Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 13.14: Questions Regarding Managed Long Term Care (MLTC) Eligibility

Date of Issuance: May 30, 2013

The purpose of this policy is to further clarify programmatic eligibility for enrollment in managed long term care plans. Some MLTC plans have sought greater clarification from the Department as a result of the request to review the use of social day care services for their enrollees.

1. **How does a MLTC plan establish an acceptable ratio or mix of Social Adult Day Care attendance and Community Based Long Term Care Services (CBLTC) to determine eligibility for either initial enrollment, or continued need for plan services?**

The primary threshold to determine eligibility for enrollment in a Managed Long Term Care Plan continues to be that a consumer, based on a functional assessment conducted in the home environment, must need and receive, or expect to receive, more than 120 days of CBLTC services. CBLTC continues to be defined as Home Health Care, Personal Care Services or CDPAS, Private Duty Nursing, and Adult Day Health Care. There are neither ratios nor service mix to consider; the primary focus continues to be the threshold of more than 120 days of the identified CBLTC services. Social Day Care is a service in the MLTC benefit package which may be authorized as an addition to the base plan of care for CBLTC but should not be the sole service provided. Plans should utilize their established service authorization criteria to determine need for Social Day Care, or any other long term care service, and the plan of care should reflect that accordingly.

2. **How does a MLTC plan address a situation in which a member no longer needs or accepts the plans services?**

A Dual Eligible who no longer needs, nor accepts, the community based long term care services of the plan is appropriate for disenrollment. Action should be taken as soon as a plan identifies this, whether at time of reassessment or during care management contact. Individual who no longer require plan services may voluntarily disenroll. If they do not seek voluntarily disenrollment, the plan must propose an involuntary disenrollment. Upon disenrollment from the plan if the individual is interested in non Medicaid community services, such as participation in community senior activities, the plan should assist in contacting or referring the individual to the Area Office on Aging or DFTA as appropriate.

At point of reassessment, non-dual eligibles who no longer score Nursing Home Level of Care (5 or above on the SAAM) are no longer appropriate for MLTC and must be disenrolled. If the non-dual eligible is in need of community based long term care services but does not score NH

Level of Care, that individual should be transitioned into a Mainstream Managed Care plan through New York Medicaid Choice or the Local Department of Social Services as appropriate.

Plans should take appropriate action within five (5) business days of identifying either of these circumstances.