

Office of Health Insurance Programs

Division of Long Term Care

Managed Long Term Care Policy 13.10: MLTC Policy Guidance – Communication with Recipients Seeking Enrollment and Continuity of Care

Date of Issuance: May 8, 2013

The purpose of this policy is to establish clear expectations for plan communication with Medicaid recipients who either contact a plan directly expressing interest, or who are being transitioned from fee-for-service to Managed Long Term Care (MLTC). The policy will also apply to recipients who approach a plan seeking information on plan to plan transfer.

In dealing with interested parties, plan representatives are permitted to screen out potential enrollment only with regard to establishing residency in the plan's approved service area and/or plan specific age requirements. Medicaid eligibility issues are to be referred to the Local Department of Social Services / Human Resources Administration.

For Medicaid recipients who are in receipt of services and are transitioning to MLTC, plan representatives may inquire about the recipient's current plan of care and service provider only for informational purposes to assist with the required in home assessment process. The MLTC plan shall not engage in any communication that infers the plan could impose limitations on provision of services, or requires specific conditions of family / informal supports; any of which could be viewed as an attempt to dissuade a transitioning recipient or interested party.

Communication is defined as phone inquiries and / or web-based inquiries. At no time should the MLTC utilize such communication as a mechanism to substitute for an assessment.

Within a Mandatory District, any Medicaid recipient that is being transitioned from fee-for-service to MLTC shall be enrolled in their plan of choice, without regard to the recipient's plan of care. The Department has determined that all recipients who are currently in receipt of fee-for-service community based long term care (CBLTC) services are appropriate for transition into MLTC.

Effectively with the release of this policy, each enrollee who is receiving services must continue to receive those services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the Plan, whichever is later. In addition, the recipient / workers relationship shall be preserved for the same 90 days period. This change is the result of an amendment to the Special Terms and Conditions of the State's 1115 Waiver with CMS.

As a reminder, any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's

right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal.

Therefore plans must treat **all** enrollees (age 21 and over eligible for Medicaid and Medicare) in mandatory counties transitioning from fee for service Medicaid in the same manner related to continuity of care and access to aid to continue through the appeal and fair hearing process.

This means that, for any individual receiving fee for service Medicaid community based long term services and supports and enrolling under any circumstance, the plan must provide 90 days of continuity of care. Further, if there is an appeal or fair hearing as a result of any proposed Plan reduction, suspension, denial or termination of previously authorized services, the Plan must comply with the appropriate actions. In particular, if the enrollee requests a State fair hearing to review a Plan adverse determination, aid-to-continue is to be provided until the fair hearing decision is issued.