

# *Medicaid*

**Medicaid Matters New York**

# *Matters*

**Managed Care Workgroup**

## MEDICAID MANAGED CARE FACT SHEET

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### **Know Your Rights: Continuing Your Ongoing Treatment While Transitioning from Medicaid into Medicaid with a Health Plan**

Prepared by Nora Chaves, Community Health Advocates, [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)

Starting October 1, 2011, most Medicaid beneficiaries will be required to join a health plan to receive health care services. This is called Medicaid managed care. The questions and answers on this sheet will help you understand your rights during the transition process.

#### **WILL I LOSE ANY BENEFITS BECAUSE I JOIN A HEALTH PLAN?**

No. Medicaid managed care plans must cover everything that Medicaid fee-for-service covers. The difference is that you will now get most services through your health plan and you will have to follow the health plan's rules.

#### **WHEN SHOULD I START USING THE HEALTH PLAN?**

Once you enroll in a health plan, you will get a welcome letter with an effective date of enrollment. After that date you should start using the health plan providers and follow the health plan rules, like getting referrals from your primary care provider (PCP) to see the health plan specialists.

#### **DO I HAVE TO STOP AN ONGOING COURSE OF TREATMENT AND START ALL OVER AGAIN WITH THE HEALTH PLAN?**

You don't have to stop your Medicaid covered ongoing treatment when you enroll in a health plan. Your health plan must cover the treatment until it has an approved plan of care in place.

#### **WHAT IF MY DOCTOR IS NOT PART OF THE HEALTH PLAN (OUT-OF-NETWORK)?**

Your health plan has to cover your treatment for a transitional period when you have a life threatening, degenerative or disabling condition; and your treating provider is not in the health plan.

The transitional period lasts for:

- 60 days, or
- Until your health plan evaluates your needs and has an in-network plan of care in place for you

You should use the transition period to ask your doctor to join the health plan or to find a doctor in your health plan who can continue the treatment. During this time you should also work with your health plan to arrange your future care.

#### **HOW WILL I GET MY PRESCRIPTIONS ONCE I ENROLL IN A HEALTH PLAN?**

Starting October 1, 2011, you will no longer use your Medicaid card to get prescriptions. You will only be able to get your prescriptions through your health plan. Each health plan has its own list of drugs and rules on how to get them. For this reason, it is important to check with your health plan to see if they cover your prescriptions, and what pharmacies you can use.

### **WHAT IF MY HEALTH PLAN DOESN'T COVER MY PRESCRIPTIONS?**

During the first 90 days from your effective date of enrollment, you have the right to a one-time fill if you need a prescription that is not in the health plan's list of drugs or that has special rules. During this time:

- Ask your doctor if there is another drug you can take from the health plan's list of drugs, or
- Ask your health plan to cover the drug you need if you cannot take a different one.
- Call Community Health Advocates (CHA) for help getting the health plan to cover the prescriptions your doctor says you need. CHA's helpline number is 1-888-614-5400.

### **CAN I CONTINUE RECEIVING HOME CARE?**

Once you enroll in a Medicaid health plan, you will receive all your home care services, including home attendant, housekeeping, home health aide and skilled nursing services, through your health plan unless you have Medicare.

Your health plan must cover any ongoing home care services you were receiving through Medicaid until it evaluates your needs and puts in place an approved plan of care.

### **WHAT IF MY HOME CARE AGENCY IS NOT IN THE HEALTH PLAN?**

If your home care agency is not in the health plan, your health plan must cover your ongoing home care services for up to 60 days from the date of enrollment or until an in-network plan of care is put in place, whichever comes first.

### **WHAT IF MY HEALTH PLAN TRIES TO STOP MY ONGOING TREATMENT?**

You can appeal any health plan decision you disagree with using the health plan's internal review process. You can also ask for a fair hearing at the same time. If you ask for a fair hearing within 10 days from the date the health plan informs you of their decision to stop services, you may be able to continue receiving treatment while you wait for your fair hearing decision.

### **WHAT IF I CANNOT GET THE SERVICE I NEED FROM THE HEALTH PLAN?**

Ask the health plan to give you a case manager if you have problems getting the services you need. A case manager is a health plan employee who helps you coordinate your care. A case manager can help you get referrals, prior authorizations, etc.

If this still does not work, you can file a complaint with the plan. You can also call the Division of Managed Care of the State Department of Health to file a complaint. Their phone number is 1-800-206-8125.

File an appeal with the plan when the plan refuses to provide you with a service that you believe is medically necessary. You can also use the plan's appeal process and request a fair hearing. For advice on how to appeal or present your case at a fair hearing, contact your local advocacy organization, such as an Independent Living Center or legal services organization. You can also call the Community Health Advocates statewide hotline at 1-888-614-5400, which provides free information and assistance to New Yorkers seeking health care services and health insurance.

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### **Attention Restricted Recipients: The Way You Receive Your Medicaid Benefits is Changing!**

**Prepared by Diane Spicer, The Legal Aid Society, [www.legal-aid.org](http://www.legal-aid.org)  
NYC Health Law Helpline: 212-577-3575, Upstate Helpline: 888-500-2455**

On August 1, 2011, Medicaid recipients who are restricted to certain providers will have to enroll in a Medicaid health plan. Before August 1, 2011, restricted recipients were “excluded” from managed care, which means that they could not join a Medicaid health plan even if they wanted to.

#### **WHAT HAPPENS NEXT?**

- If you are a restricted recipient, you will receive a “heads up” notice from the State Department of Health on or around August 1, 2011, explaining the change.
- If you live in New York City, you will also receive a mandatory enrollment notice from New York Medicaid Choice asking you to choose a Medicaid health plan. Residents of some upstate counties will receive this notice from the Local Department of Social Services. In some upstate counties restricted recipients will get the enrollment notice at recertification or after a change is made to their Medicaid case.
- The notice will come with a brochure describing the managed care program, enrollment forms, a list of Medicaid health plans in the area and a letter explaining that the State Department of Health will choose a Medicaid health plan for you if you do not choose one on your own.

#### **HOW LONG DO I HAVE TO CHOOSE A HEALTH PLAN?**

- Currently, non-disabled Medicaid recipients have 60 days to choose a plan; disabled recipients have 90 days to choose a plan. If you receive an enrollment package after October 1, 2011 you will only have 30 days to choose a plan.
- If you do not choose a plan one will be chosen for you! This plan might not work with the providers you currently see!
- After the first 90 days of enrollment you will be “locked in” to your health plan and will not be allowed to change plans during the remainder of that first year unless you have a very good reason for doing so.

#### **HOW DO I CHOOSE A HEALTH PLAN?**

Make a list of all your medical providers and figure out what Medicaid health plans each provider accepts. Some examples of medical providers are your regular doctor, your specialist, your home care services provider, your physical therapist, and your durable medical equipment provider. Choose the Medicaid health plan that most of your providers accept, especially the providers that you do not want to give up.

#### **WILL MY HEALTH PLAN CONTINUE MY RESTRICTION?**

Your new Medicaid health plan will manage your current restrictions and will have the ability to make changes to them.

## **CAN MY HEALTH PLAN CHANGE OR EXTEND MY RESTRICTION?**

Your new Medicaid health plan can continue your restriction or place a new restriction on your Medicaid case, but only for specific reasons, such as: duplicative, excessive, contraindicated or conflicting services, drugs or supplies, fraud or illegal activity.

## **WHAT ARE MY RIGHTS?**

If your restriction is continued after the initial authorization period or if a new restriction is placed on your Medicaid case, you have the right to a notice of action from your Medicaid health plan and a Fair Hearing.

Here are some steps you can take:

- If your Medicaid case is restricted without notice, request a fair hearing immediately, and ask for “aid continuing” so your services can continue until the outcome of the hearing.
- If you receive a notice advising you of a new restriction, request a fair hearing immediately. To be eligible for aid continuing you must request the hearing within 10 days of the date of the notice.
- File a complaint with your Medicaid health plan by contacting Member Services.
- File a complaint with the New York State Department of Health Managed Care hotline at (800) 206-8125.

## **HOW DO I REQUEST A FAIR HEARING?**

**In person:** 14 Boerum Place in NYC, or your county’s Local Department of Social Services  
**By fax:** (518) 473-6735  
**By telephone:** (800) 342-3334  
**Online:** [www.otda.state.ny.us/oah/forms.asp](http://www.otda.state.ny.us/oah/forms.asp)  
**By mail:** New York State Office of Temporary and Disability Assistance  
Office of Administrative Hearings  
P.O. Box 1930  
Albany, New York 12201-1930

## **WHO CAN I CALL FOR HELP?**

### **NYS DOH Managed Care Complaint Line**

Open Monday-Friday 8:30 am – 4:30 pm  
(800) 206-8125

### **The Legal Aid Society’s Health Law Help-line**

Open on Tuesdays only

In NYC: (212) 577-3575  
Outside NYC: (888) 500-2544

### **Community Health Advocates Hotline**

(888) 614-5400

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### **Attention Upstate New York Medicaid Beneficiaries Living with HIV and AIDS: You Are Now Required to Join a Managed Care Plan!**

Prepared by Nora Chaves, Community Health Advocates, [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)

**Starting October 1, 2011**, Medicaid beneficiaries living with HIV and AIDS in most New York upstate counties must join a health plan to continue getting health care. The Medicaid Managed Care (MMC) plan will administer your Medicaid benefits.

#### **HOW LONG DO I HAVE TO JOIN A PLAN?**

At some point after October 1, 2011, the State will send you an enrollment packet telling you to choose a MMC plan. You will have 30 days from the date on the notice to choose a health plan. If you don't, the State will enroll you into one. You may enroll into a plan before getting the enrollment packet. Early enrollment gets you enrolled in a plan before the plan's and the primary care doctor's list of patients get full.

First time Medicaid applicants have to choose a plan at the time of their application.

#### **WHAT ARE MY PLAN OPTIONS?**

Plan options vary by county. To get a list of the plans available in your county, contact:

- New York Medicaid CHOICE, an enrollment broker, at 1-800-505-5678. They can give you information about your plan options if they are the enrollment broker in your county. They may also refer you to your local Department of Social Services.
- Your local Department of Social Services (LDSS). You can find each county's phone number at: [http://www.health.state.ny.us/health\\_care/medicaid/ldss.htm](http://www.health.state.ny.us/health_care/medicaid/ldss.htm)
- Community Health Advocates (CHA) at 1-888-614-5400. A CHA advocate can provide you with a list of plans in your county and help you decide which plan is best for you.

#### **HOW DO I ENROLL?**

You can enroll by phone, in person, or by mail. Use the contacts above to figure out your plan and enrollment options.

#### **HOW DO I CHOOSE THE PLAN THAT IS BEST FOR ME?**

- Ask all your medical providers, including your primary care doctor, specialists, home care service and durable medical equipment providers, which plan(s) they take.
- If one of your doctors doesn't take the plan that your other doctors take, ask him/her to join that plan.

- Ask the plans in your county if they cover your prescriptions and if they have any special rules for the use of those prescriptions.
- Ask the plan if they have any special services that may help you stay healthy, like case management.
- Ask the plan if they would let your specialist be your primary care physician (PCP).
- Ask the plan which hospitals are part of the network.
- Ask the plan about transportation arrangements to your doctor visits.

### **WHO DOESN'T HAVE TO JOIN A PLAN?**

There are a few exemptions, but most people will have to join a plan within the next three years. If you think you might be eligible for an exemption, call CHA at 1-888-614-5400.

### **WILL I LOSE ANY BENEFITS BECAUSE I JOIN A PLAN?**

No. Medicaid Managed Care plans must cover everything that regular Medicaid covers. The difference is that you will now get most services through a plan and you will have to follow the plan's rules.

### **SHOULD I KEEP MY MEDICAID CARD?**

Yes. You will use your Medicaid card to get some services that are not part of your plan's benefit packet, such as COBRA case management, dental care, AIDS adult day health care services, methadone maintenance, and outpatient rehabilitative services for chemical dependence. SSI recipients will use a Medicaid card for mental health services.

### **WHEN SHOULD I START USING THE PLAN?**

Once you enroll, you will receive a letter from your plan indicating your effective date of coverage with an ID card and member handbook. You must use your plan card for most medical services, but you may need your Medicaid card for a few other services.

### **HOW CAN I CONTINUE THE TREATMENT I WAS GETTING BEFORE JOINING A PLAN?**

Once you are enrolled, the plan must ensure that you continue all the services you were receiving for any chronic, degenerative, disabling or life-threatening condition, even if the providers do not participate in the plan. The plan has to cover those services for 60 days from enrollment or until it develops a plan of care for you, whichever comes first.

### **WHAT IF MY PLAN DOESN'T WANT TO COVER SOMETHING?**

Don't take no for an answer. If you need a service that your plan should pay for, you have the right to appeal with the plan and you also have the right to a Fair Hearing.

### **WHO DO I CALL IF I HAVE A COMPLAINT?**

To file a complaint, call New York State Department of Health's Managed Care Complaint Line: 1-800-206-8125

For advice on how to appeal or present your case at a fair hearing, contact your local advocacy organization, such as an Independent Living Center or legal services organization. You can also call the Community Health Advocates statewide hotline at 1-888-614-5400, which provides free information and assistance to New Yorkers seeking health care services and health insurance.

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### **Attention Medicaid Managed Care & Family Health Plus Enrollees: The Way You Get Your Prescription Drugs Has Changed!**

**Prepared by Diane Spicer, The Legal Aid Society, [www.legal-aid.org](http://www.legal-aid.org)  
NYC Health Law Helpline: 212-577-3575, Upstate Helpline: 888-500-2455**

**On October 1, 2011**, Medicaid and Family Health Plus enrollees who previously used their NYS Benefit card to get their drugs will now have to use their Medicaid health plan card to pay for pharmacy services. This does not apply to you if you are on Medicare and Medicaid or if you are not in a Medicaid Managed Care Plan.

For Medicaid enrollees this includes prescription and over-the-counter drugs, medical supplies, hearing aid batteries and enteral formula. For Family Health Plus (FHP) enrollees it includes most prescription drugs and select non-prescription drugs and medical supplies.

#### **WHAT DOES THE CHANGE MEAN FOR ME?**

***You must use only the drugs on your health plan's list.***

Each Medicaid/FHP Health plan will have a list of drugs it covers. The list of drugs is called a formulary and must be "comparable" to what Medicaid fee-for-service used to pay for. Not all drugs covered by Medicaid will be on every plan's formulary. Contact your health plan to find out if your drugs are on their formulary.

***You must fill prescriptions at pharmacies in your health plan's network.***

Each Medicaid/FHP health plan will have a list of participating pharmacies. You can continue to use the pharmacy you use now if it is on your health plan's list of participating pharmacies, also called a network of providers. Contact your health plan or pharmacy to find out whether your pharmacy is in your plan's network.

***You must follow your health plan's rules for getting drugs.***

You may need to get prior authorization, or special permission from your doctor to use a specific drug, or you may need to use the generic version of the drug before getting the brand name drug. Also health plans may have quantity limits on specific drugs. Each health plan's rules are different for each drug. Contact your health plan to find out if there are special rules for you to get your drugs.

#### **CAN I SWITCH HEALTH PLANS IN ORDER TO GET MY DRUGS?**

You can switch to a plan that covers your drugs only during a limited time during the first year of enrollment in managed care.

- You can only switch plans during the first 90 days of enrollment in your health plan.
- After the 90 days, you are "locked in" to the plan for the rest of the year.

- Enrollees can switch plans during the “lock-in” period only for good cause. Pharmacy benefit changes are not considered good cause.
- After the first 12 months of enrollment, Medicaid managed care enrollees can switch plans at any time. However, a new lock-in period applies every time you switch plans.

## **At the Pharmacy**

### **THE PHARMACIST SAYS MY PLAN WON’T PAY FOR MY DRUGS. WHAT CAN I DO?**

- Prior to December 31, 2011, you can get a one time 30-day temporary fill of your drugs, but you need to find out what the problem is because you only get *one* 30-day fill!
- Check with the plan to make sure your pharmacy is in their network.
- Check with the plan formulary to see if your drug is listed as a covered drug.
- If your drug is on the plan’s formulary, check for any prior authorization requirements or quantity limits.

## **At the Doctor's Office**

### **WHAT CAN MY DOCTOR DO TO HELP?**

- If your drug is not on the plan’s formulary, check with your doctor to see if there are any alternative medications you could take that are on the formulary.
- If no alternatives are available and the drug your doctor says you need is not covered by the plan, your doctor can ask the plan to make an exception to their formulary rules so that you can get your drug. If the plan still says no, you can appeal that denial to internal and external reviewers. Contact your plan for information about their appeals process. You can also request a Medicaid Fair Hearing.

## **Requesting a Fair Hearing**

### **WHAT HAPPENS IF I REQUEST A FAIR HEARING?**

- If you request a fair hearing because you can’t get a drug you are currently taking, you can continue getting the drug while you wait for your fair hearing decision by asking for “aid continuing.”
- When you request a fair hearing, be sure to explain that you are currently under treatment and your drug is medically necessary.
- A fair hearing can be used at the same time as a health plan’s appeal process, which may also be called an “exception.” If the fair hearing is decided in your favor, you get the drug you requested.

### **HOW DO I REQUEST A FAIR HEARING?**

**In person:** 14 Boerum Place in New York City, or your county’s Local Department of Social Services  
**By fax:** (518) 473-6735  
**By telephone:** (800) 342-3334  
**Online:** [www.otda.state.ny.us/oah/forms.asp](http://www.otda.state.ny.us/oah/forms.asp)  
**By mail:** New York State Office of Temporary and Disability Assistance  
 Office of Administrative Hearings  
 P.O. Box 1930  
 Albany, New York 12201-1930

### **WHO CAN I CALL FOR HELP?**

**NYS DOH Managed Care Complaint Line:** (800) 206-8125, Monday-Friday 8:30 am - 4:30 pm  
**The Legal Aid Society’s Health Law Help-line:** NYC - (212) 577-3575, Outside NYC - (888) 500-2544; Tuesdays only  
**Community Health Advocates Hotline:** (888) 614-5400



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## MEDICAID MANAGED CARE FACT SHEET

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### The Managed Care Pharmacy Benefit

Prepared by Trilby de Jung, Empire Justice Center, [www.empirejustice.org](http://www.empirejustice.org)

**Effective October 1, 2011**, Medicaid's pharmacy benefit will be moved into the managed care benefit package. The pharmacy benefit includes prescription and some over-the-counter drugs, medical supplies, hearing aid batteries and enteral formula. All Medicaid recipients in managed care should have received notification from the New York State Department of Health (NYSDOH) in late August, 2011.

The Family Health Plus (FHP) pharmacy benefit will also be moved into the FHP managed care benefit package. The FHP pharmacy benefit is not as comprehensive as Medicaid's. It includes most prescription drugs and select non-prescription drugs, diabetic supplies, hearing aid batteries and enteral formula.

#### **HOW WILL MANAGED CARE CHANGE THE PHARMACY BENEFIT?**

***The pharmacy benefit will vary by plan.*** Although managed care plans are required to have drug formularies that are "comparable" to the Medicaid fee-for-service formulary, each plan will have its own formulary, drug coverage policy, and network of participating pharmacies.

***Plan formularies will be comparable to but not the same as the Medicaid formulary.*** Not all drugs covered by Medicaid will be on plan formularies, but there must be generic or therapeutic equivalents of all Medicaid covered drugs on each plan's formulary.

***Utilization controls will vary by plan, and "prescriber prevails" will not apply.*** Drug coverage policies like prior authorization and step therapy can differ from plan to plan. Prescribers will need to satisfy plan requirements and plans are not required to abide by the prescriber's judgment in the event of a dispute over the medical necessity of the drug in question.

***Pharmacy networks will vary by plan.*** Consumers must use in-network pharmacies. Letters from plans in August and September should provide more information on how to determine a pharmacy's participation status with a particular plan.

#### **WHAT ARE THE TRANSITION POLICIES?**

***Temporary fills.*** Plans are required to provide a one-time temporary fill of up to 30 days for drugs prescribed for members, both current and new, during the transition period running from October 1, 2011 through December 31, 2011.

- This includes both non-formulary drugs and drugs that are on the formulary but subject to prior approval or step therapy or any other utilization restrictions.
- The one-time, temporary fill must be provided by a participating pharmacy.

**Disruption analyses.** Plans were required to conduct disruption analyses using prescription claim data supplied by NYSDOH to identify enrollees likely to experience disruptions in care due to the plans' formulary or network of providers and pharmacies and submit plans for ensuring continued access to medically-necessary drugs.

- Plans were also directed to develop plans to ensure continued access to specialty drugs and drugs of concern, including antipsychotics, immunosuppressants, antiretrovirals, anticonvulsants, and antidepressants.
- Several plans are providing ongoing access to the drugs of concern listed above; most have guaranteed 12 months of access.

**Outreach to enrollees.** Plans have been required to communicate the changes in the pharmacy benefit to all beneficiaries and providers in the months leading up to the change. Notification should include an explanation of plan specific changes in coverage, information about pharmacy networks, and a description of the plan's exceptions and appeals process.

**Information on formularies.** NYSDOH has requested that plans post their formularies and information about their drug coverage policies on their websites, but this is not required. NYSDOH has also requested that plans dedicate a helpline to help enrollees navigate the new pharmacy benefit. For phone numbers and websites for Medicaid managed care plans, visit the Department of Health's site:

[http://nyhealth.gov/health\\_care/managed\\_care/reports/eqarr/2010/plan\\_profiles.htm](http://nyhealth.gov/health_care/managed_care/reports/eqarr/2010/plan_profiles.htm)

## **CAN CONSUMERS SWITCH PLANS IN ORDER TO GAIN ACCESS TO DRUGS?**

Changing plans is often an effective strategy for consumers eligible for both Medicaid and Medicare (dual eligibles) who receive their pharmacy services through Medicare Part D, because dual eligibles are allowed to switch plans at any time. Medicaid consumers will have this option only in the limited circumstances during the first year of enrollment in managed care.

- Medicaid managed care enrollees can only leave and join another plan within the first 90 days of joining a health plan. After the 90 days has expired, enrollees are "locked in" to the plan for the rest of the year.
- Consumers can switch plans during the "lock-in" period only for good cause. The pharmacy benefit changes are not considered good cause.
- After the first 12 months of enrollment, Medicaid managed care enrollees can switch plans at any time.

## **WHAT ARE THE APPEAL RIGHTS WHEN PLANS DENY COVERAGE?**

All plans are required to maintain an internal and external review process for exceptions and appeals. Enrollees have the right to use these procedures when prescriptions are denied. Internal and external review procedures are described in the plan's enrollee handbook and denial notices.

Medicaid managed care enrollees also have the right to request a fair hearing. If an enrollee requests a fair hearing because plan policies will result in reduction or termination of a course of ongoing treatment, he or she should qualify for aid continuing.

A fair hearing can be pursued simultaneously with the plan's review process. The decision in the fair hearing will take precedence over the plan appeal. So if a plan's denial is overturned during the managed care appeal process, the fair hearing should be withdrawn.

## **WHO YOU CAN CALL IF YOU HAVE A COMPLAINT OR NEED HELP?**

- To file a complaint, call NYSDOH's Managed Care Help Line: (800) 206-8125 (Mon. - Fri., 8:30 am - 4:30 pm)
- Consumers needing help can call the Community Health Advocates Hotline: (888) 614-5400
- Advocates in need of technical assistance can call the Empire Justice Center: (800) 724-0490

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### **Attention Individuals Who Receive Personal Care: Your Personal Care Services Are Now a Part of the Medicaid Managed Care Package!**

Prepared by Leah Farrell, Center for Disability Rights, [www.cdrnys.org](http://www.cdrnys.org)

The following information is for individuals who are eligible for Medicaid only. If you are eligible for both Medicaid and Medicare, or you obtain your personal care services through the Consumer Directed Personal Assistance Program (CDPAP), the following information does not apply to you. If you are enrolled in the CDPAP, these changes will not affect you until July 1, 2012.

Personal care services provide individuals with assistance in meeting their non-medical needs for activities of daily living, such as bathing, dressing, and eating.

#### **WHAT WILL CHANGE?**

**Effective August 1, 2011**, your Personal Care/Home Attendant services are paid for by your Medicaid managed care plan, also referred to as your health plan. This means that you are getting all of your Personal Care/Home Attendant services through your Medicaid managed care plan.

Your care and your worker should not change until your health plan reviews your plan of care. However, any requests for changes to your Personal Care/Home Attendant services after August 1, 2011 must be approved by your health plan, not your county Medicaid office.

All new requests for Personal Care/Home Attendant services after August 1, 2011 must be made through your health plan.

Your plan may choose to assess and authorize your services at any time. That means that your health plan may do a reassessment even if your current authorization period has not ended. If you have questions about this change, you should contact your health plan by calling the member services number on your health plan card. If you do not have this number, or if you need information about which personal care providers are in your health plan's network, you can call New York Medicaid Choice at 1-800-505-5678 or your local social services district for help.

#### **WHAT ARE YOUR RIGHTS?**

Notice and Fair Hearing Rights:

- If your health plan reduces or terminates your Personal Care/Home Attendant services, it must provide you with notice in advance explaining the change.
- You have the right to a fair hearing if the plan reduces or terminates services that your doctor says are medically necessary for you.

- If you make the request within 10 days of the notice and your services are reduced or terminated before your original service authorization period has expired, you should qualify for “aid continuing” while the hearing is pending.

If your personal care provider does not accept your health plan, your health plan is required to pay out-of-network home care agencies for at least 30 days after August 1, 2011. This will allow you time to find a personal care provider in your plan’s network.

You also have rights as an enrollee in a managed care plan. Your plan is required to provide you with the following information:

- What services must be provided to you by the plan and any limits on this care;
- Which treatments your plan needs to approve before it pays for the service;
- A list of providers that provide the service you need and the way to change providers within the network; and
- What steps you can take if the plan will not cover a service. This includes the right to file a grievance or complaint with the plan and the right to ask the plan to review its decision. The plan must provide you with a toll-free telephone number to use to begin the review process, and an explanation of how to appeal the decision made on review, including the timeframes that you must follow.

If your health plan does not honor your rights as an enrollee in the Medicaid managed care program, you should file a complaint with the State Department of Health Managed Care Complaint Line at 1-800-206-8125.

## **WHAT SHOULD YOU DO?**

Ask the right questions. Now that you know that personal care services will be a part of your managed care benefits package, you should begin by contacting your health plan to ensure that you can continue to receive services from your service provider.

- If your services are discontinued without notice, request a fair hearing immediately, and ask for “aid continuing” so your services can continue until the outcome of the hearing.
- If you receive a notice advising you of a change in your services that you disagree with, request a fair hearing immediately. You are eligible for aid continuing if you request the hearing within 10 days of the date of the notice and your service authorization period has not expired.
- File a complaint (grievance) with your health plan by contacting your plan’s member services. You may also want to ask the plan to review its decision and request an appeal of the review, if the plan still does not provide the services you need.

## **WHO SHOULD YOU CALL IF YOU HAVE A PROBLEM?**

To file a complaint, call the New York State Department of Health’s Managed Care Complaint Line at 1-800-206-8125.

For advice on how to appeal or present your case at a fair hearing, contact your local advocacy organization, such as an Independent Living Center or legal services organization. You can also call the Community Health Advocates statewide hotline at 1-888-614-5400, which provides free information and assistance to New Yorkers seeking health care services and health insurance.

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### **The Personal Care Benefit**

**Prepared by Carol Santangelo, The Legal Aid Society, [www.legal-aid.org](http://www.legal-aid.org)  
NYC Health Law Helpline: 212-577-3575, Upstate Helpline: 888-500-2455**

Effective August 1, 2011, personal care/home attendant services provided to non-dual eligible individuals who are enrolled in Medicaid managed care will be the responsibility of the Medicaid Managed Care Organizations (MMCOs).

Consumers participating in Consumer Directed Personal Assistance Program (CDPAP) will not be affected by this change until July 1, 2012.

#### **REGULATORY CHANGES AFFECTING PERSONAL CARE SERVICES**

Under the terms of the revised Medicaid Managed Care/Family Health Plus Model Contract, the individual MMCO providers are now responsible for setting procedures and standards specific to personal care/home attendant services currently set by 18 NYCRR § 505.14.

Regulations governing Medicaid Managed Care Programs, enacted by the State's emergency rule making authority, repeal various sections of Title 18 NYCRR that contain managed care regulations and replace them with a new Subpart 360-10, which consolidates all managed care regulations in one place and makes them consistent with Section 364-j of the Social Services Law.

#### **MANAGED CARE WILL CHANGE CONSUMERS' ACCESS TO PERSONAL CARE SERVICES**

MMCO contractors are now responsible for determining the enrollee's need for personal care agency services, including the level of care needed (Level I or Level II) according to assessment tools *to be provided by SDOH* (in New York City, the M11Q is still in use until the Statewide Uniform Assessment Tool is released). Authorization solely for Level I services may not exceed eight hours per week.

MMCO contractors are now responsible for coordinating with the consumer's personal care agency to develop a plan of care.

MMCO contractors must provide case management services to enrollees receiving PCS and coordinate with appropriate local government programs to address social and environmental issues necessary to maintain health and safety in the home.

#### **TRANSITION POLICIES AS OF AUGUST 1, 2011**

**Enrollees in receipt of PCS as of August 1, 2011** must be allowed to continue their course of treatment as authorized by the local social services districts, regardless of whether their home care provider participates in

*October 2011*

their MMCO's network, until the MMCO has assessed the enrollee's needs and an approved plan has been put into place.

**For new enrollments after August 1, 2011**, the MMCO must provide transitional care consistent with the Model Contract and the State Department of Health's Transitional Care Policy which provide that:

- Transitional care for new enrollees undergoing a course of treatment with a *participating* provider is required until the health plan's approved treatment plan is in place;
- Transitional care for new enrollees undergoing a course of treatment with a *non-participating* provider is required for a period of up to 60 days from the date of enrollment if the new enrollee: 1) has an existing relationship with a non-participating provider, 2) elects to continue to receive care from that provider, and 3) has a life threatening disease or condition or degenerative or disabling disease or condition.

## **DUE PROCESS RIGHTS**

### **NOTICE**

#### **Service Authorization Determinations**

Service Authorization Determinations are the MMCO's approval or denial of a Service Authorization Request.

There are two kinds of Requests:

1. **Prior Authorization Requests:** Requests for coverage of a new service, whether for a new authorization period or within an existing authorization period, before such service is provided.
2. **Concurrent Review Requests:** Requests for home health services following an inpatient admission or for continued, extended or more of an authorized service than what is currently authorized by the MMCO.

Determinations involving PCS must include the number of hours per day, number of hours per week, and the personal care service function (Level 1 or Level 2) authorized by the MMCO:

- That were previously authorized, if any;
- That were requested by the enrollee or their designee, if so specified in the request;
- That are authorized for the new authorization period, if any;
- The original authorization period and the new authorization period, as applicable.

#### **Time Frames for Notice of Service Authorization Determinations**

##### *For Prior Authorization Requests*

MMCO contractors must make Service Authorization Determination and provide notice to consumers by phone and in writing as fast as the enrollee's condition requires and no longer than:

- Within three business days of receipt of necessary information but no more than 14 days after receipt of the Service Authorization Request;
- Expedited reviews must be made within three business days.

##### *For Concurrent Review Requests*

MMCO must make Service Authorization Determination and notice enrollee of the determination by phone and in writing as fast as the enrollee's condition requires and no longer than:

- Expedited reviews must be made within one business day after receipt of necessary information but no more than three business days after receipt of request.
- In cases of requests for home health care services following an inpatient admission, determinations must be made one business day after receipt of necessary information except when the return date falls on a weekend in which case determinations must be made within 72 hours but in any event no longer than three business days.

- In cases of requests for continued, extended or more of an authorized service than what is currently authorized, determinations must be made within one business day but no more than 14 days after receipt of request.

Time frame for determinations may be extended up to 14 days upon request of the provider or enrollee, or where there is a need for additional information. Notice of extension must be documented by the contractor and must be provided to the enrollee.

### **Time Frames for Notices of Actions other than Service Authorization Determinations**

When contractor intends to reduce, suspend, or terminate a previously authorized service within an authorization period, it must provide enrollee with a written notice at least ten days prior to the intended action.

An Action is an activity of an MMCO or its subcontractor that results in:

- the denial or limited authorization of Service Authorization, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- denial, in whole or part, of payment for a service;
- failure to provide service in timely manner as defined in regulation or Model Contract;
- failure of MMCO to act within timeframes for resolution and notification of determinations regarding complaints, grievances and appeals with reasonable promptness; or,
- denial of request for out-of-network service where there is only one participating MMCO.

Whenever a Notice of Action is issued the MMCO must notify enrollee in writing of:

- Action taken or intended;
- Reason, including clinical rationale;
- Right to file an appeal;
- Right to fair hearing, and procedures for exercising rights;
- Circumstances under which expedited review available and how to request;
- Right to aid continuing and how to request it;
- Timeframes for MMCO actions and grievances systems.

### ***FAIR HEARING RIGHTS***

**The social services district** must notify enrollee in writing of right to fair hearing and how to request a hearing where the district denies request for exemption, exclusion, enrollment, disenrollment, or to change MMCO.

**An MMCO** must notify an enrollee in writing of their right to a fair hearing and how to request a hearing whenever a notice of action is issued.

### ***AID CONTINUING***

Available when an MMCO or its approved utilization agent has terminated, suspended or reduced previously authorized treatment or proposes to do so, if:

- Enrollee has filed a request within 10 days of Notice of Action or grievance determination, or by intended date of Action, whichever is later; and
- There exists a valid order for the treatment or service from a participating provider; and
- Enrollee requests that benefits continue pending outcome of fair hearing; and
- Period of original service authorization has not expired.

If aid continuing is granted, benefits will be reinstated by MMCO until:

- Fair hearing request is withdrawn by enrollee or representative; or

- The time period or service limits of the previously authorized service have been met; or
- The participating provider order expires; or
- An adverse fair hearing decision is issued.

### **MMCO ACTION APPEAL PROCESS**

Enrollee or designee will have no less than 60 business days and no more than 90 days from the date of the Notice of Action to file an in-plan Action Appeal.

May file orally or in writing, but oral must be followed by written, signed Action Appeal.

The MMCO must resolve the appeal as fast as enrollee's condition requires but no later than 30 days.

The MMCO must make reasonable effort to provide oral notice of determination when made, and must send written notice within two business days of determination.

Expedited Appeal must be resolved no later than three business days from date of receipt of Appeal.

### **ADVOCACY**

If services are discontinued prior to reassessment, remind the plan of their obligation to provide continued services until a new plan of care is put in place, and contact the vendor to determine if they participate with the consumer's MMCO.

Register a complaint with the State Department of Health's Managed Care Complaint Line at (800) 206-8125.

Contact the NYS Department of Health Division of Managed Care (518) 473-1134.

Submit timely request for Fair Hearing with Aid Continuing. Since a Fair Hearing trumps an internal or external appeal of the plan's action, if you obtain a favorable decision in the review process you should withdraw the request for a Fair Hearing.

Under the Model Contract, it appears that aid continuing may not be available where adverse change occurs at the point of reauthorization. Since this conflicts with due process principles articulated in several federal court decisions, there is uncertainty as to what the MMCOs will actually do. The Legal Aid Society would like to be kept informed of these cases, so please send us an email at [HLU@legal-aid.org](mailto:HLU@legal-aid.org).

The phrase "as fast as the enrollee's condition requires" is not defined in the regulations. Therefore, in cases where the condition warrants a prompt resolution, it would be helpful to include a statement from the enrollee's physician that speaks to the need.

Simultaneously file Appeal Action. Expedited review will result in faster resolution than FH or Appeal Action.