

Mandatory Managed Long-Term Care in New York's Medicaid Program: Key Eligibility and Enrollment Issues

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The Medicaid Institute at United Hospital Fund is working to improve the Medicaid program in New York by providing information and analysis and developing a shared vision for change.

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Since 2012, New York State has been implementing mandatory managed long-term care (MLTC) for Medicaid beneficiaries relying on community-based long-term care services and supports for the frail elderly and physically disabled, such as personal care, home health services, and private duty nursing.

This issue brief provides an overview of New York State's mandatory MLTC enrollment policy, including the implementation schedule and beneficiaries' plan options. It examines the growth in overall managed long-term care enrollment from 2010 to 2013, as well as growth by region and product line. Lastly, it discusses key operational issues related to the major changes in eligibility and enrollment processes triggered by shifting a substantial number of high-need Medicaid beneficiaries from fee-for-service into managed care.

Since the formation of the Medicaid Redesign Team in 2011, New York State has been pursuing and implementing landmark Medicaid reforms that aim to transform how the program pays for services—and ultimately how care is delivered to Medicaid beneficiaries. The goal of these reforms is to improve the quality and effectiveness of care while containing costs. They are primarily aimed at Medicaid’s most complex and costly beneficiaries and the specialized services they depend on, which generally remain in a fee-for-service (FFS) model and still account for most of New York’s Medicaid spending.

An overarching principle of these ongoing Medicaid reforms is care management for all beneficiaries across the spectrum of physical health, behavioral health, and long-term care services and supports. This goal will be achieved by a combination of policy changes: (1) expanding the scope of existing managed care plans, (2) authorizing new types of managed care plans specializing in services previously delivered principally through FFS, and (3) expanding the application of mandatory enrollment in managed care. Ultimately, under the State’s vision for Medicaid, managed care’s dominance as a model will extend far beyond what has been called “mainstream” managed care—which focuses on primary and acute care—and will include long-term care, behavioral health care, and services for individuals with developmental disabilities.

This issue brief first provides an overview of the State’s mandatory MLTC enrollment policy, including the implementation schedule and beneficiaries’ plan options. Second, it examines the growth in managed long-term care enrollment between December 2010, before the mandatory policy was proposed, and October 2013. It also examines enrollment growth by region and product line, as well as the accompanying changes to the structure of the MLTC market. Third, it discusses key operational issues related to the major changes in eligibility and enrollment processes mandatory MLTC has triggered. This section relies on interviews and conversations with plans, providers, consumer advocates, and State officials. These operational issues have implications for the continued expansion of mandatory MLTC across the state, the rollout of New York’s Fully Integrated Duals Advantage (FIDA) demonstration program, and the

implementation of managed care for other specialized populations in New York's Medicaid program.

When the mandatory enrollment policy was proposed in January 2011, New York already had a significant and mature MLTC market: 30 managed long-term care plan offerings across three different product lines, in all of which the plan accepted full financial risk for long-term care services. This is why mandatory MLTC enrollment is preceding the State's planned shift to managed care for those relying heavily on behavioral health care and for the developmentally disabled.

Advancing the policy of mandatory enrollment in MLTC is also closely tied to the design and implementation of New York's FIDA demonstration program, which was authorized by the Affordable Care Act and approved by the Centers for Medicare & Medicaid Services (CMS) in August 2013. Under FIDA, a large share of the Medicaid beneficiaries covered by mandatory managed long-term care, as well as some residing in nursing homes, will be enrolled in plans that deliver an integrated benefit including all acute care, long-term care, and behavioral health services covered under both Medicaid and Medicare. Many of the MLTC plans will also likely be involved in FIDA. FIDA's coverage is slated to begin in October 2014.

Key Details of the Mandatory MLTC Enrollment Policy

Requiring enrollment in an MLTC plan for a large share of Medicaid beneficiaries using LTC services and supports on a fee-for-service basis was included in the package of 78 Medicaid Redesign Team reforms enacted into law in the New York State budget for fiscal year 2011-2012. In August 2012 New York received the necessary approval from CMS to require enrollment in a managed long-term care plan for Medicaid beneficiaries age 21 and older who are eligible for Medicare (dual enrollees, often referred to as duals) and who require home- and community-based long-term care services and supports for at least 120 days.

The services and supports counting toward the 120-day threshold include personal care services (both traditional and consumer-directed), certified home health agency (CHHA) services, medical adult day care services,

private duty nursing services, and some 1915(c) waiver program services, including Long-Term Home Health Care Program (LTHHCP) services. Medicaid beneficiaries enrolled in other 1915(c) waiver programs, including Nursing Home Transition and Diversion waiver participants and Traumatic Brain Injury waiver participants, are currently excluded from the mandatory enrollment policy.¹ Nursing home and assisted living facility residents are also currently excluded from mandatory enrollment. Additionally, duals aged 18 to 21 meeting the 120-day LTC threshold, and non-duals 18 and older and duals aged 18 to 21 assessed as nursing home eligible may voluntarily enroll in a managed long-term care plan.² Non-duals of all ages assessed as nursing home eligible are required to join a mainstream managed care plan or can elect an MLTC plan if they meet the MLTC eligibility requirements.

Medicaid beneficiaries subject to mandatory MLTC enrollment, and those choosing to enroll voluntarily, can select from three different types of plan: MLTC Partial Capitation, Program of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus.

MLTC Partial Capitation plans receive a monthly premium from Medicaid to cover long-term care services and supports, including home health services, personal care, adult day care, and nursing home care. Partial Capitation plans are not financially responsible for primary and acute care services; however, they are contractually required to coordinate with physical health care providers in order to promote better care management.

Program of All-Inclusive Care for the Elderly (PACE) plans offer the full range of Medicare and Medicaid acute and long-term care services to duals aged 55 or over who are eligible for a nursing home level of care. PACE places a particular emphasis on serving frail elderly duals, and it uses an adult day health center as the primary site for care coordination. PACE plans receive capitated payments from both Medicare and Medicaid.

¹ New York State Department of Health. February 2013. Managed Long Term Care Mandatory Enrollment (MRT#90). Report to the Governor and Legislature, February 2013. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-02_mltp_legislative_report.pdf (accessed March 26, 2014).

² New York State Department of Health. February 16, 2012. Mandatory Managed Long Term Care Enrollment Plan. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-02-26_mltp_enrollment_plan.pdf (accessed February 20, 2014).

Medicaid Advantage Plus (MAP) plans offer the full range of Medicare and Medicaid acute and long-term care services to duals eligible for a nursing home level of care. Participating plans finance all covered services and receive monthly premiums from both Medicare and Medicaid.

Implementation Schedule

The State is phasing in mandatory MLTC enrollment by region. Approaching the rollout geographically capitalized on the fact that managed long-term care plans operating downstate were poised to expand and cover the larger numbers of beneficiaries resulting from the mandatory enrollment policy.

In New York City, the policy was phased in gradually beginning in the fall of 2012; it is now fully implemented. Phasing in enrollment by service type helped ensure that the monthly enrollment volume was manageable for the plans. It also gave the State time to identify existing beneficiaries who qualified for mandatory enrollment. In Westchester, Nassau, and Suffolk Counties, the policy began in January 2013, though there was no phase-in

Rolling Out Mandatory MLTC by Region

New York City

July 2012: Medicaid beneficiaries already receiving traditional (non-consumer-directed) personal care on an FFS basis were the first beneficiaries notified of the mandatory enrollment policy. Manhattan residents were notified first, followed by those in the Bronx and Brooklyn, and then those in Queens and Staten Island through the fall of 2012.

September 2012: New-to-service Medicaid beneficiaries in New York City needing traditional personal care services for at least 120 days were required to enroll in an MLTC plan.

November 2012: New York City beneficiaries receiving services through the Consumer-Directed Personal Care Program were required to enroll in MLTC if they met the 120-day service threshold.

January 2013: Mandatory enrollment expanded to beneficiaries using medical adult day services, CHHA services, and private duty nursing.

June 2013: New-to-service applicants for the LTHHCP were required to enroll in an MLTC plan instead.

July 2013: Current LTHHCP enrollees were required to enroll in MLTC.

Westchester, Nassau, and Suffolk

January 2013: Policy began in these three downstate counties.

June 2013: New-to-service applicants for the LTHHCP were required to enroll in an MLTC plan instead.

July 2013: Current LTHHCP enrollees were required to switch to MLTC.

Other Counties

September 2013: Orange and Rockland.

December 2013: Albany, Monroe, Erie, and Onondaga.

April 2014: Columbia, Putnam, Sullivan, and Ulster.

May 2014: Rensselaer, Cayuga, Herkimer, and Oneida.

June 2014: Greene, Schenectady, Washington, and Saratoga.

July 2014: Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, and Oswego.

August 2014: Warren, Delaware, Niagara, Otsego, and Chenango.

September 2014: Essex, Clinton, Franklin, and Hamilton.

October 2014: Jefferson, Lewis, St. Lawrence, Steuben, Chautauqua, Cattaraugus, and Allegany.

November 2014: Yates, Seneca, Schuyler, Tioga, Cortland, and Chemung.

December 2014: Genesee, Ontario, Livingston, Orleans, Tompkins, Wayne, and Wyoming.

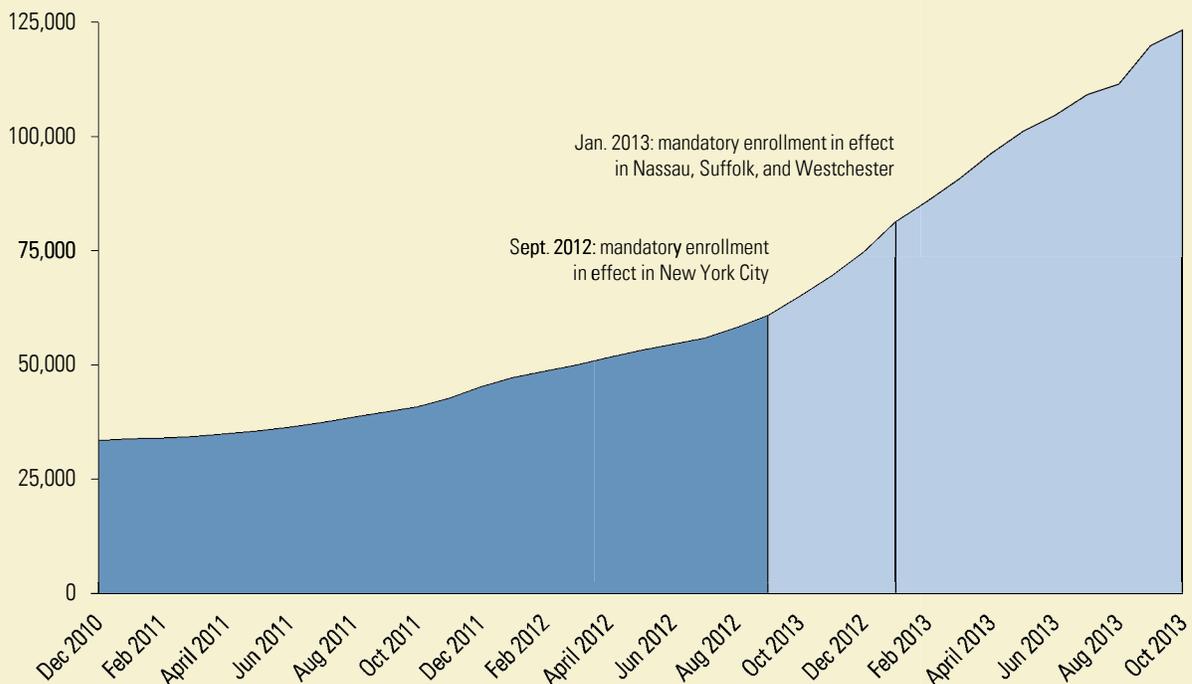
by service type (except for the LTHHCP, which required separate CMS approval). Mandatory enrollment began in other counties in September 2013 and will continue over the course of 2014.

MLTC Enrollment Trends

In December 2010, MLTC enrollment stood at about 33,000. By October 2013, enrollment had almost quadrupled to 123,000. As shown in Figure 1, growth in enrollment varied during different phases of policy implementation.

- Between December 2010 and July 2012, total MLTC enrollment increased by 22,397 enrollees (25 percent of the total enrollment growth through October 2013). These enrollments were purely voluntary; during this period there were increasingly concrete discussions about the upcoming policy change, but this component of the enrollment increase preceded formal notices of mandatory enrollment.

Figure 1
MLTC Enrollment in New York, December 2010 to October 2013



Note: Enrollment numbers include Partial Capitation, PACE, and MAP, statewide.

Source: UHF analysis of NYS DOH Medicaid Managed Care Enrollment Reports, available at: http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

- Formal notices from the State about mandatory enrollment began to reach beneficiaries in July 2012, though the mandatory enrollment policy was not effective until September 2012. Between July 2012 and September 2012, MLTC enrollment grew by 4,993 enrollees (6 percent of total enrollment growth).
- From September 2012 to December 2012, the first four months when mandatory enrollment was in effect, MLTC enrollment grew by 20,499 enrollees (23 percent of total enrollment growth). This is the period in which personal care recipients residing in New York City, the largest single cohort of the policy's target population, were enrolled. Consistent with the size of this cohort, almost a quarter of the total growth in MLTC enrollment occurred during these four months.
- Between January 2013 and July 2013, when mandatory MLTC enrollment expanded to Nassau, Suffolk and Westchester counties and to all current beneficiaries except those enrolled in the LTHHCP, MLTC enrollment grew by 27,749 enrollees (31 percent of total enrollment growth).
- Between July 2013 and October 2013, when MLTC expanded to include LTHHCP enrollees and beneficiaries in Orange and Rockland counties, MLTC enrollment grew by 14,179 (16 percent of total enrollment growth).

Partial Capitation is the dominant model within New York's MLTC market. Partial Capitation enrollees accounted for 86 percent of all MLTC enrollees in December 2010 and 92 percent by October 2013; they also accounted for 94 percent of the increase in enrollment over this period. The share of MLTC enrollees in PACE plans declined from 11 percent in December 2010 to 4 percent in October 2013, and the share of MLTC enrollees in MAP plans remained at 4 percent (Figure 2).

Since Partial Capitation plans make up most of MLTC enrollment and MLTC's growth since 2010, we focus our analysis on this model.

Partial Capitation Enrollment by Region

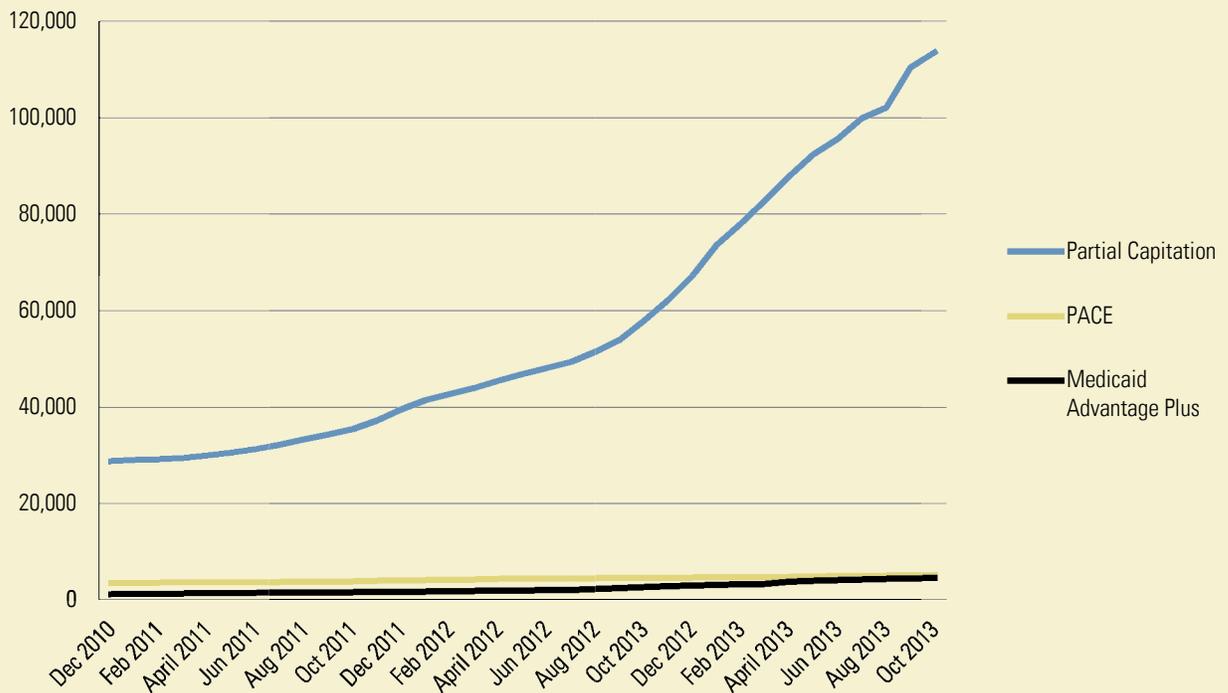
New York City residents accounted for 93 percent of statewide enrollment in Partial Capitation plans in December 2010, before implementation of the mandatory enrollment policy. This share remained relatively stable and

reached a high of 95 percent in January 2012. By October 2013, it had fallen to 87 percent. This trajectory is consistent with the implementation of the mandatory enrollment policy. (See implementation timeline on page 5.) By October 2013, Nassau, Suffolk, and Westchester counties combined represented twice the share of New York’s Partial Capitation enrollment that they did in December 2010 (6 percent, up from 3 percent); this share is expected to increase as mandatory enrollment is fully implemented. The share of Partial Capitation enrollment attributable to the rest of the state remains low: 4 percent in December 2010 and 2 percent in October 2013. Enrollment trends by region are shown in Figure 3.

Enrollment by Partial Capitation Plan

In December 2010, there were 14 Partial Capitation plans in New York State. By October 2013, the number had nearly doubled to 27 plans and the market had become less concentrated. In December 2010, the three plans with the largest numbers of enrollees accounted for two-thirds of enrollment (67 percent). By October 2013, enrollment was more diffuse but

Figure 2
MLTC Enrollment by Plan Type, December 2010 to October 2013

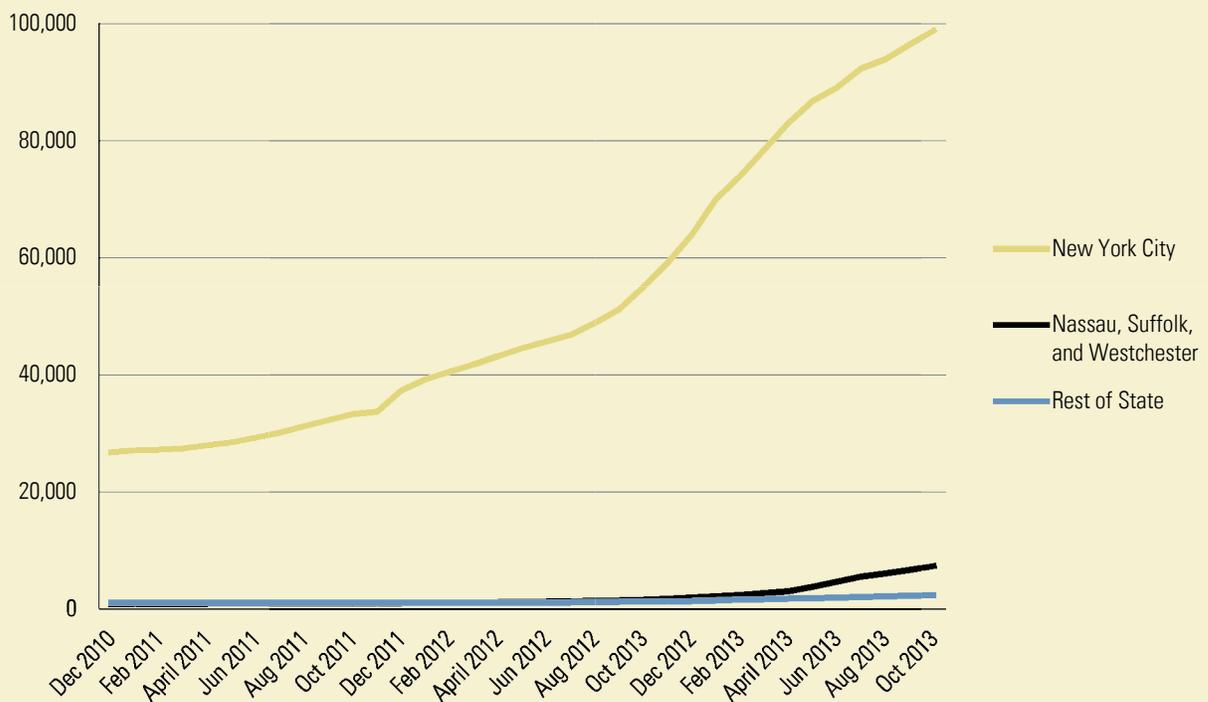


Source: UHF analysis of NYS DOH Medicaid Managed Care Enrollment Reports, available at: http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

still somewhat concentrated; the top three plans accounted for 40 percent of enrollment and the top six plans accounted for two-thirds of enrollment (68 percent). However, the current Partial Capitation market appears ripe for consolidation: as of October 2013, there were 17 plans that each had less than 3 percent of total enrollment, an average of just over 800 enrollees per plan. Once mandatory enrollment is fully implemented, there will no longer be large enrollment influxes and plans with fewer enrollees will likely experience financial challenges associated with spreading fixed costs over a small enrollee base in a competitive environment.

Enrollment growth varied substantially across plans. The two plans with the most enrollees in December 2010, VNS Choice and Guildnet, retained the two largest shares of enrollment in October 2013. However, their collective share of all enrollees declined from 57 percent to 29 percent. These two plans experienced the smallest growth in percentage terms, doubling their

Figure 3
Partial Capitation Enrollment by Region, December 2010 to October 2013



Source: UHF analysis of NYS DOH Medicaid Managed Care Enrollment Reports, available at: http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

enrollment, while plans that were smaller in December 2010 increased their enrollment by larger multiples: 12-fold (Elderplan), 19-fold (Fidelis), and 55-fold (Elderserve).

Table 1
Ten Largest Partial Capitation Plans in New York State, October 2013

Name	October 2013		Rank by Enrollment (12/10)	December 2010		Enrollment Growth from 12/10 to 10/13
	Enrollment	Share of Enrollment		Enrollment	Share of Enrollment	
VNS Choice	17,974	17%	1	8,668	33%	107%
Guildnet	13,931	13%	2	6,286	24%	122%
Elderplan*	10,787	10%	8	934	4%	1,055%
Senior Health Partners, Inc.	10,535	10%	3	2,498	10%	322%
Elderserve	10,064	9%	12	184	1%	5,370%
CCM Select	9,854	9%	4	1,838	7%	436%
Fidelis Care at Home	7,185	7%	11	382	1%	1,781%
Wellcare	5,210	5%	6	1,200	5%	334%
Independence Care Systems	4,925	5%	5	1,615	6%	205%
Amerigroup	2,875	3%	9	903	3%	218%
All Others	15,114	3%		677	14%	2,132%
Total	108,454	100%		25,185	100%	331%

* Elderplan launched in January 2011 and merged with Homefirst in February 2011; the merged entity operates under the name Elderplan. In this table, the December 2010 enrollment attributed to Elderplan consisted of beneficiaries enrolled in Homefirst.

Source: UHF analysis of NYS DOH Medicaid Managed Care Enrollment Reports, available at: http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Implementing New Eligibility and Enrollment Processes under Mandatory Enrollment

In less than three years, the State has shifted from a home- and community-based LTC system that was mostly FFS to a managed care model.³ This section reviews some of the key processes and issues related to the administration of eligibility determinations and plan enrollment under mandatory MLTC. In addition to their ongoing relevance to the continued expansion of mandatory MLTC enrollment statewide, these operational issues also apply to future implementation of mandatory managed care for

³ An accompanying brief, *Home- and Community-Based Long-Term Care in New York's Medicaid Program: New Data on Service Use and Spending*, presents more data on this shift.

duals under FIDA, for Medicaid beneficiaries with substantial behavioral health care needs, and for beneficiaries with developmental disabilities.

This section considers the key issues in four distinct but related areas of eligibility and enrollment policy and operations under mandatory MLTC—eligibility determinations, notification processes and consumer education, marketing and plan selection, and automatic assignment to a plan.

Eligibility Determinations

Changes to the eligibility standard. One of the most significant changes inherent in the move to managed long-term care is the new eligibility standard for home- and community-based services. Once an individual has satisfied Medicaid eligibility criteria related to income and assets, eligibility for mandatory managed long-term care for duals is based on the assessed need for 120 or more days of care across a spectrum of community-based long-term care services. Under the prior fee-for-service system, eligibility for Medicaid long-term care services varied by program or service type and beneficiaries needed to have a nursing home level of care to enroll in a Partial Capitation managed long-term care plan.⁴ In other words, duals' eligibility for Medicaid home- and community-based long-term care services has shifted from a standard based on a person's functional deficit score to a standard based on how many days of services he or she requires.

Ongoing implementation issues. As with any transition involving a large volume of Medicaid beneficiaries, unforeseen technological limits of the antiquated Welfare Management System can create delays in eligibility processing. Voluntary MLTC enrollment by some formerly excluded individuals required a manual override of exclusion codes that delayed enrollment. This example underscores the importance of timely reporting of any enrollment issues through feedback channels established by the Department of Health.

⁴ Hokenstad A, M Shineman, and R Auerbach. May 2009. *An Overview of Medicaid Long-Term Care Programs in New York*. New York: United Hospital Fund. Available at <http://www.uhfnyc.org/publications/880507> (accessed February 20, 2014).

Clearly communicating key eligibility changes to beneficiaries and other stakeholders will prevent unnecessary and unintended disenrollment and loss of services. For long-term care recipients, eligibility processing for spend-down beneficiaries is substantially different under managed care than it was under fee-for-service. Under the FFS system, spend-down beneficiaries submitted documentation, usually invoices, showing that they incurred enough medical expenses to lower their income to below Medicaid's income limit; however, they did not need to provide proof that they had paid these expenses. Once enrolled in an MLTC plan, however, a spend-down beneficiary is required to pay his or her required share of costs to the plan each month, and MLTC plans are permitted to involuntarily disenroll beneficiaries who do not pay their spend-down share within 30 days.⁵

Additional guidance on helping enrollees maintain Medicaid eligibility during the annual renewal process could help strengthen beneficiaries' access to and continuity of care. Plans have a contractual requirement to assist their members with the renewal of their Medicaid benefits, but they might be more inclined to help with maintaining eligibility if specific requirements and activities are laid out in policy guidance and accounted for in premium calculations.

There is an opportunity and perhaps a need for the State to educate providers and local departments of social services (LDSS) in counties new to mandatory enrollment on MLTC's major policy design and implementation issues. Managed long-term care is a relatively new concept in areas outside of New York City and the three downstate counties that constituted the initial mandatory enrollment region. LDSS staff may be unfamiliar with the differences in eligibility processing for MLTC enrollment. Currently, plans spend their own resources to educate providers and LDSS staff in these areas in order to prepare them for mandatory MLTC enrollment so that the plans can operate in these areas.

⁵ New York State Department of Health. January 1, 2011. MLTC model contract, Article V, Section D5(b)1h, page 15. Available at http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_contract.pdf (accessed February 20, 2014).

Changes to the functional assessment process. By the end of mandatory MLTC implementation, the responsibility for determining whether a beneficiary meets the eligibility criteria will have shifted twice. First, this responsibility has already moved from the local department of social services to the MLTC plans; second, by December 2014 this responsibility will transfer from the plans to an independent third party.

Before mandatory enrollment, Medicaid enrollees who needed FFS community-based long-term care services or 1915(c) waiver program services applied for them through their LDSS office, which determined financial and functional eligibility. Now, under the mandatory enrollment policy, the managed long-term care plan conducts a functional assessment that will confirm whether the beneficiary meets the MLTC eligibility criteria and will be used by the plan to determine the appropriate array and level of services. A current exception is that new-to-service beneficiaries, who cannot yet enroll through the statewide enrollment broker, must contact MLTC plans directly to request that the plan conduct a functional assessment to see whether they meet the 120-day eligibility standard for duals. To comply with changes accompanying New York's Partnership Plan Medicaid waiver, by December 2014 the State will begin implementing an independent and conflict-free assessment system for newly eligible Medicaid beneficiaries.⁶ Functional assessments will be conducted by an independent third party, not by the MLTC plans.

Ongoing implementation issues. Starting in September 2011, before mandatory MLTC began, plans were required to conduct the functional assessments previously undertaken by local departments of social services. For the most part, plans were able to complete these assessments within the mandatory MLTC 90-day transition period, with some lags during high-volume periods. Plans that used in-house staff had to recruit and train more staff than before. Plans that used contract staff or a mix of in-house and contract staff for assessments were able to accommodate larger enrollments by quickly adding more staff. However, plans that depended heavily on

⁶ Centers for Medicare & Medicaid Services. April 2013. Special Terms and Conditions for New York's Partnership Plan Section 1115(a) Medicaid Demonstration. Pages 21-22. Available at http://www.health.ny.gov/health_care/managed_care/appextension/docs/special_terms_and_conditions_04_2013.pdf (accessed March 6, 2014).

contract staff to process enrollments also had to build proper accountability and oversight mechanisms.

The upcoming shift in responsibility for conducting the functional assessments to an independent third party may pose operational challenges for plans that have dedicated significant resources to expanding this capacity during the initial phase of mandatory enrollment. It may also add administrative costs systemwide, as plans will still need to maintain the staff for regularly scheduled follow-up assessments. Switching to an independent assessment will, however, alleviate concerns that plans have the incentive to enroll less impaired beneficiaries. This concern was exemplified by the enrollment of beneficiaries whose primary service use was social adult day care and who were determined ineligible for MLTC in April 2013. (The MLTC eligibility criteria with regards to social adult day care have since been clarified; social adult day care does not count towards the eligibility threshold of 120 days of service.)

Notification Processes and Consumer Education

The State's role. Effectively communicating with beneficiaries during the implementation of the mandatory enrollment policy is vital. With the goal of preventing or at least mitigating confusion among beneficiaries, the State has instituted an extensive notification process for Medicaid beneficiaries who previously received FFS community-based long-term care services and are now subject to mandatory enrollment. Communicating effectively about a major change in pathways to care with every beneficiary in a large cohort of Medicaid beneficiaries is a major challenge; this is just as true today for implementing mandatory MLTC as it was two decades ago during the initial implementation of mandatory mainstream managed care.

Current Medicaid beneficiaries newly subject to mandatory MLTC enrollment first receive an announcement letter that explains the mandatory policy while telling them that no action is yet required. The letter directs beneficiaries to call New York Medicaid Choice, the enrollment hotline administered by Maximus, with any questions. This initial mailing includes a list of MLTC plans available in the beneficiary's county,

differentiating them by type (Partial Capitation, PACE, and MAP).⁷ Thirty days after receiving this announcement letter, beneficiaries receive an enrollment letter informing them they have 60 days to choose and enroll in a managed long-term care plan, and urging them to call the enrollment hotline.⁸ The MLTC options brochure, which describes in detail the differences between the three types of MLTC plans, is included in the packet with the enrollment letter.⁹ Reminder letters are sent 30 and 45 days after the initial enrollment letter. The second of these letters includes the name of the plan to which the beneficiary will be automatically assigned if no choice is made. If the beneficiary does not enroll in a plan, he or she receives an auto-assignment packet 60 days after the initial enrollment letter.

In addition to the notification process materials, the State released regional consumer guides for New York City, Westchester, and Long Island, which provide quality metrics for plans that were in operation in 2011, the most recent period for which the State had quality data.

Ongoing implementation issues. An ongoing concern is that low health literacy in this population may impair their ability to comprehend the letters and enclosed supplemental materials. Health literacy will continue to be an issue as the mandatory enrollment policy expands to upstate counties, especially since some of these counties have not had significant managed care penetration. Some beneficiaries are confused by the announcement letters since these letters say that no action is required at this time and do not include enrollment deadlines. Many beneficiaries do not understand the differences between the three types of plans available, despite the explanation provided in the MLTC brochure. More broadly, there is concern that the mailings do not adequately explain how the new enrollment process differs from the former process under FFS, raising the potential for involuntary disenrollment and loss of access to services.

⁷ New York Medicaid Choice. New York City Managed Long Term Care Plans. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-17_announce_itr_plan_list.pdf

⁸ Notice available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/1.1-am_notice-english-unenrolled.pdf (accessed February 20, 2014).

⁹ New York Medicaid Choice. Medicaid Managed Long Term Care: Your Options for Home Care and Other Long Term Care Services. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_guide_e.pdf (accessed February 20, 2014).

Overall, stakeholders believe that the enrollment broker, Maximus, is doing a good job informing beneficiaries about their plan options considering that enrollment counselors cannot make specific plan recommendations.

While the population making the transition from FFS to MLTC receives multiple notices directly from the State, there is no standardized consumer education for new-to-service beneficiaries that explains the separate MLTC eligibility process for these beneficiaries. As described above, new-to-service beneficiaries cannot use the State's enrollment broker and must contact an MLTC plan directly. The State is relying on LDSS staff and consumer advocates to explain and direct new-to-service beneficiaries throughout the MLTC application process.

Marketing and Plan Selection

The State's role. By closely monitoring plan marketing activities and the information consumers use to select a plan, the State aims to ensure that consumers are able to make meaningful choices based on complete and accurate information. Per MLTC contract requirements, the Department of Health approves each managed care plan's MLTC marketing plan. The plan must describe in detail the specific activities being undertaken, identify the personnel who will carry out the marketing functions, and submit for approval any proposed marketing materials. The State prohibits direct marketing activities by phone and in person, and it limits nominal gifts used during marketing activities to \$5 in value.

Ongoing implementation issues. As mandatory MLTC expands throughout the rest of New York, including areas that have had less experience with managed care, plan marketing activities warrant attention from the State. This is especially important during the period before notification letters have been mailed, because at that early stage plan marketing will likely be beneficiaries' first or only source of information about MLTC. There have been anecdotal reports that, early on, some plans engaged in expressly prohibited marketing activities, such as offering gifts above the \$5 limit. Such behavior tended to occur during the enrollment periods after the policy shift was announced but before mandatory enrollment officially began. It is not surprising that the plans would actively market themselves during this period since they need high enrollment to cover their fixed

costs, and plans with brand recognition have naturally been able to attract more enrollees.

Additional guidance on whether providers can share information on provider networks with beneficiaries will be important for preserving consumer choice going forward. As of January 2014, plans can engage in selective contracting, and providers may try to steer beneficiaries into plans that pay higher rates. The State's March 2013 guidance explicitly prohibits providers from telling clients that they have to enroll in an MLTC plan within a specific timeframe or from disseminating any information regarding mandatory enrollment requirements, but it does not specifically regulate sharing information on provider networks.¹⁰

Although the MLTC consumer guide clearly states that beneficiaries have an opportunity to switch plans each month, changing plans has been problematic since there is no standardized disenrollment process, particularly with respect to sharing the care plan developed by the previous plan. In addition, the State's administrative processing of disenrollments involves a time lag: the roster given to the plans at the beginning of each month may include people who have disenrolled, which can leave plans exposed and can pose operational challenges for continuity of care for beneficiaries.

Auto-Assignment

The State's role. As with the expansion of mainstream Medicaid managed care, the State and consumer advocates would like to ensure that as few beneficiaries as possible are automatically assigned to a plan without actively selecting one. In addition to reflecting consumer choice, care coordination will work better if beneficiaries actively choose a plan, because after going through the selection process, they (and their family members and caregivers) will be better connected and more prepared to participate in proactively managing their care in concert with the plan's care management team.

¹⁰ Office of Health Insurance Programs, Division of Long Term Care. March 13, 2013. MLTC Policy 13.06: Marketing Guidelines for Managed Long Term Care Plans and Medical Service Providers. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_06_marekting_guidelines.pdf (accessed February 20, 2014).

Ongoing implementation issues. Plans have encountered difficulties reaching auto-assignees to process their enrollments, which can hinder continuity of care and access to services. There is often incomplete contact information for such beneficiaries, and sometimes they refuse to allow the plans to conduct the functional assessment or provide in-home services. Outreach challenges are compounded when the auto-assignee has cognitive impairment. Plans report that it costs them far more to enroll someone who has been automatically assigned than someone who actively selected the plan. Fortunately, since there have been relatively few auto-assignments, this has not been a major operational or financial challenge.

Conclusion

Over the last two years, New York State has rapidly and ambitiously shifted away from fee-for-service reimbursements for home- and community-based long-term care services and supports. Under the managed care model, it has become a purchaser of long-term care benefits from managed care plans, with oversight and regulatory responsibilities for the plans that now pay service providers and coordinate a beneficiary's care. In moving away from the fee-for-service system, the State hopes that instituting a fixed capitation payment and care coordination across a fragmented delivery system will foster efficiency and improve the quality of care. As enrollment in MLTC plans rapidly expands, the State's role in monitoring plans is becoming increasingly important for the successful attainment of these goals.

The first phase of the mandatory MLTC rollout has highlighted the important roles the State plays in the eligibility and enrollment process. The State plays a critical role in ensuring that beneficiaries are well-informed consumers, that they actively select MLTC plans, and that they are engaged in their care management in concert with their plan. These roles will be reprised during the implementation of FIDA and other new specialized managed care plans for Medicaid beneficiaries with behavioral health needs and developmental disabilities.