STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 19, 2019
[redacted]
AGENCY: MAP
FH #: 7997481P

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on August 20, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Denise Caceres, New York Medicaid Choice Representative

ISSUE

Was the Agency's determination approving Appellant's Managed Long-Term Care Plan's disenrollment of the Appellant from the Appellant's Managed Long-Term Care Plan, correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. Appellant, age 74, has been authorized to receive Medicaid, and had been in enrolled in a Managed Long-Term Care plan operated by Centers Plan for Healthy Living.

2. The Appellant left the United States on [redacted] and did not return until [redacted].

3. The MLTC Plan advised the Agency's Enrollment Broker that the MLTC Plan's rules only permitted a patient to be outside the county of treatment for up to thirty days; since Appellant was absent for a longer time period, the MLTC Plan asked the Enrollment Broker to approve a disenrollment of Appellant from the MLTC Plan.

4. By notice dated [redacted], the Agency, by its Enrollment Broker, advised Appellant of the Agency's determination to approve the MLTC Plan's decision that Appellant should be disenrolled from the MLTC Plan, effective August 1, 2019, because Appellant had been away from her borough or county for a longer time than the Plan allows.

5. The Agency's notice advised Appellant that the services she receives under Managed Long-Term Care would continue while Appellant decides upon a new MLTC Plan.

6. The notice was addressed to Appellant's address of record.

7. On July 19, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Public Health Law Section 4403-f provides in pertinent part as follows concerning eligibility for managed long term care:

1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

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(c) "Operating demonstration" means the following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long term care services" means services including, but not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long term care plan may also cover primary care and acute care if so authorized.

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7. Program oversight and administration

(b)(i). The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees simultaneously with their submission to the federal government.

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(v) The following medical assistance recipients shall not be eligible to participate in a managed long term care program or other care coordination model established pursuant to this paragraph until program features and reimbursement rates are approved by the commissioner and, as applicable, the commissioner of developmental disabilities:

(1) a person enrolled in a managed care plan pursuant to section three hundred sixty-four-j of the social services law;

(2) a participant in the traumatic brain injury waiver program;

(3) a participant in the nursing home transition and diversion waiver program;

(4) a person enrolled in the assisted living program;

(5) a person enrolled in home and community based waiver programs administered by the office for people with developmental disabilities.

(6) a person who is expected to be eligible for medical assistance for less than six months, for a reason other than that the person is eligible for medical assistance only through the application of excess income toward the cost of medical care and services;

(7) a person who is eligible for medical assistance benefits only with respect to tuberculosis-related services;

(8) a person receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program;

(9) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the social services district;

(10) a person receiving family planning services pursuant to subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of the social services law;

(11) a person who is eligible for medical assistance pursuant to paragraph (b) of subdivision four of section three hundred sixty-six of the social services law; and

(12) Native Americans.

(vi) persons required to enroll in the managed long term care program or other care coordination model established pursuant to this paragraph shall have no less than thirty days to select a managed long term care provider, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider, the commissioner shall assign such participant to a managed long term care provider, taking into account quality, capacity and geographic accessibility.

(vii) Managed long term care provided and plans certified or other care coordination model established pursuant to this paragraph shall comply with the provisions of paragraphs (d), (i), (t), and (u) and subparagraph (iii) of paragraph (a) and subparagraph (iv) of paragraph (e) of subdivision four of section three hundred sixty-four-j of the social services law.

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(g)(i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the

basis for the development and provision of an appropriate plan of care for the enrollee. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner as necessary. The commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least every six months by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

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The Managed Long Term Care MODEL CONTRACT provides, in part, that:

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D. Disenrollment Policy and Process
1. Disenrollment Policy
a. The Contractor shall comply with disenrollment policies and procedures developed by the Contractor as approved by the Department. Such written policies and procedures shall address all aspects of disenrollment processing and shall contain the disenrollment forms and materials used by the Contractor. The Contractor must submit any proposed material revisions to the policies and procedures for Department approval prior to implementation of the revised procedures.
b. The effective date of disenrollment shall be the first day of the month following the month in which the disenrollment is processed through eMedNY.
c. Disenrollment by the Contractor may not be based in whole or in part on an adverse change in the Enrollee’s health or on the capitation rate payable to the Contractor. Disenrollment may not be initiated because of the Enrollee’s high utilization of covered medical services, diminished

mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs except as may be established under section D.5.a of this Article.
d. The Contractor shall continue to provide and arrange for the provision of covered services until the effective date of disenrollment. The Department will continue to pay capitation fees for an Enrollee until the effective date of disenrollment.
e. In consultation with the Enrollee and other individuals designated by the Enrollee, prior to the Enrollee's effective date of disenrollment, the Contractor shall make all necessary referrals to the LDSS or entity designated by the Department, another MLTCP or alternative services for which the MLTCP is not financially responsible, to be provided subsequent to disenrollment, when necessary, and advise the Enrollee in writing of the proposed disenrollment date.
f. If an Enrollee is transferring from the Contractor's MLTCP to another MLTCP or Medicaid Managed Care plan, the Contractor must provide the receiving plan with the individual's current person centered service plan in order to ensure a smooth transition.
g. If an Enrollee is disenrolling from the Contractor's MLTCP to receive services through an Assisted Living Program (ALP), the Contractor must pay the applicable Medicaid rate for the level of care for which the Enrollee is assessed using the Patient Review Instrument (PRI) or successor tool until the disenrollment from the MLTCP is processed. The Contractor is responsible for all other medically necessary services covered by the MLTC benefit package that are not included in the ALP rate until the disenrollment takes place.

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3. Contractor Initiated Disenrollment
a) An involuntary disenrollment is a disenrollment initiated by the Contractor without agreement from the Enrollee.
b) An involuntary disenrollment requires approval by the entity designated by the Department.
c) The Contractor agrees to transmit information pertinent to the disenrollment request to the entity designated by the Department in sufficient time to permit the entity to effect the disenrollment pursuant to the requirements of 42 CFR 438.56 (e)(1).

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4. Reasons the Contractor Must Initiate Disenrollment

If an Enrollee does not request voluntary disenrollment, the Contractor must initiate involuntary disenrollment within five (5) business days from the date the Contractor knows:

(a) an Enrollee no longer resides in the service area;

(b) an Enrollee has been absent from the service area for more than thirty (30) consecutive days;

(c) an Enrollee is hospitalized or enters an OMH, OPWDD or OASAS residential program for forty-five (45) consecutive days or longer;

(d) an Enrollee clinically requires nursing home care but is not eligible for such care under the Medicaid Program's institutional rules;

(e) an Enrollee is no longer eligible to receive Medicaid benefits;

(f) an Enrollee is not eligible for MLTC because he/she is assessed as no longer requiring community-based long term care services or, for non-dual eligible Enrollees, no longer meets the nursing home level of care as determined using the assessment tool prescribed by the Department. The Contractor shall provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) business days of the assessment making such determination; or

(g) an Enrollee is incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration.

DISCUSSION

The record discloses that Appellant, age 74, has been authorized to receive Medicaid, and had been in enrolled in a Managed Long-Term Care plan operated by Centers Plan for Healthy Living. By notice dated [redacted], the Agency, by its Enrollment Broker, advised Appellant of the Agency's determination to approve the MLTC Plan's decision that Appellant should be disenrolled from the MLTC Plan, effective August 1, 2019, because Appellant had been away from her borough or county for a longer time than the Plan allows.

A letter from the MLTC Plan, dated June 21, 2019, stating how it discovered Appellant was out of the plan's service area from May 16, 2019 through June 30, 2019, was submitted into evidence. At the hearing, Appellant testified that she actually left the United States to visit Guyana on [redacted] and did not return until [redacted]. The Appellant explained that she had gone to Guyana to assist in the administration of the Appellant's Mother's estate. However, the rule which applies in these matters is a strict one, and does not depend upon the reason for absence from the borough or county of residence. Accordingly, the Agency must be upheld here.

It is noted that the Appellant may seek information about re-enrollment from the Enrollment Broker at [redacted].

DECISION

The Agency's [redacted] determination approving Appellant's Managed Long-Term Care Plan's disenrollment of the Appellant from the plan is correct.

DATED: Albany, New York
08/23/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee