NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

May 10, 2013

Dear Commissioner:

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 federal Centers for Medicare and Medicaid Services (CMS) has approved certain changes, including enrollment of some previously exempt or excluded populations into Managed Care.

Non-Dual Eligible (Medicaid Only)

Beginning April 2013, 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). The **non-dual** population identified for this transition is comprised of approximately 2,700 adult (aged 18 and older) and 400 children (under 18 years old). Sixty-two (62) percent of the non-dual LTHHCP participants live in New York City and thirty-eight (38) percent reside in the rest of state. Previously, non-dual eligible LTHHCP enrollees were excluded from MMMC.

Mandatory MMMC enrollment of this population will occur on a statewide basis and requires that new applications for LTHHCP enrollment for **non-dual** eligibles cease on May 15, 2013.

A statewide mailing was sent the week of April 8, 2013 to all **non-dual** eligible LTHHCP participants to notify them that they will soon be required to join a Medicaid managed care plan.

Mandatory mailings in NY Medicaid Choice counties:

- A second mailing (mandatory enrollment packet) will be sent to inform consumers that they have 60 days to choose a health Plan. The packet will include the MMC brochure, a list of Plans serving the individual's county, and NY Medicaid Choice and LDSS contact information for enrollment inquiries and assistance. Also included in the packet will be notice that they are allowed 60 days to choose a plan.
- During the 60 day choice 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 non-NY Medicaid Choice counties:

- The LDSS have received a full list of those non-dual eligibles that are being targeted for enrollment into managed care. The LDSS must mail out mandatory packets for the individuals on this list. In addition, the LDSS must also send packets to any non-dual LTHHCP participant not otherwise exempt or excluded whose LTHHCP case was effective post February 1, 2013 when the list was run. We have attached a special version of the packet cover letter to be put on LDSS letterhead and mailed with the mandatory enrollment packets to **LTHHCP non-duals.** The LDSS will work with the LTHHCP agencies and the consumers to choose and enroll in a plan in the 60 day period to be tracked manually by the LDSS.

- SDOH has entered the R/E Code 91 to each LTHHCP participant's file to prevent auto assignment and allow the LDSS sufficient time to assist each non-dual client. The local department of social services (LDSS) case worker and the LTHHCP case manager will communicate with the participant, their family or other responsible person and work with the MMC Plan to assure a safe transition. The LDSS and LTHHCP provider may assist participants in choosing a Plan that best meets their needs, however, participants must be informed of all options. Once the transition period concludes, the LDSS and LTHHCP provider will no longer be part of the care management or assessment process. Please note: for this population choice of enrolling in a MLTC if eligible and an MLTC is available must be afforded as an option in addition to a mainstream plan.

The identifier for LTHHCP participation, the Restriction/Exception Code 30, **must** remain open on the client's file. To ensure continuity of care and provision of services, the code 30 will appear on the SDOH monthly Rosters to alert Plans and counties of the transition from LTHHCP. In addition, the Plans will be alerted to continuation of Home Delivered Meals and Medical Social Services as benefits if the individual is in receipt of either of these benefits at the time of the transition. On the monthly Rosters, the 30 code will appear in the Medicaid Exception code field (position 285-286). Please note: The edit that denies the combination of LTHHCP participation (the R/E Code 30) and managed care enrollment will be disabled.

Individuals who are Medicaid enrolled and meet NYS Mental Hygiene Law criteria for a developmental disability are identified by a restriction/exception code 95 in eMedNY and will remain exempt from mandatory enrollment in mainstream managed care programs, and have not been included in your list.

Transitional Care for Non-Duals – For continuity of care, the pre-existing LTHHCP service plan will continue for at least 90 days after the effective date of MMC enrollment or until the Plan's assessment, whichever is later. The LTHHCP agency is responsible to provide the Plan with the current Plan of Care (POC) to promote continuity of care. Service providers will remain unchanged throughout the transition period.

Individuals enrolled in a MMC plan 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 or AIDS may request transfer from a managed care Plan to an HIV SNP, or from an HIV SNP to another HIV SNP at any time. Persons who wish to disenroll or transfer plans must contact New York Medicaid Choice (NYMC) at 1-800-505-5678 or the LDSS (in non-NYMC counties.)

For eligible persons, the LTHHCP will remain operational to meet the needs of participants for whom MMC or other alternatives are not yet available. However, once enrolled in a managed care plan, disenrollment to return to the LTHHCP will not be permitted.

Dual Eligible (Medicaid and Medicare)

Beginning April 2013, all **dual eligible** Medicaid recipients, age 21 and over, in need of community-based long term care services for over 120 days- including 1915(c) LTHHCP waiver participants in NYC, Nassau, Suffolk and Westchester Counties – will be required to enroll in a Managed Long Term Care (MLTC) plan. Participants will receive an informational letter giving advance notice that they will soon need to choose a MLTC Plan.

Current participants, noticed above, will receive a second letter mailed to their homes, indicating that they have 60 days to choose a MLTC Plan. This notice will be sent to a small group of participants initially and continue. If the participant has not enrolled in a plan within the choice period, auto-assignment to a plan will occur.

As MLTC capacity is established statewide, new referrals and applications to LTHHCP for enrollment of dual eligible Medicaid recipients, age 21 and over, will be directed to MLTC plans. LTHHCP will

remain operational for as long as required to meet the needs of participants for whom MLTC/MMC enrollment is not an option.

Transitional Care for Duals – MLTC In order to promote continuity of care, the participant's current LTHHCP agency must provide the plan with the participants current Plan of Care. Each enrollee who is receiving community based long-term care services and supports that qualify for MLTC will continue to receive services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the Managed Care Organization (MCO), whichever is later. Upon enrollment, the plan will assume full responsibility for care management and the provision of services. Plans are required to reassess all transitioned MLTC enrollees within 30 days and base their services on their individual current needs. Once enrolled, the participant may request to change plans at any time by contacting NY Medicaid Choice at 1-888-652-6582.

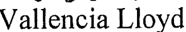
MMC and MLTC

All enrollees must be informed about the Plan's grievance system and procedure for filing Complaints and/or Appeals. This information will be made available through the Member Handbook. The State maintains a toll-free complaint line for enrollees, 1-800-206-8125 for MMC enrollees, and 1-866- 712-7197 for MLTC enrollees. The MCO will inform Enrollees of the MCO's procedures; Enrollees' right to contact the LDSS or the Department with a Complaint, and to file an Appeal or request a fair hearing; the right to appoint a designee to handle a Complaint or Appeal; and the toll free Complaint line. The MCO will maintain designated staff to take and process complaints and assist Enrollees in complaint resolution. The MCO will make all information regarding the Grievance System and sites where Enrollees typically file complaints and appeals available and usable by people with disabilities.

For a subsequent reduction, termination or suspension of service within an authorization period, the Plan will issue a Notice of Action, giving the person the right to request an appeal and offering aid continuing as long as the authorization period is valid or until the appeal is decided. A denial would trigger a Notice of Action as well, but no aid continuing (because the person did not have the service to begin with). If the appeal is adverse to the member, either in whole or in part, the person would be given a fair hearing notice. Aid continuing would apply to a reduction, suspension or termination as long as the authorization period is still active.

If you have any questions about this transition please contact Laura Fiato for Mainstream Managed Care at 518-473-1134 or Vicki Rockefeller for Managed Long Term Care at 518-474-5271.

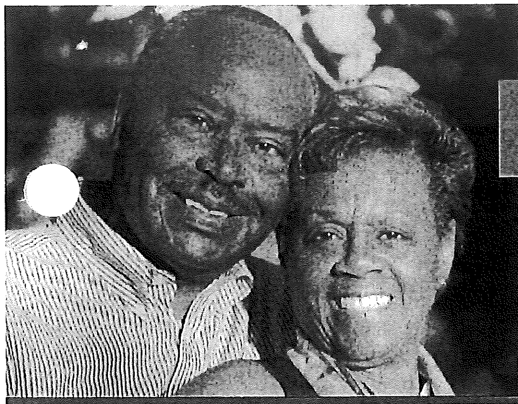
Sincerely,



Vallencia Lloyd
Director
Division of Health Plan Contracting and Oversight

Mark Kissinger
Director
Division of Long Term Care

Attachment:
Packet Cover Letter



AN IMPORTANT MESSAGE TO

Long Term Home Health Care Program Clients

If you get services through the **Long Term Home Health Care Program,** the way you get your care has changed. You or your child must join a health plan. Your health plan will make sure you get the home care and other health services you need.

Here are some things you should know about choosing a health plan:

- **You have 30 extra days to choose a health plan.** For example, if the enclosed letter says that you must choose a plan by June 1 this means you will have until July 1 to choose your plan.
- You can stay with your long term home health care agency by choosing a health plan that works with the agency. Call your agency to ask about the health plans they work with.
- Or, you can join a health plan that works with another home care agency. You can call the health plans listed on the enclosed Plan List to ask about their home care providers.

Questions? Call New York Medicaid Choice

Our counselors will be glad to assist you. We can also enroll you in a health plan over the phone.

New York
Medicaid Choice

1-800-505-5678 TTY: 1-888-329-1541

Monday-Friday, 8:30 am to 8:00 pm
Saturday, 10:00 am to 6:00 pm

Visit us at **nymedicaidchoice.com**

LTHHC-IN-051