Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 13.01: Transition of Care for FFS Participants in Mandatory Counties

Date of Issuance: January 17, 2013

The purpose of this policy is to clarify that members transitioning from FFS Medicaid are afforded protections related to continuity of care.

The Partnership Plan terms and conditions (28 (d)) requires:

- Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later.
- 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 60 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 aid to continue requirement identified above. 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.

The Medicaid fee for service community based long term services and supports include any of the following over 120 days:

- Personal Care Services
- Consumer Directed Personal Care
- ADHC
- Private Duty Nursing
- Home Health Care