

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 13.01: Transition of Care for Fee For Services Participants in Mandatory Counties

Date of Issuance: February 6, 2013

The purpose of this policy is to clarify that members transitioning from FFS Medicaid are afforded protections related to continuity of care.

The Partnership Plan terms and conditions (28 (d)) require:

- Each enrollee who is receiving community-based long-term services and supports, as specified below, that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later.
- Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R. § 438.404, mailed at least ten days before the proposed effective date of the change (as required by 42 C.F.R. § 431.211), that clearly articulates the enrollee's right to file an internal appeal (either expedited, if warranted, or standard), the right to have authorized services continue pending the resolution of the internal appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the internal appeal.

Therefore plans must treat **all** enrollees (age 21 and over eligible for Medicaid and Medicare) in mandatory counties transitioning from fee for service Medicaid in the same manner related to continuity of care and access to aid to continue through the internal appeal and fair hearing processes.

This means that, for any individual receiving fee for service Medicaid community based long term services and supports, as specified below, and enrolling under any circumstance, the plan must provide 60 days of continuity of care. Further, if there is an internal 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 that is upheld after an internal appeal, aid-to-continue is to be provided until the fair hearing decision is issued.

This policy applies to the following Medicaid fee-for-service community based long term care services and supports:

- Personal care services;

- Consumer directed personal assistance;
- Home health services;
- Private duty nursing; and
- Adult day health care

NOTICE OF ACTION

SAMPLE

Date of Notice: _____ **Effective Date:** _____

Member Information

First Name	Last Name	Member ID#
Address		Tel. No.

Dear _____ :

We are writing to tell you about changes we plan to make in your Medicaid home care and other long-term care services, and about your right to request an appeal if you do not agree with the changes to your services.

Because of a change in State law, our Managed Long Term Care plan took over the job of approving and managing all of your Medicaid long term care services, including home care.

We are required to continue, for 60 days, the long term care services that you were approved to receive immediately prior to your enrollment in our Managed Long Term Care Plan.

WE INTEND TO CHANGE YOUR SERVICES AS FOLLOWS:

Change your: _____ **From** _____ **To:** _____

The reason we are making this change is: _____

WE INTEND TO DISCONTINUE YOUR SERVICES AS FOLLOWS:

Discontinue your: _____

The reason we are making this change is: _____

YOUR RIGHT TO REQUEST AN APPEAL

If you do not agree with an action that we take, you may appeal. **You should not request a fair hearing at this time** – You must first request an **Internal Appeal within** our plan. This means that we review the reason for our action to decide if we were correct. If the result of the Internal Appeal is unfavorable to you, we will send you a letter explaining how to

request a fair hearing.

HOW TO REQUEST AN INTERNAL APPEAL –You can file an appeal with the plan by:

1) **Telephone :**

2) **Mail :**

WHEN to request an Internal Appeal – You must file your appeal request within **45 calendar days** of the date on this letter, **but if you want your current services to continue unchanged**

while the internal appeal is held and decided (called “Aid Continuing “) you must request the Internal Appeal no later than 10 days from this mailing.

- **You may request an “expedited” internal appeal** if you or your provider feel that a serious problem to your health or life could result if your appeal is not decided quickly. Expedited appeals are decided within 2 days of the date that the plan receives your appeal request and all information needed. If we do not think your condition needs a fast decision, we may treat your appeal as a standard appeal. We must decide standard appeals within 30 days of the day the appeal is received unless an extension is requested or more information is needed.

You may present information to the plan about your case and look at your case file in order to get ready for your appeal. To request the case file call us at: _____.

We will send you our decision on your internal appeal in writing. The decision on your Internal Appeal will explain these further appeal options, and how and when to request these options.