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National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

SPECIAL REPORT

NEW YORK TRANSFER OF MEDICAID LTSS INTO MANAGED CARE APPROVED:

WHAT CMS REQUIRED, AND WHAT THIS MEANS FOR OTHER STATES

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Mandatory managed care has been a significant presence in New York Medicaid for some time. Under the Partnership Plan demonstration approved in 1997, most Medicaid beneficiaries were enrolled into managed care. In 2006, the managed care authority for the disabled and aged populations was transferred to a new demonstration, the Federal-State Health Reform Partnership.

On August 31, 2012, the Center for Medicare and Medicaid Services (CMS) agreed to amend both of these managed care demonstrations to include long-term services and supports (LTSS) on a mandatory basis.[1] As part of the approval, CMS amended the Special Terms and Conditions (*STC*) that govern New York's operation of the demonstrations. The STC are significant both because they will govern New York's amended demonstration, and also because the provisions of the STC give an indication as to how CMS may handle other states' proposals to move LTSS into a managed care structure.

The approval letter, the Partnership Plan STC, and the Federal-State Health Reform STC each are available *on-line*.[2]

Program Goals

The stated goals of the managed LTSS (MLTSS) program are both worthy and familiar. The program is meant to reduce admissions to hospitals and nursing facilities, and improve beneficiaries' safety, satisfaction, quality of care, and quality of life.[3]

Population Subject to Mandatory Enrollment

New York has had two managed programs for Medicaid benefits (along with small managed care programs that integrate Medicaid and Medicare benefits).[4] The Mainstream Managed Care program, with enrollment exceeding three million, is a mandatory program that provides a limited amount of LTSS. The Mainstream program cannot accept dual-eligibles (persons eligible for both Medicaid and Medicare).

The Managed Long-Term Care program (MLTC program) has been optional, but now will be mandatory for dually-eligible beneficiaries over age 21 who receive home and community-based services (HCBS) for at least 120 days. In addition, voluntary enrollment will be available to

1 Letter from Marilyn Tavenner, CMS Acting Administrator, to Nirav Shah, M.D., Commissioner of New York Department of Health (Aug. 31, 2012) (CMS Approval Letter).

2 *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-partnership-plan-ca.pdf*

3 Health Reform Partnership Special Terms and Conditions (Health Reform STC) at 3; Partnership Plan Special Terms and Conditions (Partnership STC) at 3.

4 A good resource is a table entitled "*Summary of Managed Care Plans in Medicare and Medicaid*," prepared by the Evelyn Frank Legal Resources Program of Selfhelp Community Services, Inc.

dually-eligible beneficiaries from age 18 to 21, and Medicaid-only adults (age 18 or older) who have care needs that would justify admission to a nursing facility.[5]

As amended, the MLTC program will provide benefits that mirror those under the state's HCBS waivers, which at this time are not included in the demonstration. This exclusion likely will change in the future: in the amendment approval letter, CMS states that is holding discussions with the state regarding the transitioning of the HCBS Long-Term Home Health Care Program waiver into managed care.[6]

The MLTSS program is unavailable to persons who are in HCBS waiver programs, receiving hospice services, or living in ICF/MRs or assisted living facilities. In addition, a small group of populations have the right on request to be exempted from MLTSS: this includes Native Americans, and persons eligible for the Medicaid buy-in program for the working disabled.[7]

Enrollment in MLTSS "may be phased in geographically and by group." Specifically, enrollment will begin in New York City and then expand statewide.[8]

Services

The list of LTSS benefits is extensive. Personal care of course is covered, along with nursing facility care, adult day health care, and durable medical equipment. Covered outpatient health care includes dental care as well as podiatry, optometry, and audiology. Covered home health care includes assistance from a nurse or home health aide, along with physical, occupational and speech therapy. In order to assist enrollees to remain in their own homes, the benefits also include (among other things) home-delivered meals, non-emergency transportation, social and environmental supports, and personal emergency response systems.[9]

Other Medicaid services are provided on a fee-for-service basis or, for persons enrolled in the Mainstream Medicaid Managed Care Program, through managed care. Covered LTSS services must be coordinated with other appropriate services, including those available on a fee-for-service basis.[10]

5 CMS Approval Letter.
6 CMS Approval Letter.
7 Health Reform STC at 12-13; Partnership STC at 14-15.
8 Health Reform STC at 6-7, 19-20, 43-45; Partnership STC at 3, 6, 22, 64-66.
9 Health Reform STC at 39; Partnership STC at 57.
10 Health Reform STC at 21; Partnership STC at 24.

Special Income Standard for Persons Moving from Nursing Facilities

A more lenient income standard applies for a person enrolling in the MLTSS program as part of a move from a nursing facility. The income standard consists of the HUD fair market rent minus 30 percent of the Medicaid income level for a single-person household. In order to identify good candidates to utilize this income standard, the state is obligated to work with nursing home staff, health plans, and beneficiaries' family members.[11]

Assessments

Functional eligibility tests are to be administered by the managed care organization (MCO) or Prepaid Inpatient Health Plan (PIHP), using a state-designated standardized assessment tool. Assessments must be performed within 30 days of referral or initial contact, with reassessments performed at least annually. To assure compliance with these time requirements, the MCO/PIHP must notify the enrollment broker of assessments performed for persons referred by the enrollment broker. To assure that assessments are being performed correctly, the state will review a sample at least annually.[12]

Service Planning

All LTSS recipients must have a person-centered individual service plan at the MCO/PIHP. The state must establish minimum guidelines regarding these person-centered plans, which must include qualifications for persons developing the person-centered plan, how enrollees are informed of services available to them, and an MCO's responsibilities for implementing and monitoring person-centered plans.

Each person-centered plan is developed by the enrollee "with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include." To enable broad participation, care planning meetings must be held at a location, date, and time convenient to the enrollee and to his or her invited participants.[13]

At a minimum, the plan must address all accessed needs, and must include a back-up plan in case regular services and supports are unavailable. Plans must be modified as warranted by changes in an enrollee's needs, and at least annually. So that the change-as-necessary clause is not an empty provision, each MCO/PIHP must have a process that enables enrollees to request a change to the person-centered plan.[14]

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11 Health Reform STC at 10; Partnership STC at 12.
12 Health Reform STC at 16; Partnership STC at 17-18.
13 Health Reform STC at 14; Partnership STC at 16.
14 Health Reform STC at 14-15; Partnership STC at 16.

Self-Direction

The amended Special Terms and Conditions contain significant detail regarding self-direction. New York already has a consumer directed personal assistance program, and that program will continue to be available on a fee-for-service basis until the program is incorporated into managed care. Thereafter, once incorporation is complete, self-direction of HCBS must be available to enrollees. This self-direction must include both how services are provided and who provides those services. Enrollees perform all of the following tasks: recruiting, hiring, scheduling, evaluating, verifying time worked, and discharging as necessary.[15]

To assist enrollees with self-direction, the state and MCO must have a support system providing enrollees with information, training, counseling, and assistance. Fiscal assistance, including payroll and other services, is provided by an IRS-approved Fiscal/Employer Agent.[16]

At an enrollee's option, self-direction may be performed by "a non-legal representative freely chosen by the [enrollee]." A representative cannot be a provider of services, as otherwise the representative would be supervising and training himself or herself.[17]

An enrollee at any time may choose to leave the self-directed model and receive HCBS services without self-direction. In addition, an enrollee may be taken off self-direction against his or her will, if the enrollee's health, safety, or welfare needs would not be met with continued self-direction, if the enrollee consistently demonstrates a lack of ability to carry out the self-direction tasks, or if there has been fraudulent use of funds.[18]

Continuity of Care

When an enrollee enters managed care, any pre-existing service plan continues in effect for 60 days or until a care assessment is performed, whichever is later. Any reduction or denial of services can be appealed. In addition, the MCO/PIHP must submit data for state review for any notice of action that reduces split-shift or live-in services, or reduces authorized hours by 25 percent or more. The MCO/PIHP also must report the number of appeals and fair hearings requested regarding these reductions.[19]

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15 Health Reform STC at 18; Partnership STC at 21.
16 Health Reform STC at 18; Partnership STC at 21.
17 Health Reform STC at 18; Partnership STC at 21.
18 Health Reform STC at 18-19; Partnership STC at 21.
19 Health Reform STC at 15; Partnership STC at 17.

Network Capacity

The network capacity requirements appear to be relatively weak, as the requirements are written to be conditional. An MCO/PIHP is obligated only to ensure that each enrollee "have a choice of provider, *where available*, which has the capacity to serve that individual within the network."[20] In a similar vein, an MCO/PIHP is required to "contract with at least two providers in each county in its service area for each covered service in the benefit package *unless the county has an insufficient number of providers licensed, certified, or available in that county*."[21] These requirements may be of some use to assure that enrollees in rural areas have at least some choice of provider, but they likely are of relatively little relevance in urban areas, where the problem is not that there are no providers, but that the number of participating providers may be far outstripped by the enrollee population.

On the other hand, it should be noted that an MCO/PIHP annually must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees, along with the available providers, and the "geographic location of providers and Demonstration populations, as shown through GeoAccess, similar software or other appropriate methods." In turn, the state must submit the relevant data to CMS as part of the state's annual reporting.[22]

Qualifications for Providers

If an MCO/PIHP does not have policies regarding non-licensed providers, it must "create alternative mechanisms to ensure the health and safety of its enrollees." An MCO/PIHP must incorporate criminal back ground checks and the review of abuse registries, although these obligations apply only "[t]o the extent possible."[23] In addition, in the contracts with MCOs/PIHPs, the state must set standards for LTSS providers. These standards "should" consider special health needs of enrollees and physical accessibility. In addition, relating to network adequacy and related issues, the standards should consider time/distance standards, whether an enrollee has a choice of provider, and the out-of-network requirements if a provider is not available within the specified access standard.[24]

Protecting Enrollee's Health and Welfare

Through contracts with MCOs/PIHPs, the state must ensure that a system is in place to identify, address, and seek to prevent incidents of abuse, neglect and exploitation. Such a system would

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20 Health Reform STC at 15; Partnership STC at 16 (emphasis added).
21 Health Reform STC at 15; Partnership STC at 16 (emphasis added).
22 Health Reform STC at 22; Partnership STC at 25.
23 Health Reform STC at 15; Partnership STC at 17.
24 Health Reform STC at 21-22; Partnership STC at 25.

include critical incident monitoring and reporting to the state, as well as investigations of wrongful death or incidents in which injury was caused by a medication error or use of a restraint.[25]

Quality of Care

By the end of November 2012, the state must submit to CMS an updated quality strategy that addresses HCBS services. In developing this update, the state must obtain the input of Medicaid beneficiaries and other stakeholders, and post a draft of a revised quality strategy for public comment. Thereafter, as the quality strategy is adopted and implemented, the state must submit annual reports to CMS on the implementation and effectiveness of the quality strategy.[26]

As part of its quality monitoring, the state must ensure that approved assessment instruments are being used, and that assessments for functional eligibility are being performed accurately. In addition, the quality strategy must ensure that MCOs/PIHPs "are appropriately creating and implementing service plans based on enrollees' identified needs," that LTSS are "provided by qualified providers" and, regarding health and welfare, that an MCO/PIHP "identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation" on an ongoing basis.[27]

Financial Incentives

The MLTC program is only partially capitated, meaning that an MCO may have financial incentives in favor of nursing facility care over HCBS.

Advisory Committee

A required advisory group is "comprised of individuals and interested parties appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities who are impacted by the Demonstration's use of managed care, regarding the impact and effective implementation of these changes on individuals receiving LTSS."[28]

Reporting to CMS Regarding LTSS

The state is required to submit quarterly reports to CMS, and those reports must include items specific to LTSS, including a listing of critical incidents and the resulting investigations. Regarding

25 Health Reform STC at 15; Partnership STC at 17.
26 Health Reform STC at 21, Partnership STC at 24.
27 Health Reform STC at 21, Partnership STC at 25.
28 Health Reform STC at 22; Partnership STC at 26.

appeals and grievances, the report must list the number and types of grievance and appeals, along with the total number of complaints, grievances, and appeals by type of issue, with a listing of the top five reasons for the event. In addition, the reports must include various data related to assessments, including the number of enrollees who receive an assessment within 30 days and the total number of assessments for enrollment, along with the number of persons who did not qualify for MLTSS. Regarding a system-wide issue — rebalancing towards HCBS and away from nursing facility utilization — the state must report on rebalancing efforts performed by the plans, including the total number of persons transitioning in and out of nursing facilities.[29]

Evaluation

The state is required to evaluate the program and, in preparation, must submit a draft evaluation guide to CMS by October 1, 2012. The Special Terms and Conditions documents list a variety of LTSS-related questions that should be addressed by the evaluation, including questions regarding the characteristics of the enrollee population, and enrollee satisfaction with care providers. Regarding enrollee safety, CMS specifically mentions falls and medication management.[30]

29 Health Reform STC at 26, 28, 40-42; Partnership STC at 38, 41, 60-62.
30 Health Reform STC at 37; Partnership STC at 53.