May 20,2022 9:30 am -11:00 am

DOH NY Medicaid Choice Involuntary Disenrollment (No CBLTSS) reason Webinar Transcript

Good morning. This is Jonathan Bick from the Office of Health Insurance Programs. Division of health plan, contracting, and oversight. It appears that the number of participants joining is slowing down so. I think we can get started with today's webinar. I wanted… sorry can we just start the recording? Make sure the recording is restarted. Thank you.

We are recording, thank you. I wanted to say, thank you everyone for joining today's webinar.

We wanted to make sure that plans were clear on the restart of this particular involuntary disenrollment reason, and review some of the reasons that have already been started.
As noted, a webinar is being recorded, and I will hand it over to Sibil to review the webinar.

Good morning, everyone,

I'm going to run by the webinar logistics. All participants will remain muted. Throughout the presentation, all questions during the presentation should be submitted through the question-and-answer function. A question-and-answer, the period will be held at the end of the presentation, and we'll review. Questions that were submitted during the training in the Q and A function.

The webinar is being recorded and will be posted along with slides on the department health webpage COVID-19 Guidance for Medicaid Providers (ny.gov) under the section Other Answers provided to the questions submitted during the webinar will be based on current information and this may not constitute a complete or final answer.

Questions will be answered as time permits and any questions, we are unable to answer will be included in FAQ documents.

Additional questions may be submitted after the presentation to MLTCinfo@health.ny.gov

Thank you.

Jonathan
If you could move to the next slide. What we'll be discussing today on the agenda is a background of the resumed and voluntary disenrollment to date. Will be reviewing and detailing the instructions to request the voluntary. Have this enrollment specific to not in receipt of community, based long-term services and support, will be reviewing some scenarios as examples. Providing a summary and again, a Sibil mention will have a period. We'll be going back and looking at your questions. And then as noted, there's an appendix. to this presentation and of course, this PowerPoint and including the appendix will be posted on The Department's website.

First, you know I'll be doing a few slides and then I'll be handing it over to Dianne Kiernan who is the director of the bureau of managed long-term care, then Maximus will be doing some slides as well.

First, we'd like to review the background of the resumed voluntary disenrollment to date.

Next slide, please.

Jonathan

I think as plans are aware The Department of Health issued a notice at the beginning of the Covid-19 pandemic to MLTC Plan regarding the extension of Medicaid coverage. Under the Family's 1st Coronavirus Relief Act which informs the plan that only members that have moved out of state, requested to be in disenrolled or were deceased could be disenrolled from plans.

The subsequent rulemaking later at the end of 2020 permits and encourages state Medicaid programs to resume certain disenrollment processes if comparable coverage is maintained. In other words, they maintain their Medicaid eligibility, but the state States should be moving to disenroll these to the appropriate Medicaid coverage.

Since then, the department began the resumption of additional and specific MLTC involuntary disenrollment processes prospectively.

In the next slide,

We'll review those resumed and started to date, the effective dates, and the New York Medicaid Choice reason code, and again there's a lot of detail on the covid-19 guidance from Medicaid providers NY.GOV Under other guidance resumption of additional and voluntary disenrollment. So that provides the resources there.

Next Slide thank you.

First, we restarted, I should say MLTC October 1st, 2021: No longer in the Medicare product and this is specific to note member is no longer a member of the plans' Medicare Advantage program alignment. We also restarted in October 2021 that the reason for, and no longer resides in the planned service area.

In January of 2022, we restarted two additional reasons: a member or family member engages in behavior that seriously impaired the contractor's ability to furnish services, reasons other than those, resulting in the member's special needs Using code 31 and the member has been absent from the planned service area for more than 30 consecutive days. and you know reason code 27 A. B. and C.

And today will be reviewing the next reason will be for disenrollment effective date July 1st, and thereafter: Does not receive at least one of the following community-based long-term services and supports within the previous calendar month.

Next slide, please.

When requesting involuntary disenrollment MLTC plans are required to submit these disenrollment reasons to New York Medicaid Choice What we're doing in those processes detail an involuntary disenrollment. Is a disenrollment initiated by the plan without agreement

from the member, and an involuntary disenrollment requires approval by New York Medicaid Choice as designated by the Department.

I will hand it over to Dianne, who is going to go into some more detail on the CBLTSS and overall submission of the disenrollment packaging.

Dianne- Good morning, everyone and welcome again. I'm going to speak about some programs and policies, guidance here on instructions and then I will turn it over to Michelle Granger from Maximus, who will get at the specific instructions that Maximus will be looking for from the plans

Next slide, please.

This slide, we're going to see is the plan's responsibilities are high level in blue. and New York, Medicaid choice responsibilities are high level in the yellow. So, let's start in the upper left. What we'll be talking about and instructions on today are starting on the left. The plans will conduct the analysis of the outreach to members not receiving in the previous calendar month.

Then the plans will initiate an involuntary disenrollment request. and prepare the package, we'll be talking a little bit more about what is part of that package, the timing of the package, the involuntary disenrollment form in the detailed supporting evidence, and then the plan must notify the member once those last two steps are completed.

The package will be sent to New York, Medicaid Choice team; They have two teams that receive the package details and make an outcome determination including the timing of the disenrollment request.

The New York, Medicaid choice prepares a member notification of that outcome and prepares the notification files sent to the plans. Those are the D and T files that, um, will speak a little bit more to; further in this presentation.

Next slide, please.

The First thing that needs to happen and should already be happening, is the plans should be running an analysis of members who are not receiving CBLTSS in the previous calendar month As always, the Partial Capitation, the Medicaid Advantage Plus and the PACE plans are required to reach out to the member in multiple ways.

First upon enrollment, assess and develop the member's plan of care plan monthly for case management updates, every 90 days, if a voluntary care plan was temporarily put in place, and we have the reference here to the voluntary plan of care website location where you can review that guidance, and reaching out to the member when there's a change in condition.

Through these care management outreach activities, plans should have been identifying and engaging with their members who have not been receiving any authorized CBL TSS services throughout the public health emergency. The plan is to analyze and identify members monthly that are not receiving at least 1 of the following CBLTSS: within the previous calendar month and determine when to initiate a disenrollment.

Next slide please,

We're speaking today specifically about this involuntary disenrollment reason. The member does not receive at least 1 of the following community-based. Long-term services and supports CBLTSS within the previous calendar month. These reasons are: nursing services in the home, therapies in the home, health aid services, and personal care services in the home adult day health., private duty, nursing, or consumer-directed personal assistant service CDPAS.

The above reason involuntary disenrollment reason applies to the Partial Cap, the MAP and the PACE plans. I want to point out this note here, the instructions were provided in the webinar today, and on the date Dear HPA letter that was issued on April 26th related to member outreach.

For these disenrollment procedures apply only during the continuance of the Covid- 19 public health emergency and we will emphasize this again throughout the webinar.

Next slide, please

A reminder here is a voluntary vs involuntary disenrollment during the remainder of the public health emergency, the plan should continue this care management outreach. As I just described in slide 10 with the resumption of this additional involuntary disenrollment reason.
The plan informs the member that they cannot remain in the plan.

If they are not receiving, at least one of the CBLTSS services authorized in their plan of care within the previous calendar month if the member agrees to voluntarily disenroll, the plan must follow contractual requirements for a member-initiated disenrollment. The member must sign the form, or if they're unable to sign the form, they must provide verbal consent. Which must be documented in the submission to New York, Medicaid choice.

However, if the member does not agree to voluntarily disenroll the plan must follow the requirements for involuntary disenrollment in the April 26, 2022, Dear, Health Plan Administrator notices, and this webinar. During the public health emergency, additional member outreach before initiating this voluntary disenrollment reason is required. The plan must first identify the members that have not received services in the previous calendar month, and before initiating that involuntary disenrollment outreach to the member to discuss why services have not been received when an involuntary disenrollment will be initiated, or when to restart the service, which would stop the involuntary disenrollment from proceeding

next slide.

I'm going to now go over two slides on when to and when not to initiate an involuntary disenrollment request.
Next slide,

This scenario is when to initiate a request for involuntary disenrollment or the reason, is no CBLTSS in the previous calendar month, the member may not have received the services because: they chose not to receive plan services, as their family or other natural supports are providing the needed assistance, the member no longer requires these services, or the member has declined or refused the services. These are examples of when to initiate a request for involuntary disenrollment.

Next slide

This slide covers when not to initiate a request for involuntary disenrollment for no CBL TSS. A member may not be involuntarily disenrolled from an plan if the reason they did not receive in

the previous 30 calendar days was: Nursing is the only service in the member's plan of care and the scheduled frequency results in no scheduled nursing service in the previous calendar month; a member has been assessed to need personal care or personal assistance, but the plan is unable to locate in the network, provider to furnish the service and it's working to find an out-of-network. Next scenario members that have a current temporary and voluntary plan of care change on record., that is reconfirmed every day every 90 days. Per April 23rd, 2020, Covid- 19 guidance, voluntary plan of care schedule change as described in the link presented here and again, I'm emphasizing the outreach this member is required to occur every 90 days.

Another scenario is the reconfirmation of the member's continued agreement. With a voluntary care plan occurring at least every 90 days. Plans must inform the member that continued non-receipt will result in the initiation of a disenrollment. Therefore, a plan should not initiate this enrollment until reconfirms the voluntary care plan with the member,

and the last scenario is a member is hospitalized during the previous calendar month.

That the member was identified as not receiving CBL TSS. now, in all those scenarios. You can just go back for a minute and all these scenarios should be documented in the member's case file.

Thank you, next slide

How to initiate a disenrollment with the member.

Next slide I have two slides here before I'm going to turn it over to Maximus and have Michelle Granger from the New York Medicaid Choice team describe more specifics, but before I turn it over to her, I'm covering two things that are emphasized in this note below.

Plan outreach to the member before submitting the request to New York, Medicaid choice. This is a key feature in the Dear Health Plan letter and the webinar instructions here. If the member meets the criteria above, which are shared in the previous slides on when to initiate, the plan must outreach to the member to discuss voluntary and involuntary disenrollment options with that member. If the member does not voluntarily agree to be disenrolled from the plan or if the plan is unable to contact or communicate with the member. After having made, at least 5, reasonable attempts within 30 days to engage the member, those 5 attempts should be a combination of phone calls and written notifications. This is a new procedure, and the policy is being communicated with the resumption of this particular voluntary disenrollment reason. The plan may begin the involuntary disenrollment process for lack of CBL TSS. Again, please note this emphasis on the bottom of the slide.

The instructions provided here related to member outreach for no CBL TSS disenrollment procedures apply only during the continuous or the Covid-19 public health emergency.

So member outreach needs to occur before initiating the involuntary disenrollment and the member outreach needs to have at least 5 attempts either by phone and or mail that are documented. Not 4 attempts not 3 attempts - 5 or more.

Next slide, please.

The involuntary disenrollment request. If no contact was made with the member and or with their authorized representative, the MLTC plan must document specific dates and times of that combination of at least 5 phone and mail attempts within the last 30 days again.

During a public health emergency, a home visit is not required but may be utilized as an attempt to contact.

The dates of the outreach attempts should be reasonably spaced across the 30-day outreach period and on different days of the week, and times of the day. It's logical to try to meet outreach to someone at different times. The 30-day period starts on the date the report of members not receiving is run, and it usually is beginning of each month. All information should be submitted to New York Medicaid Choice via the secure file transfer portal also known as MOVE IT. If the plans have any questions please contact New York, Medicaid Choice the health plan affairs department. Which many of you already do regularly. We have noticed that since the Dear Health Plan letter was released on April 26th, we've had quite a few additional people join that traffic.

Next slide, please.

The plan is responsible for member notification. Once a plan has been identified that a member has not been receiving and the member has either declined to voluntarily disenroll or the plan was unable to contact the member. The plan must send to the member and their authorized rep written notification this is referred to, as the notice of intent to disenroll notice, which must have already been preapproved by the department. This notice is sent to the member and, or their authorized rep at least 30 calendar days before the effective date of the involuntary disenrollment.

The notification makes the member and or their authorized rep aware that New York Medicaid Choices reviewing the request to disenroll the member, the services that the member is currently receiving continue while New York Medicaid Choice reviewing the information so those are the program and policy highlights.

I'm turning it over to Michelle Granger from Maximus the New York Medicaid Choice team. She will cover the New York Medicaid Choice instructions for the package.

Next slide please,

Thank you, Dianne.
Good morning, Everybody. My name is Michelle Granger. I'm the Director of the Clinical Quality Assurance department here at Maximus for the New York Medicaid Choice and now will be presenting the information on behalf of Maximus.

The first thing that we're going to talk about this morning from us is the timing of the disenrollment request. I'm going to make my slide just a little bit bigger as you can see here on this grid. We've outlined you would identify the members when you would outreach to them, when to notice the member and the enrollment forms would be sent to New York Medicaid Choice. When the plan identifies members that are found not to be receiving the services in the previous calendar month the CBLTSS example is April - the outreach to the member would be upon contact with the member to determine the reason for them, not receiving services. An example would be that would be done in May, (April had no services) you would outreach to them.

Step 1, for the Notice of Intent to Disenroll sent to the member at least 30 days before that disenrollment effective date. For example, here, is that no later than June 1st, for July 1st, this enrollment and need to have that letter of 30 days in advance. Step 2 is involuntary reason form

sent to New York Medicaid Choice. For example, here between May 11th and June 9th for July 1st, the disenrollment date. Again, they had no services in April, you would do your outreach in May and it's the same 5 outreach attempts. The same Dianne was just referring to, you would then need to send them a letter, letting them know they're going to be disenrolled and then send the package information we need to process the request when the plan identifies that a member is found not to be receiving CBLTSS in the previous calendar month. Again, here you're going to make at least 5 attempts to contact within 30 days, you would contact them in May - 5 different dates and times, combination of letters and phone calls. Step 1 again is going to be to send the intent to disenroll letter at least 30 days in advance of that effective date. You want to send it no later than June 1st for July 1st disenrollment

Step 2. You would then send the involuntary disenrollment form to Maximus to the NYNC Department. Send that between June 1st and June 9th for that July 1st disenrollment or you'd send it between June10th and July 8th for August 1st effective disenrollment.

Again, you want to make sure that you are making those outreach attempts, and you send that notification to your member at least 30 days in advance.

Next slide please,

Involuntary disenrollment package. After you have conducted your member outreach and sent the intent to disenroll letter to that member and their authorized representative you must submit a completed managed long-term care involuntary disenrollment request form to the New York Medicaid Choice along with the supporting documentation specified below.

This is referred to as the involuntary disenrollment package or involuntary disenrollment due to lack of receipt of the CBLTSS. In the previous calendar month, the plan must complete the managed long-term care involuntary disenrollment request form and you would select the involuntary disenrollment reason on page 2 of that form for no CBLTSS. Below you see a little screenshot of what that form looks like and what that section looks like.

Next slide, please

The MLTC involuntary disenrollment request form sample. The next couple of slides will outline what the form looks like and the various sections that are in the form. The plan must print on the form or typed on the form and complete all the information on page 1. We need to make sure that you'll give us your plan name, the name of the nurse case manager, the phone number, the member's name, and phone number want to make sure we have that information. We can know which consumer or which member you're referring to and if we have any questions can contact the plan. Select 1 of the reasons for disenrollment and provide all the supporting documentation. Note here, the plans may contact the HP department and Medicaid Choice to request a form. If you do not have it already.

Next slide, please.

What is required for supporting documentation? For no CBLTSS in addition to the completed form plans must submit a signed letter with their contact information on the letterhead. It should include the following information reason: NO CBLTSS was received in the previous calendar month.

Again, should have the name and client identification number, the same name of the member who did not receive the services of at least 1 of the CBLTSS that were identified in their plan of

care, must specify the authorized schedule of services that the members should have been receiving, and the name of the agency or agencies which should have been providing those services, if that's available for a period the services have not been received which should be in the previous calendar month, if the contact was made include the reason why the member has not received the services and a description of the safe discharge plan, which includes information that any referrals to other providers of applicable services, or supports, which are made on behalf of that member and the status of such referrals.

A reminder here, if contact was made, and the member can ultimately choose to voluntarily request a disenroll, they must sign that voluntary enrollment form or they must provide verbal consent to that having been completed. The involuntary disenrollment evidence packet is not needed if they're going down the voluntary disenrollment process.

Next slide, please

New York medical Choiceis processing involuntary this enrollment request what happens once gets to New York Medicaid Choice.

Next slide, please

The first step is that New York Medicaid's Choice will determine if that package is complete. Did the plan submit everything to us for us to process as NYMC reviews? Submit your request and they'll look to see if the involuntary disenrollment package referred to as the package is complete. New York, Medicaid Choice will issue a request for additional information again, that complete package includes that letter had all the things that were just on the previous slides making sure the form is complete your contact information. I it is not complete, the department will request additional information via emails back to them, Move It via secure system. Plan will have 6 business days to submit that missing information. If the missing information is not received within those 6 business days, the original request will be closed, and the plan must submit a new and voluntary disenrollment request. If closed again, the plan is notified through Move It and the member will remain an enrollee on that plan.

If the package is complete New York Medicaid Choice will review to determine the request and if the request is because the plan is unable to reach that member and how the member was contacted but refused to voluntarily to enroll based on the outcome of the review of the processing team, or the clinical quality assurance department will complete the secondary review and decide on that request.

So, again, initially comes in, we look to see if all the information was submitted if it wasn't, the processing team will request the additional information. You'll have 6 business days to submit it, If it's not submitted, the request is closed. If it is submitted, it will continue down the path, and if it is for an involuntary disenrollment, because of no contact, the processing team will continue with that. If it's based on clinical, it will go to our clinical quality assurance department.

Next slide, please

Unable to reach your contact the member.

The reason for this is because the plan is unable to contact that member. The plan is required to submit documentation of the dates and times and the attempts to contact the member along with the method of how that attempt was made phone, mail or in person. Again, as Dianne said, it should be 5 attempts over various dates and times and methods to try to get a hold of them, there

should be at least 5 documented attempts that were made over different days times, including that combination of telephone calls and mail attempts must be over 30 days and that begins after the member has been identified as being a non-receipt of services.

So, once you get the report that tells you that the person is not getting the services, you should ensure outreach attempt happens and the written notification is issued; encouraged to be included for our fair hearing case if the consumer decides to request of fair hearing afterward. The processing team will review the package to ensure that the attempts meet the requirements to contact the member based on the review of the submitted package. The processing team will decide to either approve or confirm the request to disenroll a member or overturn the plan's request and get some more information on the member. The decisions will be communicated back to the plans via the D file. The files will be referred to in the appendix at the end of the PowerPoint.

Next slide, please.

When the member refuses to disenroll and they're not receiving CBLTSS. It's the reason for this disenrollment because the member was not in receipt of the community-based services, in the previous calendar month and the criteria were met to A. initiate the involuntary disenrollment. B. The member was able to be contacted and see C. the members refusing to voluntarily disenroll from the plan.

The request is reviewed by the clinical quality assurance specialist the QANS. which staffed by our end by nurses to assign to review the submitted documentation and review the most recent community health assessment in the UAS, if it's available. The QANS will review the information submitted to determine if there is a safe discharge plan and if a member continues to need services and the plan, if there is a plan in place to have services provided by somebody else. This will only apply if the member was contacted and refused to enroll. If there is no safe discharge plan in place, the request for involuntary disenrollment will be denied.

If the QANS need additional information after they have reviewed what you've submitted and they feel there is some additional information, QANS will contact the plan. The plan will have two days and that's 2 business days. If that information is not received by the end of that two days on that 2nd, business day, the quality assurance team will review what was submitted and make our decision based on what was in the original package. Again, all of these requests for involuntary disenrollment, when the member refuses to disenroll voluntarily will be reviewed by an. R. N. to determine if there's a safe discharge plan in place, once that QANS made a decision based on the information that they've received they will decide and notify the plans via MOVE It. It is whether it's been requested, approved, or has been denied.

Next slide, please

All submissions along with their supporting information must be submitted within the established process and schedule window for the request for all involuntary disenrollment in our process timeline. We are currently within the May 11th to June 9th submission for disenrollment effective July 1st. You can see submissions usually are about the 10th or 11th of the month and see it following the 10th to 11th for each month.

We will make our decisions effective as soon as we can, and it'll be affected the following 1st and the following month.

Plan and member notification what are the possible outcomes in the New York choice? If the involuntary form is complete and its approved, the member will be disenrolled fee for service or transferred into another plan, according to involuntary disenrollment category and processing schedule. We might disregard an involuntary form due to issues with the form, incorrect or missing documentation, insufficient Medicaid eligibility, plan has requested to withdraw. The plan will be notified via secure email through MOVE IT of all disregarded forms and the reason why.

As plans reach out to New York, Medicaid Choice with any follow-up inquiries and again, you know, the form does not proceed to review for approval, the member remains enrolled in the plan.

The final and 3rd option of an outcome is overturned involuntary form is completed and just reviewed by a clinician who determines that the request be overturned or denied, and the member remains enrolled in the plan. Note: the member is notified by New York, Medicaid Choice of the denial via an involuntary disenrollment overturned notice. Plan notification will also occur through D and T files which are included in the appendix.

Next slide, please

Some members are mailed outcome notices at the conclusion of the involuntary disenrollment review process when New York Medicaid Choices either approves or overturns the plan's request to involuntary disenrollment.

When the request to involuntary disenrolls member from the plan is approved, the plan will issue the involuntary confirmation notice to the member. We'll have a sample of that on the next slide when the member. When overturned request to involuntary disenroll is done, NYMC will issue the same involuntary disenrollment request overturned notice to a member.

NY Medicaid Choice will mail, the outcome notices within 2 to 3 business days to the member's address on file and the authorized representative address if applicable. Outcome notices are generated in English and are available in Spanish.

If New York Medicaid Choice disregards the request and notice was sent to the member from New York Medicaid Choice, it is also the plan's responsibility to notify the member of the outcome.

This is the sample of the Involuntary disenrollment requests, and confirmation notice. Every notice is 2 pages. It will contain in the introduction the reason for the disenrollment is what happens next, questions and it provides Maximus number for them to call us. In the section on the independent consumer advocacy network, it will tell them what their options are, fair hearing rights and this applies to the notice, including aid to continue. The disenrollment notice has contact information if the member disagrees with the disenrollment NYMC 1-888-401- 6582 Medicaid Choice number. We want to note here, that if the member does request a fair hearing the notice issued by New York Medicaid choice, and the clinical quality assurance department, will represent at the fair hearing.

Next slide, please.

MLTC Involuntary disenrollment request overturned notice. This is a notice that will go to the member to let them know that we have Overturned the request. The enrollee remains enrolled with your plan this includes the following sections, they will get an introduction, a decision

section, a question, and call section. They will also have the what happens next section and the independent consumer advocacy network, they will see that for similar information. But they will not have their hearing rights because they are remaining enrolled with your plan.

In the next 2 slides, we will outline couple of scenarios that we have.
Scenario 1 and 2.

The next slide

Scenario number 1 is the member who was contacted. Dolores has been enrolled in a plan for 2 years. Dolores has been receiving daily personal care services PCS for February. During March, Dolores did not receive any other CBLTSS. Dolores has declined the need to have PCS any longer. The plan contacts Dolores on April 3rd, they declined to have any services, but Dolores also declined voluntary disenrollment from the MLTC plan. The plan will then submit the request to New York Medicaid Choice for an involuntary disenrollment. Complete the package by submitting all the required information, including any clinical evidence that supports the safe discharge. The QANS department will review the submitted clinical information and they approve the plan's request to disenroll Delores. She will receive a confirmation notice from New York Medicaid Choice that she will be disenrolled from MLTC the plan, the effective date of the disenrollment and her fair hearing rights/. The plan will be notified via MOVE IT.

Scenario number 2- member is not contacted. Rocky had been enrolled in a plan for 3 years. Rocky has been receiving consumer-directed personal assistant services CDPAS for February. During March, Rocky did not receive CDPAS or any CBLTSS services. Rocky refuses services as Rocky's daughter is now living with him and providing care to Rocky. The MLTC plan attempted to contact Rocky 5 times by combination of phone and letters in April. The MLTC plan documented all attempts and dates of outreach and the lack of response. Rocky was unable to be reached. The MLTC plan will submit the request to Medicaid Choice for the involuntary disenrollment package to NEW YORK Medicaid choice. NYMC decides to process the request and send a confirmation notice to Rocky. The plan is also to notify the Rocky of the Disenrollment.

If New York Medicaid Choice decides to overturn the request, the MLTC plan is notified through MOVE IT of that determination. An involuntary disenrollment request overturned Notice would then be mailed to the member to notify Rocky of the outcome. Rocky would remain enrolled in the plan. The plan would be out of compliance with the contractual obligations to involuntary disenroll Rocky as he is not receiving CBLTSS.

Summary next slide.

New York state is resuming the process to request an involuntary disenrollment for members who have not received the community-based long-term support services in the previous calendar month. Plans may submit the request beginning May 11th, 2022, and thereafter to New York, Medicaid Choice for determination. Include the supporting information. and again, we want to make sure that you fill out the form with all the necessary information. Submit your request on your letterhead with all the contact information. All need to be part of the package when it's submitted. Upon receipt of that request New York Medicaid Choice will review to determine if all the required information has been submitted with the request.

A determination to either approve and the same member is notified via MOVE IT and that's to approve the request to disenroll.

If overturned, again a notice is sent to the member and the member stays in enrolled in the plan.

If disregarded, no notice is sent to the member by New York Medicaid Choice, but MLTC will be notified via MOVE IT. The consumer, the member remains enrolled in your plan at that point.

Next slide, please

Contacting health plan affairs HPA at New York, Medicaid Choice. Contact HPA and New York Medicaid Choice directly via email if you have a very generic question. If you are sending information about a specific member contains PHI, the HPA request must be contacted through MOVE IT and the secure application.

Can we go to the next slide?

We'll you can see the samples in the Appendix of the D. and T files you should be familiar with them.

Next slide please,

The D file is a plan notification and so as a T file, the end of this presentation contains the information and what's contained in the files. A final decision is made on an involuntary disenrollment in the D file, not a new file. It is an existing file that has been in production. Once that file is generated it posts daily to designate to MOVE IT. So, again, this is not a new process if the members disenrolled the New York Medicaid Choice, we'll generate a T file to notify the plan after the disenrollment has successfully been processed with the effective date of disenrollment.

Next slide, please.

And this is what the default contains just so you're aware can the case number and then the type of request data request, the plan names the reason for the request, we have specific reason codes. In this case, it's reason code 42 for no CBL TSS in the last 30 days, the status of that request and the date of the decision and this is just a shot of what that file would look like. The T-file will contain the following information: plan name, date, the type, enrollment or transfer transaction code, consumer name, their date of birth, their address, their phone number, expiration date, or which is also disenrollment date. The disenrollment source, in this case, would be involuntary disenrollment with that, let me go back to the questions.

Thank you, everybody,

thank you, Michelle.

This is Dianne Kiernan, and we have several questions here in the Q &A
And we will go mute momentarily to prepare answers to those. You will see some answers have been provided to those questions and we'll, we'll be back with you in just a minute.

Q 1- There is a question here. What is the HPA email?
Michelle and the Maximus team or can you answer that question with the email?
we'll get back to you on the HPA email.

This is Michelle from Maximus.

Q2. I see a couple of questions about what a safe discharge plan is.

A. Really what we're looking for. We want to make sure that that member is safe and that they're still getting services. If needed it could be that there's a family member in Rocky's case. Their daughter was providing the services, maybe they don't need services. They could be getting it from a community-based organization, we just need to make sure that we're not abandoning that consumer, that they're still having services that they need they're getting or if they've refused them. But we need to clear the document. What is the plan and how are we're going to ensure their safety?

Q3 I see a question about what is moving is a secure application and I am by no means technical.

That is a way to transfer data back and forth between the plans and maximize.

Q4 Hi, Jonathan. I think I'm going to answer or address the question.
How should plan handle members that refuse to speak with the plan?
If the member has threatened the plan and requests to stop receiving calls, are we.
to continue outreach for 5 attempts before opening the voluntary disenrollment.
not sure of the timing of when the member may have in this scenario, indicated to stop receiving calls but if you're in the outreach period for this voluntary disenrollment reason and you contact the member via phone, and they are saying, don't call me you're not able to communicate the, you know, the outreach what's going on with the potential and voluntary disenrollment? I think you could, you would send a letter to confirm during that 30-day, period, and you could also attempt to home visit. If appropriate again, it sounds like there might be a behavioral issue with this particular consumer you should have to, contact and I think you would want to document in your packet to New York Medicaid Choice that you attempted to contact by phone, for example, and a member refused to discuss and you followed up with some mailings.

Q.5 Sherry is asking will the slide deck be sent out after the call or will be posted.

A. Sibil, if you want to go back to the 1st slides. I think it's a slide 2 maybe, where we have the website listed where it will be posted. Thank you very much.

The Covid-19 guidance where we posted out materials on the other. Involuntary disenrollment that started, we will be posting this slide deck there, you should be able to see that within a couple of days.

Q6- I think someone is asking for a mail outreach attempt counts as an outreach attempt, and 1 of the 5 attempts is required. If a member can't be reached via phone or in-person yes. it's a combination we would revise that you use a combination of methods, especially if you're not able to contact via phone, try mail vice versa. Once the contact is made, then you're able to discuss with the enrollee. You met here obligations there, so you, you know, try a combination. When I say modalities , ways to contact people, phone, mail and mail does count as 1 of the 5 attempts.

Q7 Michelle from Maximus looks like there are a couple of questions about timeframes.

Just so we are clear on the timeframe, or if the packages are sent to us and the processing team. Request additional information, your plan has 6 business days to submit it. On the 7th business

day, it's not submitted, the request will be disregarded. So it can be sent in at the very end of the 6-business day and we would continue with that request.

Also, there was another question about how long the Maximus usually will process them generally, we try to do 3 days to process review it to make their determination. whether that's the clinical or non-clinical teams they generally will have about 3 days because we want to make sure that all the notices get out to both plans and members.

Q8. This is Dianne there's a question here. Please confirm that moving forward members who are refusing services. Or is unable to reach falls under no longer receiving services reason on the form.

A. Those could be 2 different situations but if the member is refusing services, and it's documented in the outreach that the member is refusing services, and they're on the analysis, they did not receive services in the last month then, yes, this would be part of the no CBL TSS. Along with the supporting documentation that's been described the other scenario is if the member's refusing, but the analysis is showing, that they did receive services.

That's a different scenario. So, it depends on what you're running in your analysis. Each month and what's going on with each of those cases and what you have documented,

Q9. Do we need to notify both a member and the authorized representative in writing about the enrollment?

A. This is based I think it's based on, you know, the consumer's preference and what. they indicated to you the plan as to where the authorized reps should be included. if the authorized rep that they've permitted the authorized rep to be included in enrollment the notification then the plan needs to send it to the authorized rep because that's what this is, so you need to look at that case file and see what permissions and authorizations have been given by the enrollee for authorized reps certainly as best if you need to do that.

Q10 Can the Letter of Intent to Disenroll be used in the written form of the 5 attempts at outreach? A- No, that does not count as 1 of the 5 outreaches. The Notice of Intent to Disenroll occurs after outreach.

Q11 Our members that are currently in a short-term, nursing home we have or custodial nursing home, stay or long-term nursing homes.

A - They are, excluded from this. They would not be included for this reason. The long-term nursing home stays disenrollment's are being conducted in a batch every several months by the state, and we have not started the next batch yet.

Q12. If a member initiated a voluntary plan of care change in the past but the plan has not been reconfirmed every day will that be considered a valid reason for involuntary disenrollment?

A. I think there are a couple of things here that need to be peeled away from each other. The temporary voluntary plan of care every 90 days is the policy and the plan is responsible for reconfirming every 90 days with the member. Then you will run your analysis and find out if the member is not receiving, then reach the member again, so you're either reconfirming or you're doing your monthly outreach. You have all those steps that you should be outreaching the member anyway but that is if a member has a voluntary plan of care on file the policy is to reach out to them to reconfirm every 90 days.

Q13. Wendy is asking a question if the consumer is that out of the service area for more than 30 days, and came back to the surface area.

A. When a consumer was out of the area, and when the consumer is back in the area, but refuse service. I think there's a little bit of unwinding here, but it sounds like a very particular circumstance, but 1st of all we did restart the out-of-service area for more than 30 days. I don't know, in this particular example, when the plan became aware, they are out of the service area they should have gone down that path with the out-of-service area, but if the timing is such that. The person's back before you could initiate that the out-of-service area does enrollment, then I would utilize the no CBLTSS within the last 30 days. Yes you could count the last 30 days wherever they are in that circumstance, but to do without knowing the specifics of this particular case, I would say, try to start with the service area for more than 30 days first but understand, there might be some timing that reason has always been an active reason under the public health emergency. There are certain nuances to this question.

Moved out of state or member is deceased, or member voluntarily chooses to disenroll. those have been active reasons for disenrollment throughout the public health emergency,

Q14. I believe the member is scheduled for reassessment this month that is separate then the plan's analysis that the member has not been receiving in the previous calendar month and the outreach that should already be occurring or must occur with the identification of that member, not receiving there is this window to reach out to the member to say what is going on.

A. In your case notes, based upon the outreach to that member will determine whether you should continue that reassessment schedule or not, but I think this is running that analysis that the member's not receiving services reach out to the member now, thank you.

Q15. Previously, if it if there's a long-term nursing home stay the state is handling those, this enrollment with the batch disenrollment process which plans have certainly a role in as, you know?

A. If it is a short term, stay you would not initiate.

Q16. If the plan is unable to reach members? Notice of Intent to Disenroll has not been approved?

A. Please submit that to your plan manager because 5 phone attempts alone do not meet the protocols we just described in this webinar or the Dear Health Plan letter.

Q17. If a member requested to put all personal care services on hold due to COVID, does that fall into the temporary volunteer plan Process?

A. It sounds like the again, that process was outlined in April 2020 and the guidance is there on the website. Sounds like there should have been a temporary voluntary plan of care change there but as we noted in the slides, and we've been discussing the plan, well, it needs to check in on every 90 days. The Slides here indicated in that check-in the plan will need to inform the consumer that they're going to need to start receiving to stay in the plan.

You know there could be other services besides PCS just that's important to remember. It's not just personal care. It follows, that we listed any previous protocols about outreaching members or

members who are unable to be reached in the past, the protocols are described in the Dear Health Plan letter on April 26. In this webinar, today 5 outreach attempts to the member a combination of phone and letter. 5, not 4, not 3; at least 5 reasonable attempts over 30 days. Reminder that Maximus overturn notice mean something is missing or Maximus disregarded or return something is missing and incomplete in the package or needs to be clarified in the package. So please look for that communication from Maximus and make those corrections.

Q18. What's going to happen after the end of the public health emergency?
A- We don't know exactly when the public health emergency will end, but we plan to continue with restarting some of the other involuntary disenrollment reasons in the coming months. We'll evaluate where we are, what the federal guidance on the public health emergency is, and we'll reevaluate these enrollment reasons, and the instructions for not in receipt of CBLTSS. We can't give you instructions about what will happen and when exactly because we don't know when the emergency will end. We certainly will keep plans in the loop.

You know as any instructions changes for not a receipt of CBLTSS we will provide plans with the necessary guidance on that topic, and we are also working on the updating the form. We know that the involuntary enrollment form some of the reasons are going to need to modify to accommodate the additional reasons. Lookout for that too for our updated form on the Web site where the other resumption of additional involuntary disenrollment. guidance has been posted.

I want to thank the team, New York, Medicaid Choice and Maximus team, and certainly, I want to thank this large number of participants. We are grateful that you took the time this morning to go over this reason and appreciate your attention to this. We look forward to continuing to work together with plans for this reason, and to process these as appropriate.

And we look forward to continuing working with plans on this reason, and other forthcoming reasons for involuntary disenrollment.

We appreciate all your engagement with us and of course, with the consumers that we serve.

So, thank you again and I hope everyone has a great rest of your Friday.

Take care, thank you.