** – The written notice a Medicaid managed care plan must provide to the enrollee when it issues a less-than-fully-favorable decision on an internal plan appeal. Under the amended regs, this notice can be appealed to a Medicaid Fair Hearing or an External Appeal.

FIDA **Fully Integrated Duals Advantage** – FIDA is the most recent addition to the State's MLTC menagerie. As part of a Federal demonstration under the Affordable Care Act, FIDA was created to more seamlessly integrate the Medicare and Medicaid programs within a single managed care plan. Of the three fully-capitated plans in New York, FIDA has the most beneficiary-friendly features, such as simplified enrollment, across-the-board transition rights, integrated appeals, the broadest benefit package (including waiver services), and an interdisciplinary care team. In spite of these advantages, enrollment has been low, most likely due to limited participation by providers and lukewarm marketing by plans who prefer the rate structure of other product lines.

FIDA-IDD **Fully Integrated Duals Advantage for Individuals with Intellectual or Developmental Disabilities** – A new version of FIDA, offered by only one plan, Partners Health Plan, for dual eligibles in the OPWDD waiver.

IAD **Initial Adverse Determination** – This is the written notice a Medicaid managed care plan must provide to the enrollee whenever it makes an adverse benefit determination. Under the amended regs, this notice can only be appealed by an internal plan appeal, not a fair hearing.

LDSS **Local Department of Social Services** – The county governmental department responsible for local administration of state welfare programs, including (for the aged, blind and disabled) Medicaid eligibility. Assessment, authorization, and contracting for home care services was largely removed from LDSS jurisdiction when MLTC was made mandatory in 2012-2013. However, individuals may still receive home care through their LDSS if they are excluded from MLTC (e.g., OPWDD, hospice, Native American) or under immediate need personal care services.

LHCSA **Licensed Home Care Services Agency** – These are the home care agencies that provide the majority of home care workers in the state. They contract with Medicaid managed care plans such as MLTC, as well as Local Departments of Social Services for those individuals still on fee-for-service Medicaid. Unlike CHHAs, LHCSAs are not Medicaid providers, so they cannot bill Medicaid directly (unless under contract with an LDSS).

MAP **Medicaid Advantage Plus** – A fully-capitated Medicaid and Medicare managed care plan in New York. This is the least integrated of the three Medicare-

Medicaid products. It is essentially a Medicare Advantage plan connected loosely to a Medicaid managed care plan from the same company. Unlike Medicaid Advantage, it includes coverage for long-term care services such as home care and nursing home.

MLTC **Managed Long Term Care** – Somewhat confusingly, the term MLTC is used to refer both to a general category of Medicaid managed care plans that include long-term care services for dual eligibles, as well as one particular type of plan included within that category. Partially-capitated Medicaid Managed Long Term Care plans are the most common type of MLTC, and include only a subset of the Medicaid benefit package and no Medicare benefits. The other varieties of "MLTC" – FIDA, MAP and PACE – include all Medicaid and Medicare benefits as well.

MMC **Mainstream Medicaid Managed Care** – This is the type of Medicaid managed care plan that the majority of Medicaid recipients in New York State are required to enroll in. These are comprehensive HMOs that include almost all services in the Medicaid benefit package, including long-term care services like home care and nursing home. People with Medicare, spend-down, or comprehensive third-party insurance are not eligible for MMC.

PACE **Programs of All-inclusive Care for the Elderly** – These are the oldest of New York's fully-capitated managed care plans. They are site-based, and enrollees must receive most of their medical care from providers employed by the PACE center. Many enrollees participate in adult day care programs at the PACE center, but they also cover all other Medicare and Medicaid services, including home care.