**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** August 30, 2018
[redacted]
**AGENCY:** MAP
**FH #:** 7818925L

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 September 27, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For New York Health Options (a/k/a the Agency)

Denise Caceres, New York Medical Assistance Choice, Quality Assurance Specialist

For the Managed Long Term Care Plan
Debra Ferguson, Fair Hearing Specialist, Centers Plan for Healthy Living

## ISSUE

Was an Agency determination dated August 23, 2018, based on the request of a Managed Long Term Care Health Plan, to disenroll the Appellant from the 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, age 47, is currently in receipt of Medical Assistance for himself only.

2. The Appellant has concurrent enrollment in Managed Long Term Care (MLTC) and the Office of Persons with Developmental Disabilities (OPWDD).

3. The Appellant has been receiving care and services, from a partially capitated (see, https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm) managed long-term care plan operated by Centers Plan for Health Living (hereinafter cited as the MLTCP) since February 1, 2017.

4. The Appellant has been in receipt of personal care services in the amount of 42 hours a week.

5. Effective October 2, 2017, the Appellant was in receipt of waiver services ("comprehensive case management", for the period of October 2, 2017 through June 30, 2018, code 35 on EMedNY, (Case Management Program; Medicaid Service Coordination/Case Management Program (Medicaid OMH, COBRA, AI TCM, OPWDD) per GUIDE TO RESTRICTION EXCEPTION (RE) CODES AND HEALTH HOME SERVICES, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf)), and transitioning to CCO/HH Enrollment Level 2, code 16, effective July 1, 2018 to the present, through the Office of Persons with Developmental Disabilities (hereinafter cited as OPWDD).

6. On or before August 23, 2018, the MLTCP submitted a request to Medicaid Choice, the designated agency, to disenroll the Appellant from MLTC services as an excluded person.

7. On August 23, 2018, the Agency notified the Appellant that it reviewed "the Plan's decision to end your enrollment. After a review of your case, we agree with the Plan" because "The Plan showed proof that you are in a healthcare facility or waiver program for longer than 45 days, or …."

8. On August 30, 2018, the present fair hearing was requested on behalf of the Appellant.

## APPLICABLE LAW

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, Supplemental Nutrition Assistance Program benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, Supplemental Nutrition Assistance benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Managed Long Term Care (MLTC) Involuntary Disenrollment Request Procedures
(typically reproduced in handbooks of individual MLTC Plans)

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.

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)

Proposed involuntary disenrollments identified as the member continuing to need/receive services are to be viewed by plans as transfers. These will typically be nonpayment of surplus and health and safety disenrollments. Plans must be prepared to communicate existing plans of care to receiving plans; in coordination with NYMC as necessary. PLEASE NOTE: This transfer does not apply to an Enrollee who is being involuntarily disenrolled due to service need identified as only SADC or Level I Housekeeping.

All additional documentation provided by the plan and their subcontractors such as home care agencies to NYMC must be on Plan letterhead (dated and with legible signatures). 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.

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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

(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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(b) 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. Copies of such original waiver applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

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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 prospective enrollee.

(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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10. Notwithstanding any inconsistent provision to the contrary, the enrollment and disenrollment process and services provided or arranged by all operating demonstrations or any program that receives designation as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, must meet all applicable federal requirements. Services may include, but need not be limited to, housing, inpatient and outpatient hospital services, nursing home care, home health care, adult day care, assisted living services provided in accordance with article forty-six-B of

this chapter, adult care facility services, enriched housing program services, hospice care, respite care, personal care, homemaker services, diagnostic laboratory services, therapeutic and diagnostic radiologic services, emergency services, emergency alarm systems, home delivered meals, physical adaptations to the client's home, physician care (including consultant and referral services), ancillary services, case management services, transportation, and related medical services.

11. The department shall develop transition and continuity of care policies for participants in home and community based long term care, including the long term home health care program, as they move to managed long term care plans addressing:

(a) a timetable and plan for implementation and transition by participants, plans and providers;

(b)informative disclosure of participants' options as to impending actions affecting or relating to the home care services they receive;

(c) reasonable opportunity for plans' and providers' good faith pursuit of contracts, program changes or state approvals relevant to plan implementation;

(d) notice that a participant with a previously established plan of care provided by a certified home health agency or long term home health care program, or provided pursuant to the personal care or consumer directed personal assistance service programs, may elect to have such care plan continued subject to the participant's next comprehensive assessment; and

(e) delineation of responsibilities for service delivery and care coordination, to avoid conflict, duplication and unnecessary disruption of direct care staffing for the patient, and maintain compliance with state and federal statute and regulation, including the provisions of this section, article thirty-six of this chapter and section three hundred sixty-five-f of the social services law. In addition, the department shall provide technical assistance to long term home health care providers with contracting options under this section. The department shall work with affected stakeholders in the development of these policies.

12. Notwithstanding any provision to the contrary, a managed long term care plan may expand the services it provides or arranges for to include services operated, certified, funded, authorized or approved by the office for people with developmental disabilities for a population of persons with developmental disabilities, as such term is defined in the mental hygiene law, including habilitation services as defined in paragraph (c) of subdivision one of section forty-four hundred three-g of this article, subject to the following:

(a) Such plan must have the ability to provide or coordinate services for persons with developmental disabilities as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities. Such criteria shall include, but not be limited to, adequate experience providing or coordinating services for persons with developmental disabilities;

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such plan lacks the experience required in paragraph (a) of this subdivision, the plan shall have an affiliation arrangement with an entity or entities with experience serving persons with developmental disabilities such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

(a-2) Each enrollee shall receive services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided that all such services are consistent with such person's wishes to the extent that such wishes are known. With respect to an individual receiving non-residential services operated, certified, funded, authorized or approved by the office for people with developmental disabilities prior to enrollment in the plan, such guidelines shall require the plan to contract with the current provider of such non-residential services at the rates established by the office for ninety days in order to ensure continuity of care. With respect to an individual living in a residential facility operated or certified by the office for people with developmental disabilities prior to enrollment in the plan, the plan shall contract with the provider of residential services for that residence at the rates established by the office for people with developmental disabilities for so long as such individual lives in that residence pursuant to an approved plan of care;

(b) The provision by such plan of services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject the joint oversight and review of both the department and the office for people with developmental disabilities. The department and such office shall require such organization to provide comprehensive care planning, assess quality, meet quality assurance requirements and ensure the enrollee is involved in care planning;

(c) Such plan shall not provide or arrange for services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until the commissioner and the commissioner of the office for people with developmental disabilities approve program features and rates that include such services, and determine that such organization meets the requirements of this subdivision and any other requirements set forth by the commissioner of the office for people with developmental disabilities;

(d) An otherwise eligible enrollee receiving services through the plan that are operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall not be involuntarily disenrolled from such plan without the prior approval of the commissioner of the office for people with developmental disabilities. Notice shall be provided to the enrollee and the enrollee may request a fair hearing regarding such disenrollment;

(e) The office for people with developmental disabilities shall determine the eligibility of individuals receiving services operated, certified, funded, authorized or approved by such office to enroll in such plan and shall enroll individuals it determines eligible in a plan chosen by such individual, guardian or other legal representative;

(f) The office for people with developmental disabilities, or its designee, shall complete a comprehensive assessment for enrollees who receive services operated, certified, funded, authorized or approved by such office. This assessment shall include, but not be limited to, an evaluation of the medical, social, habilitative and environmental needs of each prospective enrollee as such needs relate to each individual's health, safety, living environment and wishes, to the extent that such wishes are known. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Such plan of care shall be focused on the achievement of person centered outcomes and shall be consistent with and help inform any other person-centered plan required for the enrollee by the commissioner of the office for people with developmental disabilities. The initial assessment shall be completed by such office or a designee other than the plan and shall be completed in consultation with the prospective enrollee's health care practitioner as necessary. Reassessments shall be completed by such office or its designee, which may be the managed long term care plan in which the person is enrolled or proposes to enroll. The commissioner of the office for people with developmental disabilities shall prescribe the forms on which the assessment shall be made.

(f-1) The plan shall provide the department and the office for people with developmental disabilities with a description of the proposed marketing plan and how marketing materials will be presented to persons with developmental disabilities or their authorized decision makers for the purposes of enabling them to make an informed choice.

(g) Plans providing services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject to all requirements applicable to DISCOs operating under section forty-four hundred three-g of this article with respect to quality assurance, grievances and appeals, informed choice, participation in development of plans of care and requirements with respect to marketing, to the extent that such requirements are not inconsistent with this section.

(h) No person with a developmental disability shall be required to enroll in a managed long term care plan as a condition of receiving medical assistance and services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until program features and reimbursement rates are approved by the

commissioner and the commissioner of the office for people with developmental disabilities and until such commissioners determine that there are a sufficient number of plans authorized to coordinate care for persons with developmental disabilities pursuant to this article operating in the person's county of residence to meet the needs of persons with developmental disabilities, and that such plans meet the standards of this section.

13. Notwithstanding any inconsistent provision to the contrary, the commissioner may issue a certificate of authority to no more than three eligible applicants who are eligible for Medicare and medical assistance to operate managed long term care plans that are authorized to exclusively enroll persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law. The commissioner may only issue certificates of authority pursuant to this subdivision if, and to the extent that, the department has received federal approval to operate a fully integrated duals advantage program for the integration of services for persons enrolled in Medicare and medical assistance. The commissioner may waive any of the department's regulations as the commissioner, in consultation with the commissioner of the office for people with developmental disabilities, deems necessary to allow such managed long term care plans to provide or arrange for services for persons with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety.

14 The provisions of subdivisions twelve and thirteen of this section shall only be effective if, for so long as, and to the extent that federal financial participation is available for the costs of services provided thereunder to recipients of medical assistance pursuant to title eleven of article five of the social services law. The commissioner shall make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of the social services law, and/or submit one or more applications for waivers of the federal social security act, as may be necessary to ensure such federal financial participation. To the extent that the provisions of subdivision twelve and thirteen of this section are inconsistent with other provisions of this article or with the provisions of section three hundred sixty-four-j of the social services law, the provisions of this subdivision shall prevail.

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**Office of Health Insurance Programs**
**Division of Long Term Care**
**MLTC Policy 13.03: Definition of Community Based Long Term Care (CBLTC) Services**
**Date of Issuance: January 25. 2013**

The Department has engaged in ongoing communications with Managed Long Term Care Plans and other stakeholders throughout the course of development for the Medicaid Redesign initiative of Mandatory Managed Long Term Care. During these communications the definition of community based long term care (CBLTC) has repeatedly been presented as the primary condition of eligibility for enrollment in a Managed Long Term Care plan.

Despite various written communications, conference calls and trainings; it has come to our attention that there may be some confusion as to the correct operating definition of CBLTC. A requirement of eligibility for enrollment in a Managed Long Term Care plan is for the consumer to demonstrate

need for CBLTC Services for more than 120 days. These services are defined as: Nursing Services in the home, Home Health Care (which is further defined as traditional CHHA services such as therapies or home health aide service in the home), Personal Care Services in the home (including Level 1), Adult Day Health Care, Private Duty Nursing; and effective November 1, 2012 Consumer Directed Personal Assistance Services. Social Day Care, used as a substitute for in home Personal Care Services, is no longer considered as a CBLTC service for purposes of determining plan eligibility. Social Day Care remains a benefit in the service package.
Please note that this definition is applicable on a Statewide basis to MLTC Partial Cap, Medicaid Advantage Plus, and PACE plans. Plans should revise any member materials or policies and procedures accordingly.

**Office of Health Insurance Programs**
**Division of Long Term Care**
**MLTC Policy 13.03(A): Definition of Community Based Long Term Care (CBLTC) Services, Applicability to Program of All Inclusive Care for the Elderly (PACE) and Medicaid Advantage Plus (MAP)**
**Date of Issuance: October 8, 2013**
The purpose of this document is to address questions and concerns that have been expressed regarding the application of MLTC Policy 13.03, Definition of Community Based Long Term Care (CBLTC) Services, to the Program of All Inclusive Care for the Elderly (PACE) and Medicaid Advantage Plus (MAP).
Managed Long Term Care (MLTC) Policy documents are directed, as applicable, to all three product lines with operating authority pursuant to Article 4403-f, under the rubric of MLTC: Partially Capitated Medicaid Plans, Medicaid Advantage Plus (MAP) Plans, and PACE.
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.
The PACE Model is designed around the PACE Center, where consumers receive medical services such as physician, nursing, and therapies; in addition to socialization, recreation therapy, meals and personal care. Although the PACE Centers are not licensed as an ADHC, the medical components provided at the Center under Article 28 Diagnostic and Treatment Center licensure are the equivalent to need for ADHC as per the definition of CBLTC Services.
Please note that this definition is applicable on a Statewide basis to MLTC Partial Cap, Medicaid Advantage Plus, and PACE plans.

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**Office of Health Insurance Programs**
**Division of Long Term Care**

**MLTC Policy 13.15: Refining the Definition of Community Based Long Term Care Services**
**Date of Issuance: June 10, 2013**

The purpose of this policy is to further clarify the definition of community based long term care. Individuals who only require assistance with housekeeping tasks do not meet the intent of community based long term care services.

Individuals with a need for assistance with both Instrumental Activities of Daily Living (e.g. housekeeping tasks) and Activities of Daily Living (e.g. bathing, grooming, toileting etc) and meeting the eligibility standard of requiring more than 120 days of community based long term care services will continue to be appropriate for MLTC enrollment. Upon periodic reassessment of MLTC member, whether at six month or 90 days, if it is determined that the member solely requires discrete housekeeping services, they should be considered no longer MLTC eligible and be disenrolled. These individuals should be directed to other community resources for assistance.

Any individuals, not presently in receipt of Personal Care Services or Consumer Directed Personal Assistance Program, who are assessed by the MLTC plan as needing only discrete Level I housekeeping services will no longer meet the threshold for enrolling into MLTC. They should be, as indicated above, directed to other supports.

This action allows the Department to refine our enrollment criteria.

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New York Medicaid Redesign Team 1115 Demonstration Extension, December 7, 2016 through March 31, 2021—Technical Corrections, pages 22-23: (https://www.health.ny.gov/health_care/managed_care/appextension/docs/2017-01-19_renewal_stc.pdf)

b. Managed Long Term Care (MLTC). This component provides a limited set of Medicaid state plan benefits including long term services and supports through a managed care delivery system to individuals eligible through the state plan who require more than 120 days of community based long term care services as indicated on the uniform assessment tool. See Attachment B for a listing of MLTC services. Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in under the MLTC column in Table 1(except those otherwise excluded or exempted as outlined in 3(a)(ii) of this section).

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ii. Exclusions and Exemptions from MLTC. Notwithstanding the eligibility criteria in STC3of this section, certain individuals cannot receive benefits through the MLTC program (i.e., excluded) while others may request an exemption from receiving benefits through theMLTC program (i.e. exempted). Excluded individuals are outside the demonstration, and are not included in Demonstration Populations. Exempt individuals are included in the demonstration and in Demonstration Populations regardless of whether they enroll in managed care. Tables 4 and 5 list those individuals either excluded or exempted from MLTC.

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Table 4: Individuals excluded from MLTC

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Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) section 1915(c) waiver program

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https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/nhtd-tbi/mltc_overview.htm:

MLTC Overview:

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Managed Long Term Care (MLTC) is a system that streamlines the delivery of long term services to people who are chronically ill or disabled and who wish to stay in their homes and communities.

These services, such as home care or adult day care, are provided through MLTC Plans that are approved by the New York State Department of Health (NYSDOH).

The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen

Transition Status:

Mandatory MLTC began in September 2012 and the transition was complete in July 2015.

Eligibility for MLTC:

Dual eligible individuals (having both Medicare and Medicaid), who are age 21 and older and who are assessed as needing community based long term care services for more than 120 days must enroll in MLTC in order to receive those services.

Effective 7/1/15 on a statewide basis, dual eligible Nursing Home residents who are age 21 and older and determined to need permanent Nursing Home placement must join a MLTC Plan.

The following may voluntarily enroll in MLTC:
a.dual eligible individuals, age 18–20, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days; and
b.non–dual eligible individuals, age 18 and older, who have been assessed as eligible for nursing home level of care at time of enrollment and also assessed as needing community based long term care services for more than 120 days.

Eligibility Requirements:

An individual must be:

•determined eligible for Medicaid by the Local Departments of Social Services or entity designated by the Department;
•determined eligible for MLTC by the MLTC Plan using the Uniform Assessment System (UAS–NY) eligibility assessment tool;
•capable, at the time of enrollment, of returning to or remaining in his/her home and community without jeopardy to his/her health and safety, based upon criteria provided by the Department; and
•expected to require at least one (1) of the following services covered by the MLTC Plan for more than 120 days from the effective date of enrollment: ◦nursing services in the home;
◦therapies in the home;
◦home health aide services;
◦personal care services in the home;
◦adult day health care;
◦private duty nursing; or
◦Consumer Directed Personal Assistance Services.

•The potential that an Applicant may require acute hospital inpatient services or nursing home placement during such 120 day period shall not be taken into consideration by the Contractor when assessing an Applicant´s eligibility for enrollment.

Populations Excluded From Enrollment:

The following individuals cannot receive benefits through the MLTC Plan:

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n.Individuals in the OPWDD Home and Community Based Services section 191S(c) waiver program;

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Managed Long Term Care Partial Capitation Contract:

ARTICLE IV
ELIGIBILITY FOR MANAGED LONG TERM CARE
A. Populations Eligible for Enrollment
I. Mandatory Enrollment Counties:
Upon approval of the Department and CMS, counties are designated as mandatory for MLTC (Mandatory). The Contractor will be notified at least sixty (60) days in advance when a county is designated as Mandatory. In these counties, dual eligible individuals (having both Medicare and Medicaid), who are age 21 and older and who are assessed as needing community based long term care services listed in section B (6) of this Article for more than 120 days must enroll in MLTC in order to receive those services. These individuals are defined as MLTC Mandatory Persons.

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B. Eligibility Requirements
Except as specified in section C of this Article, an Applicant who completes an enrollment agreement shall be eligible to enroll under the terms of this Contract if he/she:
1. meets the age requirements identified in Appendix F;
2. is a resident in the Contractor's service area;
3. is determined eligible for Medicaid by the LDSS or entity designated by the Department;
4. is determined eligible for MLTC by the MLTCP, or entity designated by the Department, using an eligibility assessment tool designated by the Department;
5. with the exception of districts designated as Mandatory for permanent Nursing Home enrollment (as defined in Article IV and Appendix O),is capable, at the time of enrollment, of returning to or remaining in his/her home and community without jeopardy to his/her health and safety, based upon criteria provided by the Department; and
6. is expected to require at least one (1) of the following Community Based Long Term Care Services (CBLTCS) covered by the MLTCP for more than 120 days from the effective date of enrollment:
a. nursing services in the home;
b. therapies in the home;
c. home health aide services;
d. personal care services in the home;
e. adult day health care;
f. private duty nursing; or
g. Consumer Directed Personal Assistance Services

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C. Populations Excluded From Enrollment
1. The following individuals cannot receive benefits through the MLTCP:

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o. Individuals in the OPWDD Home and Community Based Services section 1915(c) waiver program;

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ARTICLE V
OBLIGATIONS OF THE CONTRACTOR

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D. Disenrollment Policy and Process
1. Disenrollment Policy
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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.
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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.
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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).

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.
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The Regulations at Section 358-2.23 define timely notice.

18 NYCRR358-2.23, Timely notice.

Timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective.

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GIS 18 MA/001 - 2018 Medicaid Managed Care Transition for Enrollees Gaining Medicare

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the Medicaid Managed Care (MMC) transition process for enrollees who gain Medicare eligibility.

1. Transition from MMC to MLTC
To ensure that enrollees who are receiving long term services and supports (LTSS) do not experience a lapse in services when they are disenrolled from MMC due to receipt of Medicare, New York Medicaid Choice (NYMC) will process all managed care transfers and disenrollments for recipients with Medicare, including recipients residing in non-enrollment broker counties. Each month, NYMC performs an electronic search to identify MMC enrollees with current Medicare or Medicare that will become effective within the next 60 days. Once identified, NYMC contacts the Medicaid managed care plans to have the plans identify those enrollees in receipt of LTSS. If in receipt of LTSS, NYMC will enroll eligible recipients into a managed long-term care (MLTC) plan. If a recipient is receiving LTSS and is excluded from MLTC, NYMC will disenroll the consumer from MMC and notify the MMC plan that the recipient is excluded from MLTC. The MMC plan is required to provide the current service authorization plan to the local district managed care coordinator to coordinate the delivery of LTSS through fee-for-service Medicaid.

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18-ADM-06
Purpose:
It is recognized that several existing regulations, policies, administrative memoranda (ADM) and Memorandum of Understanding (MOU) contain language that needs to be updated to current agency terminology as the Office for People With Developmental Disabilities (OPWDD) transitions to a new model of care management, through the use of Care Coordination Organizations (CCOs). The purpose of this ADM is to identify the language and service documentation requirements necessary in the near term to support the continuation of habilitative and other services during this transition.
Discussion:
Transition to Health Home Care Management and Basic Home and Community-Based Services (HCBS) Plan Support Services
Effective July 1, 2018, New York State will initiate the transition of the State's system of services for individuals with intellectual and/or developmental disabilities ("I/DD" or "individual(s)") from Plan of Care Support Services (PCSS) and State Plan Medicaid Service Coordination (MSC) to Health Home Care Management and Basic Home and Community-Based Services (HCBS) Plan Support services.
Service Documentation Requirements During the Transition Period

There will be a one-year transition period from July 1, 2018 through June 30, 2019 ("transition period"). During this transition period, both Individualized Service Plans (ISPs) and/or Life Plans may be in effect throughout the OPWDD service system.

An individual's ISP, created prior to July 1, 2018, will remain in effect until that individual's Life Plan is developed and implemented. An individual's ISP must be converted into a Life Plan pursuant to the requirements in the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. While the annual plan review date will typically correspond to the date of transition to the Life Plan, there may be instances where the dates do not correspond. However, all ISPs must be transitioned to Life Plans on or before June 30, 2019, as outlined in the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

Once an individual's Life Plan has been developed, finalized, and signed/approved by all required parties, per the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual, the Life Plan becomes the active plan of care document. Beginning on July 1, 2018, Life Plans, as opposed to ISPs, will be created for individuals who are new to the OPWDD system, in accordance with the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

During the one-year transition period to CCOs, the term "Life Plan" will be implied to replace any references to the ISP in any MOU, ADM, policy, or regulation, except with respect to specific billing requirements for ISP documentation for any remaining service claims. After an individual's ISP transitions to a Life Plan, the previously required ISP documentation will no longer be applicable to support service claims. Instead, service claims must be supported by a copy of the individual's Life Plan covering the time period of the claim. CCOs are responsible for creating, updating, and maintaining Life Plans. The Life Plan must be completed per the requirements in the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

The Life Plan will be the active document to define an individual's person-centered goals/valued outcomes and safeguard needs. When an individual's ISP transitions to a Life Plan, his/her goals/valued outcomes and safeguards will be integrated into the Life Plan. Attaching Habilitation Plans to the Life Plan will not be required, as these components will become embedded within the Life Plan itself. Section IV [four] of the Life Plan identifies HCBS and State Plan services that have been authorized for the individual.

Under an ISP, individuals' goals were carried out via a Habilitation Plan, which was created by the Habilitation provider. For individuals with a Life Plan; however, the identified goals/valued outcomes are carried out via a Staff Action Plan created by the Habilitation provider. Additional guidance about Staff Action Plan requirements will be issued by OPWDD.

Effective July 1, 2018, the term "Staff Action Plan" is implied to replace any reference to a Habilitation Plan in any existing policy, regulation, ADM or MOU, for individuals who have a Life Plan as the controlling active plan of care. For individuals who continue to have an ISP as the controlling active plan of care, Habilitation Plans remain in place and Habilitation providers must continue to follow the guidance regarding Habilitation Plans as prescribed in ADM# 2012-01 until the individual's Staff Action Plan is developed and finalized.

An Individual Plan of Protection (IPOP) is a compilation of all supports and services needed for an individual to remain safe, healthy and comfortable across all settings. For individuals who have an ISP as the controlling active plan of care and receive Individualized Residential

Alternative (IRA) Residential Habilitation services, there is a requirement for an IPOP. For individuals who have a Life Plan as the controlling plan of care, the IPOP and safeguards will be integrated into Section III [three] of an individual's Life Plan. The individual's goals/valued outcomes and safeguards will be implemented via a Staff Action Plan. Providers may develop internal guidance documents about the implementation of specific/detailed protective oversight measures within residential and day programs. Those materials must align with the overarching protections stated in Section III [three] Individual Safeguards/Individual Plan of Protection (IPOP) of the individual's Life Plan.

Transition from Medicaid Service Coordinator to Care Manager

Effective July 1, 2018, the person coordinating an individual's services and supports and developing his/her Life Plan will be called a Care Manager. All references to a Medicaid Service Coordinator in existing policy, regulation, ADM and/or MOU will be replaced by/intended to mean Care Manager beginning July 1, 2018.

Life Plan Specification of Duration, Effective Date, and Frequency for HCBS Waiver Services

CCOs are responsible for creating, updating, and maintaining Life Plans. The Life Plan must be completed pursuant to the requirements in Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

A Life Plan identifies a date range that is in effect based upon its twice-annual review. The authorized HCBS Waiver services identified in the Life Plan are "in effect" during this period unless otherwise noted in an addendum. The effective date for the HCBS Waiver service is the effective date (i.e. review date) of the Life Plan identified in the effective date column of Section IV [four]. The duration of the HCBS Waiver service is identified in the Life Plan through the comment column in Section IV [four]. The frequency of the HCBS Waiver service is identified in the Life Plan through the unit column in Section IV [four].

Additionally, New York State regulations require each Medicaid provider to prepare records to demonstrate the provider's right to receive Medicaid payment for a service. These records must be prepared "contemporaneously.". 18 NYCRR 504.3(a).

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Care Coordination Organization/Health Home (CCO/HH) Provider Policy Manual, Version 2018-1 July 2018, (https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/CCO_HH_Policy_Manual.pdf) pages 15-16:

1.5 Federal CCO/HH Provider Functional Requirements

The CCO/HH model of service delivery supports the provision of timely, comprehensive, high-quality Health Home services that operate under a whole- person approach to care that integrates medical, behavioral health, developmental disability services, and other needed supports and social services. The whole-person approach to care must address the clinical and non-clinical care needs of the individual.

As described in the CMS SMDL #10-024 and Section 1945(b) of the Social Security Act, designated CCO/HH providers are required to address the following Health Home functional components listed below.

1. Provide quality-driven, cost-effective, culturally appropriate, and person-centered CCO/HH services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

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5. Coordinate and provide access to comprehensive Care Management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;

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8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered Life Plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;

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Additional information regarding Federal CCO/HH Provider Functional Requirements can be found at the following link:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf

**DISCUSSION**

The uncontested evidence in the record establishes that the Appellant is in receipt of Medical Assistance for himself only, and has concurrent enrollment in MLTC and OPWDD. The Appellant has been in receipt of personal care services in the amount of 42 hours a week through his MLTCP. On or before August 23, 2018, the MLTCP submitted a request to Medicaid Choice, the designated agency, to disenroll the Appellant from MLTC services as an excluded person. On August 23, 2018, the Agency notified the Appellant that it agreed with the MLTCP and would disenroll the Appellant from MLTC effective September 1, 2018.

The August 23, 2018 notice provided 9 days-notice. Consistently, the New York Medicaid Choice Managed Long Term Care (MLTC) Involuntary Disenrollment Request Procedures provides that all involuntary disenrollment requests must be submitted to the Agency and the Agency is to process all complete submissions within 6 business days. Furthermore, under the Model Contract, the effective date of disenrollment shall be the first day of the month following the month in which the disenrollment is processed through eMedNY. Thus, where the Agency was able to complete the process prior to the end of August 2018, the first of the month can, and did, result in a notice of fewer than 10 days. Therefore, there is no issue to decide regarding the notice created by and provided to the Appellant.

Presently, based on the New York Medicaid Redesign Team 1115 Demonstration Extension, December 7, 2016 through March 31, 2021—Technical Corrections, pages 22-23, individuals in an OPWDD waiver program are excluded from MLTC. Review of the evidence establishes that the Appellant enrolled into the MLTCP on February 1, 2017, prior to OPWDD eligibility and, therefore, was not in the class of excluded persons when first enrolled. Based on this history, the evidence establishes that it was actions taken either by the Appellant or those on his behalf to obtain OPWDD services, making the Appellant ineligible for MLTC participation by October 2, 2017. Therefore, there was no error by the Agency to disenroll the Appellant.

The Appellant's representative contends that the Agency erred by not providing "the current services authorization plan to the local district managed care coordinator to coordinate the delivery of LTSS [long term services and supports] through fee-for-services Medicaid", quoting from GIS 18 MA/01. The scenario posited from GIS 18 MA/01 is not analogous to the instant matter and cannot be used to create new policy. In that GIS, the person was disenrolled from Medicaid managed care because of dual Medicare/Medicaid eligibility, was excluded from MLTC and, to avoid discontinuance of LTSS, the coordinator was to be notified of the need for fee-for-service Medical Assistance. These were actions that involved transition between plans, not between a plan and a mutually exclusive different entity with its own authority to obtain services, OPWDD.

In the present case, the exclusion from MLTC was initiated by or on behalf of the Appellant, resulting in a response from the Agency, a response that was mandated by the current 1115 Demonstration Extension. GIS 18 MA/01 does not direct the Agency to coordinate services with any other agency. When faced with the situation of the member created OPWDD ground for exclusion, the Model Contract's mandatory basis for a contractor initiated disenrollment does not address this. Rather, in the instant case, there was a contractor initiated disenrollment that was transmitted to the Agency as the entity designated to approve enrollment. and disenrollment. In such an instance, there are no comparable procedures in the contract to continue personal care services.

This result is consistent with the contention from the Agency that it was incumbent upon OPWDD to assume the transitional duty, and is supported by the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Manual. Materially, but not exclusive in its wording, OPWDD CCO/HH system is designed to "Coordinate and provide access to comprehensive Care Management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care" and to "[c]oordinate and provide access to long-term care supports and services". The Appellant was in overlapping receipt of case management from OPWDD, followed by the July 1, 2018 transition to the CCO/HHL model, cumulatively since October 2, 2017. Thus, the Appellant has had one year of service from OPWDD by the time of the instant hearing with the claim that the Agency was somehow at fault in not ensuring the continuation of personal care services while not in managed long term care.

In reviewing the various policies, the CCO/HH Provider Manual provides clear guidance – OPWDD was to provide the transitional care across settings; this obviates the need to have to draw an analogy with GIS 18 MA/01, create policy regarding provision of long term care services at a fair hearing, and place the Agency in violation of the waiver by continuing to

provide services it was no longer authorized to provide. The Manual further noted that OPWDD is to "coordinate and provide access to long-term care supports and services." These provisions are consistent with the Agency's contention that the Appellant's source for relief rests with OPWDD. The Appellant's representative's contention that the Agency is the responsible party to ensure a transition of services is not supported by the evidence.

The Appellant's representative was proffered an adjournment to notify OPWDD about the instant hearing and appear. The Appellant's representative declined. This declination left made for the non-disclosure of the Appellant's interaction with OPWDD. This leaves open a question as to whether the present hearing was to improperly circumvent OPWDD. The evidence cannot support speculation as to what actions OPWDD did or did not take. Therefore, as only the Agency appeared, combined with the evidence submitted on behalf of the Appellant, the substantial weight of the credible evidence regarding the legal responsibilities supports the Agency. The evidence on behalf of the Appellant fails to support Agency error or a claim to a greater amount of benefit.

Based on the foregoing, the determination by the Agency is sustained.

**DECISION**

Agency determination dated August 23, 2018, based on the request of a Managed Long Term Care Health Plan, to disenroll the Appellant from the plan was correct.

DATED: Albany, New York
10/22/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee