STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 25, 2016
[redacted]
AGENCY: HMO
FH #: 7350459N

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 18, 2016, 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

Nathan Weiner, Fair Hearing Representative

ISSUES

Was the Agency's determination not to enroll the Appellant in a Managed Care Plan correct?

FACT FINDING

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 sixty-nine, resides with her husband, age fifty-six, and her son, age twenty-three.

2. The Appellant had previously been in receipt of Family Health Plus benefits through August 31, 2012, during which time the Appellant was enrolled in a Managed Care Plan.

3. The Appellant's Medical Assistance authorization for the period from July 1, 2015, through June 30, 2016, under Fee-for-Service Medicaid was subject to an excess income spenddown.

4. Under the Welfare Management System (WMS) category code "06," "provisional" eligibility was provided when the monthly excess income spenddown was not met. Under WMS category code "02," "outpatient" eligibility was provided when the excess income spenddown was met.

5. The Appellant was provided with outpatient Medicaid coverage for the months of March, April and June, 2016.

6. On July 25, 2016, the Appellant requested this fair hearing.

APPLICABLE LAW

18 NYCRR 358-5.9. Fair hearing procedures.

(a) At a fair hearing concerning the denial of an application for or the adequacy of medical assistance 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.

An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. An applicant or recipient does not have the right to a fair hearing in all situations. 18 NYCRR 358-3.1(a), (f).

A person who is sixty-five years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise is eligible for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance Program. Social Services Law Section 366.1(c)(2).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result - net income - is compared to the statutory "standard of need" set forth in Social Services Law Section 366.2(a)(7) and 18 NYCRR Subpart 360-4. If an applicant's or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

The amount by which net income exceeds the standard of need is considered "excess income". If the applicant or recipient has any excess income, he/she must incur bills for medical care and services equal to or greater than that excess income to become eligible for Medical Assistance. In such instances Medical Assistance coverage may be available for the medical costs which are greater than the excess income. If a person has expenses for in-patient hospital care, the excess income for a period of six months shall be considered available for payment. For other medical care and services the excess income for the month or months in which care or services are given shall be considered available for payment of such care and services. 18 NYCRR 360-4.1, 360-4.8.

Administrative Directive 87 ADM-4 provides detailed instructions regarding the appropriate application of medical bills to offset excess income so that an individual can become eligible for Medical Assistance. This offsetting process is called "spenddown". Said Directive further provides that whenever a spenddown is indicated, the Agency is required to include a copy of the letter "Explanation of the Excess Income Program" along with the Notice to the recipient whenever an acceptance, intended change, denial, or discontinuance indicates a spenddown liability situation. Administrative Directive 87 ADM-4 provides that some over-the-counter drugs and medical supplies such as bandages and dressings may be applied to offset determined excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items may not be so applied.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

Section 364-j (1)(c) of the Social Services Law defines "Managed Care Program" as a program in a social services district in which Medicaid recipients enroll on a voluntary or mandatory basis to receive Medicaid services, including case management, directly or indirectly (including by referral) from a managed care provider ("Medicaid Managed Care Health Plan"), including as applicable, a special needs managed care plan or a comprehensive HIV special needs plan.

However, Section 364-j(3)(e) of the Social Services Law provides that the following categories of individuals may be required to enroll with a managed care program when program features and reimbursement rates are approved by the Commissioner of Health and, as appropriate, the Commissioners of the Office of Mental Health, the Office for People with Developmental Disabilities, the Office of Children and Family Services, and the Office of Alcoholism and Substance Abuse Services:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program; provided, however, nothing herein shall: (a) require an individual enrolled

in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program; or (b) make enrollment in a Medicare managed care plan a condition of the individual's participation in the managed care program pursuant to this section, or affect the individual's entitlement to payment of applicable Medicare managed care or fee for service coinsurance and deductibles by the individual's managed care provider.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals;

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law;

(v) a person receiving services provided by a residential alcohol or substance abuse program or facility for the developmentally disabled;

(vi) a person receiving services provided by an intermediate care facility for the developmentally disabled or who has characteristics and needs similar to such persons;

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through existing waivers under section nineteen hundred fifteen (c) of the federal social security act or who has characteristics and needs similar to such persons;

(viii) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title;

(ix) a person receiving services provided by a long term home health care program, or a person receiving inpatient services in a state-operated psychiatric facility or a residential treatment facility for children and youth;

(x) certified blind or disabled children living or expected to be living separate and apart from the parent for thirty days or more;

(xi) residents of nursing facilities;

(xii) a foster child in the placement of a voluntary agency or in the direct care of the local social services district;

(xiii) a person or family that is homeless;

(xiv) individuals for whom a managed care provider is not geographically accessible so as to reasonably provide services to the person. A managed care provider is not

geographically accessible if the person cannot access the provider's services in a timely fashion due to distance or travel time;

(xv) a person eligible for Medicare participating in a capitated demonstration program for long term care;

(xvi) an infant living with an incarcerated mother in a state or local correctional facility as defined in section two of the correction law;

(xvii)a person who is expected to be eligible for medical assistance for less than six months;

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

(xix) individuals 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;

(xx) 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 local social services district;

(xxi) a person receiving family planning services pursuant to subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of this title;

(xxii)a person who is eligible for medical assistance pursuant to paragraph (d) of subdivision four of section three hundred sixty-six of this title;

(xxiii) individuals with a chronic medical condition who are being treated by a specialist physician that is not associated with a managed care provider in the individual's social services district; and

(xxiv) Native Americans.

Department regulations at 18 NYCRR 360-10.5(d) provide as follows concerning the procedures used by a local district to determine requests for exemptions and exclusions:

(d) Determination of a Medicaid recipient’s eligibility for an exemption or exclusion shall be the responsibility of the social services district.

(1) Determinations made prior to enrollment.

(i) If a Medicaid recipient requests an exemption or exclusion from enrollment in an MMCO, the Medicaid recipient or the Medicaid recipient's representative must file a written request with the appropriate social services district. The social services district shall require the Medicaid recipient to provide documentation to support the request for an exemption or exclusion where appropriate.

(ii) The social services district must make a determination within 10 days after receipt of all necessary information and notify the Medicaid recipient in writing whether the request for an exemption or exclusion is granted or denied.

(iii) When a request for an exemption or exclusion is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title

(2) Determinations of a Medicaid recipient’s eligibility for an exemption or exclusion from enrollment in a managed care program after enrollment has occurred.

(i) When the social services district becomes aware that an enrollee is excluded from participating in accordance with subdivision (c) of this section, the social services district or its designee will initiate disenrollment of the enrollee.

(ii) A Medicaid recipient may apply for an exemption or an exclusion by filing a written request with the appropriate social services district. The social services district shall require the Medicaid recipient to provide documentation to support the request for an exemption or exclusion where appropriate.

(a) The social services district must make a determination in sufficient time to ensure that the disenrollment will be effective no later than the first day of the second month following the month in which the social services district received the request, unless the recipient requests expedited disenrollment pursuant to paragraph (iii) of this subdivision.

(b) The social services district must notify the recipient in writing of its determination to approve or deny the request for an exemption or exclusion.

(c) When a request is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title.

(iii) An enrollee may request an expedited disenrollment or change if; an immediate risk to the enrollee's health exists, the enrollment was non-consensual, or for other reasons as set forth in the contract between the MMCO and the State. The social services district may request documentation to substantiate the request. The effective date of the expedited disenrollment or change must comply with the timeframes found in the contract between the MMCO and the State.

(a) The social services district must notify the recipient in writing of its determination to approve or deny the request for an expedited disenrollment.

(b) When a request is denied, the social services district must provide a written notice that explains the reason for the denial, states the facts upon which the denial is based, cites the relevant statutory or regulatory authority for the denial, and advises the Medicaid recipient of his or her right to a fair hearing. The notice must comply with subdivision (a) of section 358-2.2 of this Title.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment.

GIS 15 MA/12 entitled "Medicaid Managed Care Exemptions and Exclusions" provides, in part, that:

POPULATIONS EXCLUDED FROM ENROLLMENT

Resident of State-operated psychiatric facilities;

Residents of state certified or voluntary operated treatment facilities for children;

Participants in capitated long term care demonstration projects;

Medicaid eligible infants living with incarcerated mothers in state or local correctional facilities;

Individuals who are expected to be MA eligible for less than 6 months (except for pregnant women);

Blind or disabled children living separate from their parents for 30 days or more;

Permanent residents, under age 21, of residential health care facilities (RHCF) and temporary residents of RHCFs at the time of enrollment;

Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY);

Individuals receiving hospice services at time of enrollment;

Individuals with access to comprehensive private health insurance;

Persons in receipt of Medicaid/Medicare;

Foster care children placed by voluntary agencies or in the care and custody of the Office of Children and Family Services;

Spend-down medically needy;

Individuals under 65 years of age, who have been determined eligible by the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal, Prostate Cancer;

Individuals receiving family planning services only;

District 97, Fiscal responsibility of State OMH;

District 98, Fiscal responsibility of State OPWDD.

DISCUSSION

The record in this matter establishes that the Appellant, age sixty-nine, had been in receipt of an authorization for provisional of Fee-for-Service Medicaid with a monthly spenddown of excess income during the period from January 1, 2015, through June 30, 2016. The record also shows that the Appellant was authorized for Medical Assistance under "provisional" coverage (code "06" on the WMS MA History screen) except for the months of March, April and June, 2016, when the Appellant was provided with "outpatient" coverage (code "02" on the WMS MA

History screen), the latter coverage presumably provided when the Appellant met her monthly excess income spenddown for the respective month. The record also shows that, prior to the aforesaid coverage periods, the appellant had been in receipt of Family Health Plus, the last period of coverage under said program was from October 1, 2011, through August 31, 2012. It is noted that provision of Medical Assistance under the previous Family Health Plus benefits program would have been provided via enrollment in a Managed Care Plan.

At the hearing, the Appellant contended that she was previously enrolled in a managed care program administered by MetroPlus, that about 2 years ago, upon the advice of her sister, she disenrolled from MetroPlus and enrolled in Centers Plan for Healthy Living, a Medicare Advantage Care Plan, that she is dissatisfied with Centers Plan and wants to re-enroll with MetroPlus, that she asked to be re-enrolled but was denied, and therefore asked for this fair hearing. It is noted that the Appellant did not present any credible or persuasive evidence which might establish that a request to re-enroll in a managed care plan had been made or that the Agency denied any such request.

Based upon the foregoing, it appears that the prior enrollment in MetroPlus occurred when the Appellant was a recipient of Family Health Plus. The Appellant, however, is now age sixty-nine and a recipient of a Medicaid Fee-For-Service authorization subject to a monthly excess income spenddown, The so-called determination of the Agency not to re-enroll the Appellant in a managed care plan and to continue to authorize "provisional" Fee-For Service coverage in those months where the excess income spenddown has not been met, and/or to provide community outpatient coverage during those months when the excess income spenddown has been met, is sustained.

It is noted that the Appellant's current eligibility for Medical Assistance, Medicaid benefits, subject to an excess income spenddown excludes the Appellant from enrollment in a "mainstream" Medicaid Managed Care Plan.

DECISION

The Agency's determination not to enroll the Appellant in a Managed Care Plan is correct.

FH# 7350459N

DATED: Albany, New York
09/01/2016

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee