Managed Long Term Care
Frequently Asked Questions and Answers- #2

Q1. Will Long Term Home Health Care Provider's be allowed to directly contract with Care Coordination Model's as a downstream service provider?

A1. Yes.

Q2. How does a plan withdraw an application in NYC once Maximus has already processed it? Do they contact Maximus directly or can it be done electronically?

A2. Withdrawals must be handled by HRA on a case by case basis. Maximus provides the consumer with education to avoid unnecessary withdrawals.

Q3. If a consumer chooses a plan within the 60 day timeframe they have to choose a plan upon receiving the mandatory enrollment packet, the plan has 30 days to do an assessment. The Department orally stated that continuity of care begins during patient's effective enrollment date.

a. What does that mean?

A: The effective date of enrollment is the first day of the month.

b. Does that mean the plan's assessed hours are effective on the patient's enrollment date?

A. Yes, the Continuity of Care policy applies. Receiving plans must honor the pre-existing service plan for at least 60 days after enrollment, or until a care assessment is completed whichever is later.

c. How will new users and plan to plan transfers be treated?

A. New users will be assessed by the plan and develop a plan of care. If the new user agrees with the care plan an enrollment agreement is signed. For plan to plan transfers the policy is the same.

d. How will plan to plan transfers be treated for involuntary disenrollment?

A. For plan to plan transfers, no assessment prior to enrollment is required and the continuity of care policy applies. The receiving plan must assess within 30 days of enrollment. The receiving plans must honor the pre-existing service plan for at least 60 days after enrollment, or until a care assessment whichever is longer.

e. Does the transition policy apply to people who received the mandatory enrollment packet?

A. Yes.

f. Does the transition policy apply to consumers who are auto-assigned?

A. Yes.

Q4. Was/will an addendum that fleshes out the requirements for personal care, similar to the one that was included in the mainstream contracts, be added to the Managed Long Term Care contracts, and if so, when?

A4. No, policy guidelines do not have to be part of contracts to be applicable.

Q5. If a member who wishes to voluntarily transfer from one MLTC to another, this will now be considered a transfer. Are these members considered voluntary and are they still covered under this transition? Also, does this hold true for PCS members in an MCO who wish to voluntarily transfer to an MLTC?

A5. For plan to plan transfers, no assessment prior to enrollment is needed and continuity of care policy applies or until a care assessment is completed. Medicaid only MCO members consumers must be assessed by a MLTCP prior to enrollment and must need more than one hundred twenty (120) days of community based long term care services and meet the nursing home level of care.

Q6. Will eligibility for MLTC be tied to the SAAM in mandatory counties?

A6. In mandatory counties, eligibility for Managed Long Term Care will not be tied to the SAAM score for partial managed long term care plans. Nursing home level of care remains a requirement for PACE, MAP and Medicaid only consumers.

Q7. If I am a dual eligible consumer, must I enroll in a MLTC?

A7. If you are a dual eligible consumer over 21, require CBLTC for more than 120 days and reside in a county that has been approved by CMS for mandatory enrollment, you are required to join a Managed Long Term Care plan to continue receiving community based long term care services per state law.

Q8. Can a plan disenroll someone who does not pay their spend down?

A8. Yes.

Q9. Are MLTC plans responsible for paying a member's Medicare co-pay for skilled rehabilitation services provided in a skilled nursing facility?

A9. Yes.

Q10. Has the date for CDPAP transition changed?

A10. The transition to MLTC and mainstream managed care for CDPAP is now 10/1/2012.