Medicaid Managed Care

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What is Medicaid Managed Care?

- Medicaid Managed Care (non-duals)
- Partial Cap Managed Long Term Care (duals and non-duals)
- Medicaid Advantage (duals)
- Medicaid Advantage Plus (duals)
- Program for All-Inclusive Care for the Elderly (duals)
- Fully Integrated Duals Advantage (duals)

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Care Management for All

- Medicaid Managed Care (MMC)
  - Current Enrollment: 3.5 million
  - Medicaid-only without other coverage
- Managed Long Term Care (MLTC)
  - Current Enrollment: 115,000
  - Medicaid-only at SNF LOC or Dual in need of 120+ days of LTC
- Medicaid Advantage (MA)
  - Current Enrollment: 10,000
  - Dual enrolled in Medicare Advantage Plan offered by MA Plan
- Medicaid Advantage Plus (MAP)
  - Current Enrollment: 5,000
  - Dual enrolled in Medicaid Advantage Plan offered by MAP Plan and at SNF LOC
- Program for All-Inclusive Care for the Elderly (PACE)-
  - Current Enrollment: 5,500
- Fully Integrated Dual Advantage (FIDA)
  - Targeted Enrollment: 160,000
  - Dual eligible over age 21 in Demonstration County and SNF LOC or in need of 120+ of LOC

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Federal & State Statutes

- SSA § 1903(m)
- SSA § 1932
- PHL Article 44
- PHL Article 49
- SSL 364-j

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Federal & State Regulations

- 42 CFR Part 438
- 10 NYCRR Part 98
- 18 NYCRR SubPart 360-10

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Utilization Management- Federal Requirements

- Practice Guidelines
- Written Policies and Procedures
  - No more restrictive that State Medicaid program
  - May not arbitrarily reduce amount, duration, or scope
  - Must be reasonably expected to achieve purpose
- Notice Requirements

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Utilization Management-State Requirements

- Medical Director
  - Supervision & Oversight
- Written Policies and Procedures
- Clinical Review Criteria
- Accessibility of Appropriate Personnel
- Adverse Determinations Made By Clinical Peer Reviewer
- Member and Provider Notice

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MMC & MLTC Contractual Requirements

- **Prescriptive Timeframes**
- **As fast as the enrollee's condition requires but no later than:**
  - Pre-authorization
    - Urgent-3 business days after receipt of request
    - Non-Urgent-3 business days after receipt of necessary information, no more than 14 days after receipt of request
  - Concurrent Review
    - Urgent-1 business day of receipt of necessary information, no more than 3 business days after receipt of request
    - Non-Urgent-1 business day of receipt of necessary information, no more than 14 business days after receipt of request
    - Home Health Care Exception After Hospitalization-1 business day of receipt of necessary information, except when subsequent day is weekend or holiday (72-hours), but no more than 3 business days
  - Extensions-14 days if in best interest of enrollee, decision within 1 business day of necessary information for concurrent requests and 3 days of necessary information for prior authorizations

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Notice-Initial Adverse Determination

- Initial Adverse Determination (IAD)
  - Description of Action
  - Right to File Appeal
  - Process & Timeframe
  - What Information Needed to make Determination on Appeal
  - Specific Clinical Review Criteria Relied On
- Fair Hearing Notices (MMC-only)
  - DOH Prescribed Form
  - Completed with Enrollee Information, Requested Service, and Reason for Denial

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Appeals

- Internal Appeals
  - Mandated to have 1 level of appeal
    - Must be Reviewed by Clinical Peer Reviewer not involved in 1st determination
  - Can have additional levels of appeal
    - Some plans opt to allow appeal to Board or Committee reporting to Board
    - Timeframe runs at same time as External
- Final Adverse Determination (FAD)
  - Results and Reasons for Determination Including Clinical Rationale
  - External Appeal timeframe and applications
- Fair Hearing Notices (MLTC)
  - DOH Prescribed Form
  - 60 Days to file

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Fair Hearings

- All MCO Decisions Subject to Fair Hearing
  - Must be filed within 60 days of first denial (MMC) or 60 days of appeal denial (MLTC)
  - Must be filed within 10 days to receive Aid to Continue
- Conducted by OTDA
  - Scheduling
  - Orders Aid to Continue
  - Determines Home Bound Status
  - Manages Requests for Adjournments and Withdrawals

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Fair Hearings

- MCO required to appear, but may request waiver of appearance
- Obligation to Provide Evidentiary Packet
- Denials-Burden on Beneficiary
- Terminated or Reduced Services-Burden on Plan

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External Appeals

- Application filed within 45 days of Final Adverse Determination
- Fee Waived for Medicaid Recipients
- Right to External Appeal
  - Medical Necessity Denials
  - Out of Network Denials

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FIDA Initial Determinations

- IDT makes most service authorization determinations pursuant to a plan of care
- Occasional Periodic Episodic Authorizations
  - Cannot wait one day, health care professional member of IDT authorizes
  - Can wait one day, must notice IDT members and give opportunity for input
- Denials must go to FIDA medical director

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FIDA Appeals

- Integrated Appeals Process
- Internal Appeals
  - 60 calendar days to file
  - For aid continuing, must file within 10 calendar days
  - Decision within 72 hours for expedited or 30 calendar standard

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FIDA Appeals, con't

- Automatic Administrative Hearing—Fair Hearing
  - Benefits continue pending appeal
  - Decision within 90 days of request (30 days in subsequent years)
- Medicare Appeals Council
  - Decision within 90 days of request
- Federal District Court

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Other Requirements

- Person Centered Planning
  - Must consider total needs of patient when reducing/denying
- Service Authorization Linked to Case Management
- Participating in Discharge Planning

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Best Practices

- Document, document, document—if it isn't written, it doesn't exist
- Submit **all** relevant records
- Advocate
  - Discuss with Care Manager
  - Cover letters
  - Specify what is unique

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Common Problems

- Reductions not supported by assessments
- Reductions without documented change in circumstances
- Delayed authorizations for new period

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Common Problems, con't

- Reduction in skilled services without considering incidental PCS
- CDPAS with other home services
- Discharge planning from SNF
- LTHHCP Transition

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Upcoming Solutions

- 10 days notice before action
- No reductions or terminations on non-business days
- Aligning transitional care policies across LTC benefits
- Transitions from MMC to MLTC

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Providers Have Rights Too

- Adverse Determination Notices Must Be Sent to Requesting Provider
- Request Reconsideration if adverse determination made without attempting to discuss
- Appeal Retrospective Adverse Determinations (i.e., non-payment for rendered service)
- External Appeal for concurrent or retrospective denials
- “Enrollee Designee”

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- Questions

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