Medicaid Redesign: Changes to Medicaid & Medicaid Managed Care

The Legal Aid Society
Health Law Unit
Health Law Helpline:
212-577-3575

Medicaid Redesign

- Medicaid Redesign Team (MRT) was appointed by Governor Cuomo to reduce costs and increase quality and efficiency in the Medicaid Program
- Recommendations incorporated in state budget and adopted in March 2011
- Major changes to N.Y. Medicaid Program to be implemented over the next 3 years

Today's Training- How MRT Affects:

- Mandatory Medicaid Managed Care Enrollment
  - Exemptions & Exclusions
  - Mandatory Enrollment Process & Enrollment of Special Populations
  - Enrollee Rights & Access to Care in Managed Care
- Changes to the Medicaid Managed Care & Fee-For-Service Medicaid Benefit Package

Medicaid Managed Care

- Unlike fee-for-service Medicaid in Medicaid managed care (MMC), beneficiaries must:
  - Enroll in a Medicaid Managed Care plan
  - Follow the plan's rules for accessing services including
    - Choosing a Primary Care Physician (PCP)
    - Obtaining referrals to specialists
    - Obtaining prior authorization for medical services
    - Receiving in-network treatment

New Mandatory Populations

- MMC originally mandated enrollment for non-disabled Medicaid recipients only
- Gradually, more and more disabled and chronically ill populations have been mandated to enroll in MMC
- Mandatory enrollment for people living with HIV and AIDS (PLWHA) was rolled out from September 2010 through March 2011 in NYC
- As a result of MRT, almost all non-duals not currently enrolled in managed care will be mandated to enroll over the next two years

Non-Mandatory Populations

- Two categories of Medicaid beneficiaries do not have to join Medicaid Managed Care plans. They are either **exempt** or **excluded.**
  - **Exempt** -- People who **can** join a Medicaid Managed Care plan if they want to, but are not required to join.
  - **Excluded** -- People who **cannot** join a Medicaid Managed Care plan, even if they want to.
- Most exemptions and some exclusions will be eliminated over the next 2 years.

Exemptions Remaining after MRT

- Individuals with chronic medical conditions who are in active treatment with a specialist physician who does not participate in any MMC plan
  - exemption lasts 6 months or until treatment is complete (whichever happens first)
- Individuals who are dually eligible for Medicare and Medicaid and enrolled in a Medicare Managed Care plan (Medicare Advantage enrollees)
- Native Americans

Exclusions Remaining after MRT

- Individuals who are dually eligible for Medicare and Medicaid and not in a Medicare Managed Care plan (Original Medicare recipients)
- Excess Income or Spend-down Program
- Eligible for less than 6 months of coverage (e.g. for the treatment of an emergency condition)
- Coverage limited to TB related services, FPBP, Breast and Cervical Cancer Early Treatment Program
- Individuals with other comprehensive insurance
- Individuals receiving hospice services

Exemptions Eliminated In Year One- October 2011

- People Living with HIV & AIDS (upstate- 1,200 ppl)
- Individuals who have an ongoing relationship with a PCP who does not take MMC
- Pregnant women with prenatal provider who does not take MMC
- Non-SSI Seriously and Persistently Mentally Ill Adults / Seriously Emotionally Disturbed Children (10,000 state-wide)
- Individuals without a choice of PCP within 30 minutes/ 30 miles
- Individuals who cannot be served in MMC due to a language barrier

Other Common Exemptions to be Eliminated

- Homeless Persons (4/12)
- Foster Children (4/13)
- Medicaid Buy-In for Working People with Disabilities (4/13)
- Non-OPWDD Waiver Recipients & “look-alikes” (4/13)

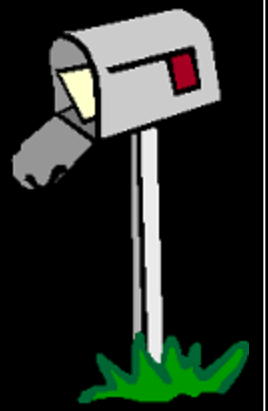
Exclusions to be Eliminated

- Restricted Recipients (8/11)
- Individuals enrolled in the Long Term Home Health Care ("Lombardi") Program and those with similar characteristics/needs (4/12)
- Residential Treatment Facilities & "look-alikes" (4/13)
  - ICF/MR; State Psych; NH; Chemical Dependence

Mandatory Enrollment Process

Mandatory Enrollment Process

- New York Medicaid Choice, the enrollment broker for Medicaid health plans in NYC, sends mailers to Medicaid recipients:
  - Mandatory Enrollment Package
    - Letter with auto-assignment date
    - Brochure describing managed care program, enrollment forms, list of health plans
- Following receipt of the initial enrollment package, enrollees who have not chosen a plan will receive a confirmation notice, stating name of plan for auto-assignment and effective date of coverage.



Mandatory Enrollment Process

- Currently, non-disabled enrollees have 60 days to choose a plan; disabled enrollees have 90 days to choose a plan
- Beginning 10/1/11, all newly mandated individuals have 30 days to choose a plan before being auto-assigned
- New Medicaid beneficiaries must choose at application
- 9 month “lock-in” period begins after first 90 days of enrollment

Logistics for Streamlined Enrollment Process

- New Medicaid applicants:
  - Choose at application OR have 5 days to contact NY Medicaid Choice or are auto-assigned the first of the following month after eligibility is determined.
- New SSI beneficiaries:
  - 30 days to choose, will receive:
    - Mandatory Enrollment Packet
    - Enrollment Confirmation Notice

Logistics for Streamlined Enrollment Process

- Newly mandated beneficiaries:
  - 30 days to choose, will receive:
    - Mandatory Enrollment Package
    - Enrollment Confirmation Letter

New York Medicaid Choice
1-800-505-5678

- Assistance with phone enrollment or enrollment forms
- Assistance with plan transfers
- Requesting exemptions
- Determining which primary and specialty care providers participate in which plans
- Information on health plans
- Information on Home Care Networks, but **no** information on Prescription Drug Formularies or Utilization Review Mechanisms

Special Enrollment for Specific Populations

Special Needs Plans for PLWHA

- HIV Specialist as PCP
- HIV Case Manager
- Information about HIV medications and side effects
- Treatment adherence services
- HIV prevention and risk reduction education
- Coordination of all medical and wellness services, including “carved out” services

Advocacy Tips!

- HIV+ enrollees can choose MMC plan or a Special Needs Plan (SNP), except Upstate where no SNPs are available.
- Automatic plan assignment if they don't choose, but no auto-assignment to SNP
- "Lock-in" does not apply when switching to from MMC to SNP or SNP to SNP

Services Available in SNPs

- HIV Specialist as PCP
- HIV case manager
- Information about HIV medications and side effects
- Treatment adherence services
- HIV prevention and risk reduction education
- Coordination of all medical and wellness services, including “carved out” services

Mandatory Enrollment for Restricted Recipients 8/11

- Restricted recipients will be mandated to enroll in MMC plans.
- Beneficiaries with restrictions will receive notices regarding the change and enrollment information
- Plans will manage current restrictions and will have ability to make decisions about changes / new restrictions in the future for all enrollees

Mandatory Enrollment Process for Restricted Recipients

- Restricted recipients will receive a “heads up” notice from the State Department of Health on or around August 1, 2011, explaining the change.
- They will also receive mandatory enrollment packets from New York Medicaid Choice or in some upstate counties from The Local Department of Social Services asking them to choose a health plan.
- In some upstate counties restricted recipients will get the mandatory enrollment packet at recertification or after a change is made to their Medicaid case.

Advocacy Tips!

- If your client is currently restricted and wants to keep their current providers help them choose a plan their providers accept
- Continued or new restrictions can only be for specific reason proscribed by State and come with fair hearing rights
  - Duplicative, excessive, contraindicated or conflicting services, drugs or supplies
  - Fraud or illegal activity

Mandatory Managed Long Term Care- April 2012

- Mandatory enrollment of all duals who need community-based long term care for at least 120 days
  - Personal Care Services; Home Health Aide; Adult Day Health Care
- Can choose Managed Long Term Care (MLTC); Medicaid Advantage Plus; or PACE Program

Mandatory Managed Long Term Care Models

- Differences are in benefit packages and carved out services
- Benefit package changes and limitations apply to FFS, MMC and MLTC plans
- Enrollment by plans only, effective 9/1/11
- Current eligibility is nursing home level of care but will change to community-based long term care standards as counties go mandatory

Behavioral Health Organizations & SNP Models

- Behavioral Health Organizations will be implemented to provide behavioral health services to all MMC recipients
- Mental Health Special Needs Plans and /or Integrated Care Plans will be created in the future to provide mental and physical health services to the SPMI/SED population

Changes to MMC Benefit Package

Personal Care services carved in to benefit package 8/2011

- 8 hours per week limit to those receiving only housekeeping (Level 1) services
- Plans must honor current Medicaid prior authorization for services and reassess upon reauthorization
- Plans will use M11Q (in NYC) until state-wide Uniform Assessment Tool is ready
- Plans must comply with personal care regulations regarding initial and re-authorization for services

Advocacy Tips!

- Make sure your client's agency is in the plans' network! Plans were given list of HRA contracting agencies and agencies that their members currently serve
- Plans required to provide a 30 day transitional care benefit for all members receiving services from out-of-network providers
- Plans required to provide a 60 day transitional care benefit for new disabled or chronically ill enrollees receiving an ongoing course of treatment

Pharmacy carved in to benefit package 10/2011

- Plans will have their own network of pharmacies and utilization management controls (step therapy, prior authorization, mail order, benefits administrator)
- Formularies must be “comparable” to the Medicaid fee-for-service formulary
- Includes medically necessary prescriptions, OTC drugs, medical supplies, enteral formula and hearing aid batteries

Advocacy Tips!

- Until January 1, 2010 plans must provide a temporary 30 day fill of previously authorized formulary drugs without requiring new prior authorization or step therapy requirements.
- Plans must also provide a 30 day one time temporary fill of non-formulary drugs.
- Plan must have Transitional Care Policies addressing out of network usage, non-formulary drugs or drugs which need prior authorization, step therapy, or have quantity limitations.

Other Changes to the Medicaid Managed Care Program

- Skilled nursing facility services carved in to benefit package 10/2012
- Transportation services carved out of benefit package 10/11, except for MLTC
- PERS carve-in 1/12
- Consumer Directed Personal Assistance Program carve in 7/12

Enrollees' Rights and Access to Care in Managed Care

Rights of People with Disabilities or Chronic Conditions in Managed Care

- **Specialist designated as PCP**
- **Standing referral**
- **Out-of-network specialty care**
- **Out-of-Network Center of Excellence / Specialty Care Center**
- **Transitional Care**

Transitional Care Upon Enrollment

- New enrollees receiving an ongoing course of treatment for a medical condition or disease which is either life-threatening or degenerative and disabling have the right to receive transitional care with an out-of-network provider for up to 60 days from their date of enrollment, or until their new managed care plan can make an in-network plan of care.

Treatment in an Emergency

- **Right to go to the emergency room in accordance with the "Prudent Lay Person" standard:**
  - If symptoms start suddenly, and are so severe or painful that a prudent lay person (a thoughtful, ordinary person) with an average knowledge of medicine and health could expect that not getting immediate medical attention would cause serious health problems or damage.
  - ER does not need to be in network
  - Individual must be stabilized in ER

Other Changes to the Medicaid & Medicaid Managed Care Program

- Prescription Footwear Benefit limitation and carve-in 4/1/11
  - Children under 21; Diabetic treatment plan; Shoe attached to lower limb orthotic brace
- Compression & Support Stockings limited to severe varicosities and edema during pregnancy and treatment of venous stasis ulcers
- Eliminate Part D Wrap
- Enteral Formula limited to tube feeding, metabolic disorders only
- OT/PT limits- 20 outpatient visits per calendar year

Contact Information

- **The Legal Aid Society**
  Health Law Unit
  Health Law Helpline:
  212-577-3575