STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 21, 2018
[redacted]
AGENCY: MAP
FH #: 7708201N

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 June 28, 2018, 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

Silvia Kalvin, Fair Hearing Representative (June 28, 2018 only)

For Medicaid Choice, the Agency's and New York State Department of Health's Designated Agent

Sandra Paul, Fair Hearing Representative (April 26, 2018 only)
Denise Caceres, Fair Hearing Representative (June 6 and June 28, 2018 only)

ISSUES

Was the determination of the Agency, without notice, to reduce the Appellant's Medical Assistance authorization, effective March 1, 2017, from full coverage to community coverage without long-term care correct?

Was Medicaid Choice's determination not to enroll the Appellant into a 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. The Appellant had been in receipt of Medical Assistance authorization for full coverage.

2. Effective March 1, 2017, the Agency reduced the Appellant's Medical Assistance authorization from full coverage to community coverage without long-term care, without notice.

3. On March 9, 2018, Medicaid Choice sent a letter to the Appellant informing her that she was eligible for Managed Long-Term Care (MLTC) Services and she must enroll in an MLTC plan by May 19, 2018.

4. On April 28, 2018, Medicaid Choice sent a letter reminding Appellant that she must enroll in a managed care plan by May 19, 2018.

5. On June 23, 2018, Medicaid Choice sent a letter to Appellant informing her that she is eligible for Managed Long-Term Care (MLTC) services and she must enroll in a MLTC plan by September 2, 2018.

6. On February 21, 2018, this fair hearing was requested on behalf of Appellant.

APPLICABLE LAW

In general, a recipient of Medical Assistance or Services has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Medical Assistance or Services; or has determined to change the amount of one of the items used in the calculation of a Medical Assistance spenddown. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for a Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Medical Assistance in another district.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single

notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

Section 22 of the Social Services Law provides that applicants for and recipients of Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

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, considering 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:

Managed Long-Term Care Partial Capitation Contract, FROM: September 1, 2012
TO: December 31, 2014

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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.

New York Medicaid Choice provides detailed instructions to Managed Long-Term Care Plans regarding involuntary disenrollment requests which, includes, in part:

> All involuntary disenrollment requests must be submitted to NYMC with the NYMC involuntary disenrollment form and required supporting documentation. Completed forms and supporting documentation must accompany the NYMC Transmittal Form and sent to NYMC. NYMC will process all complete submissions within 6 business days. If the 6 business day falls after the pull-down date, the transaction will be effective the subsequent month. If submitted information is insufficient, NYMC will issue a request for additional information to the plan. Plans must submit missing information within 6 business days upon request. If missing information is not received within 6 business days, the original request will be withdrawn and the plan must submit a new involuntary disenrollment request.
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> Behavioral/Safety and Surplus involuntary disenrollment requests will be completed within 14 business days and will result in a transfer. (Note: An additional 14 days is needed to assist consumer with choosing another plan)...All documentation must be signed by the plan representative….Plans must submit any additional documentation requested by NYMC. Plans are reminded that, upon concurrence, NYMC will issue a Notice of Fair Hearing to the Enrollee which includes rights to request aid continuing within 10 days from issuance. Disenrollment or transfer will not be processed until the 10 days have elapsed. If an Enrollee requests aid continuing he/she will remain in the original plan until FH is conducted.

Office of Health Insurance Programs, Division of Long Term Care, MLTC Policy 14.06: Implementation of the Conflict-Free Evaluation and Enrollment Center (CFEEC), Date of Issuance: September 30, 2014:

The purpose of this policy is to inform Managed Long-Term Care Plans (MLTCP) of a change in the enrollment process for individuals seeking Community Based Long Term Care (CBLTC) services.

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The Department has established a system, in cooperation with Maximus, that all new MLTCP enrollees must have a Uniform Assessment System (UAS) on record prior to enrollment. The Department will develop a system edit to prevent individuals from enrolling into a plan without an UAS conducted by Maximus on file first.

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MLTC Policy 13.03(A): Definition of Community Based Long Term Care (CBLTC) Services

The Department has repeatedly communicated with MLTC Plans and other stakeholders with regard to the definition of CBLTC Services as a primary condition of eligibility for enrollment in a Managed Long-Term Care plan. Consumers must demonstrate need for CBLTC Services for more than 120 days, and these services are defined as: Nursing Services in the home, Home Health Care (which is further defined as traditional Certified Home Health Agency (CHHA) services such as therapies or home health aide service in the home), Personal Care Services in the home (excluding Level 1), Consumer Directed Personal Assistance Services, Adult Day Health Care (ADHC), and Private Duty Nursing.
The demonstrated need for CBLTC Services for more than 120 days is the baseline requirement for enrollment in a Partially Capitated Plan, Nursing Home Level of Care is an additional condition of enrollment that is required for both the PACE and MAP products….

In a "Dear Managed Long-Term Care Plan" dated April 26, 2013, the Department advised in part that Plans must consider the individual needs of each enrollee during the assessment process and must clearly identify the need for social day care as a service in the plan of care. MLTC plans should not enroll a recipient in social day care unless the recipient has a functional or clinical need for community based long term care services (CBLTCS) – defined specifically as personal care services in the home, home health care, private duty nursing, consumer directed personal assistance services, and adult day health care. The need for the CBLTCS must be documented during the initial assessment process, clearly identified in the plan of care, and evaluated on an ongoing basis during reassessments. Social day care can contribute to the total care plan but **cannot** represent the primary service provided to the enrollee as detailed in MLTC Policy 13.03: Community Based Long Term Care Services. Enrollees who no longer demonstrate a functional or clinical need for CBLTCS need must be disenrolled from their MLTC plan.

DISCUSSION

In this matter, the uncontroverted Medical Assistance (MA) History and All Change Actions establishes the Appellant had been in receipt of Medical Assistance authorization no. [redacted] for full coverage. The MA History and All Change History also shows that effective March 1, 2017, the Agency reduced the Appellant's Medical Assistance authorization from full coverage to Medical Assistance authorization no. [redacted] for community coverage without long-term care. Although duly notified of the date and time of the hearing as well as issue in same, the Agency did not present a notice informing the Appellant of the reduction of her Medical Assistance authorization from full coverage to community coverage without long-term care. Thus, the Agency's determination to reduce the Appellant's Medical Assistance authorization/coverage cannot be upheld.

With regards to Appellant's enrollment in a Managed Long-Term Care Plan, the computer-generated eMedNY shows that Appellant had been enrolled in a managed care plan, Centers Plan for Health Living LLC from May 1, 2016 until March 31, 2017. The uncontroverted evidence establishes Medicaid Choice sent a letter dated March 9, 2018, to the Appellant informing her that she was eligible for Managed Long-Term Care (MLTC) Services and she must enroll in an MLTC plan by May 19, 2018. Also on April 28, 2018, Medicaid Choice sent a letter reminding Appellant that she must enroll in a managed care plan by May 19, 2018. On June 23, 2018, Medicaid Choice sent a letter to Appellant informing her that she is eligible for Managed Long-Term Care (MLTC) services and she must enroll in a MLTC plan by September 2, 2018.

At the hearing, the Medicaid Choice representative explained that Appellant's daughter has contacted Medicaid Choice to enroll Appellant in a MLTC plan. The Medicaid Choice representative also explained that it was unable to effectuate the enrollment because Appellant's Medical Assistance authorization was for community coverage without long term care. Notably, Medicaid Choice offered a stipulation to enroll the Appellant in the MLTC plan, Centers Plan for Healthy Living LLC in the event Appellant's Medical Assistance authorization includes long-term care. Notably, the Appellant's daughter agreed to the above-cited stipulation.

Also at the hearing, the Appellant's daughter testified that Appellant is currently residing at a nursing home facility and awaiting discharge from same. She stated Appellant desires home care services upon her discharge. The Appellant's daughter further testified she received the letter dated March 9, 2018 informing the Appellant to enroll in an MLTC plan by April 28, 2018 and contacted Medicaid Choice to enroll Appellant in the MLTC plan, Centers Plan for Healthy Living LLC. She explained that Medicaid Choice did not enroll Appellant because her Medical Assistance authorization changed from full coverage to community coverage without long-term care. The Appellant's daughter stated neither she nor Appellant received a notice informing Appellant of a reduction of her Medical Assistance. The Appellant's testimony is credible as it was consistent, detailed and not rebutted by the Agency or Medicaid Choice.

Considering Appellant did not have a Medical Assistance authorization for long-term services during her attempt to enroll in a MLTC plan and the reversal of the Agency's

determination to reduce Appellant's Medical Assistance authorization from full coverage to community coverage without long-term care, Medicaid Choice's determination not to enroll Appellant was correct when made.

DECISION AND ORDER

The determination of the Agency, without notice, to reduce the Appellant's Medical Assistance authorization, effective March 1, 2017, from full coverage to community coverage without long-term care was not correct and is reversed. The Agency is directed to:

1. Restore the Appellant's Medical Assistance authorization for full coverage retroactively to March 1, 2017.

2. Continue the Appellant's Medical Assistance authorization for full coverage.

Medicaid Choice's determination not to enroll the Appellant into a Managed Long-Term Care Plan was correct when made. The Agency is directed to:

1. Enroll the Appellant in the Managed Long-Term Care Plan, Centers Plan for Health Living LLC.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
07/17/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee