STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 17, 2019
[redacted]
AGENCY: MAP
FH #: 7996206Q

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 January 6, 2020, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Managed Long Term Care Plan

Debora Ferguson, Centers Plan for Healthy Living, a Medicaid Managed Long Term Care Plan

Interested Party

Michael Johnson, New York Medical Assistance Program, Fair Hearing Representative

ISSUE

Is there an issue to be reviewed by the Commissioner regarding the Appellant being disenrolled from the Managed Long-Term Care Plan in which she has been participating?

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. 1. The Appellant, [redacted], is in receipt of Medical Assistance and has been enrolled in the [redacted] ("Managed Long-Term Care Agency's") Managed Long Term Care Plan at all relevant times since January 2019 or February 2019.

2. The Appellant has been in receipt of personal care services per week from the Managed Long- Term Care Agency, presently in the amount of 30 hours per week (6 hours per day, 5 days per week). The amount of personal care services hours provided to the Appellant by the Managed Long Term Agency is not a disputed issue in this fair hearing.

3. On May 21, 2019, the local department of social services, [redacted] Medical Assistance Program issued a Notice providing that the Appellant's Medical Assistance would be discontinued effective July 3, 2019 due to a failure to submit a renewal form by May 10, 2019. That notice advised the Appellant that as a result of the discontinuance of Medicaid, the Appellant's home care services and Managed Long Term Care Plan enrollment services would also be discontinued.

4. The Managed Long Term Care Agency verbally advised the Appellant that he may be disenrolled from the Managed Long Term Care Plan as a result of the Medicaid discontinuance.

5. On July 17, 2019, the Appellant requested this fair hearing and received aid continuing. The Managed Long Term Care Agency did not disenroll the Appellant from the program as a result of the aid continuing directive.

6. During the pendency of this fair hearing, the Appellant recertified eligibility for Medicaid with the local department of social services and was determined eligible to receive Medicaid and Managed Long Term Care assistance effective July 3, 2019 through the present.

7. As a result of the aid continuing directive and subsequent recertification of Medicaid eligibility, the Appellant has not experienced a gap in Managed Long Term Care assistance coverage as of the date of this fair hearing.

APPLICABLE LAW

Regulations in Title 18 NYCRR define an investigation of eligibility and degree of need as a continuous process concerned with all aspects of eligibility for Public Assistance and care, including Medical Assistance, from the period of initial application to case closing. Investigation means the collection, verification, recording and evaluation of factual information on the basis of which a determination of eligibility and the degree of need is made. As part of this investigation, it is the responsibility of an applicant or recipient of Public Assistance and care to verify his/her place of residence. 18 NYCRR 351.1, 351.2, 360-1.2 and 360-2.3. Section 360-2.3 of the Regulations provides the Agency (Local Department of Social Services District) has a continuing obligation to collect, verify, record and evaluate factual information concerning a recipient's eligibility for Medical Assistance. Section 360-2.2(e) of the Regulations require social services districts to redetermine a recipient's eligibility at least once every 12

months and whenever there is a change in the recipient's circumstances that may affect eligibility. The district may redetermine eligibility more frequently.

Under section 366-a (5) of the Social Services Law, continuing eligibility for assistance must be reconsidered from time to time, or as frequently as required by the regulations of the New York State Department of Health. Effective April 1, 2003, a personal interview may not be required as part of the redetermination of eligibility. Instead, the recipient must be provided with a renewal form developed by the Department of Health, which requests information which is necessary to determine continued eligibility for Medical Assistance and which may have changed.

The applicant's or recipient's failure or refusal to cooperate in providing necessary information is a ground for denying an application for a Medical Assistance Authorization or for discontinuing such benefits. Note that, pursuant to Section 366-a(2)(b) of the Social Services Law, an applicant or recipient may attest to the amount of his or her accumulated resources, unless such applicant or recipient is seeking Medical Assistance payment for long term care services.

Social Services Law Section 366-f(1)(b) provides that long term care services shall include, but not be limited to care, treatment, maintenance, and services: provided in a nursing facility licensed under Public Health Law Article 28; provided by a home care services agency, certified home health agency or long term home health care program, as defined in Public Health Law Section 3602 of the public health law; provided by an adult day health care program in accordance with regulations of the Department of Health; or provided by a personal care provider licensed or regulated by any other state or local agency; and such other services for which Medical Assistance is otherwise available under this chapter which are designated as long term care services in law or regulations of the Department of Health. Individuals who currently have, or who need, community-based or institutional long-term care, as defined above, will continue to be required at renewal to document income, change of residence and resources. See 08 OHIP/ADM-4.

Administrative Directive 04 OMM/ADM-6, page 15, provides in part as follows: For renewals (non-chronic care) mailed on or after August 23, 2004, Medicaid-only recipients who are subject to a resource test will be instructed to itemize their resources and send in documentation if they are receiving Medicaid coverage for long-term care services. If a recipient provides the value of his/her resources, but fails to provide adequate resource documentation, the social services district must determine the recipient’s on-going eligibility for Community Coverage Without Long-Term Care.

DISCUSSION

At the fair hearing, the Managed Long-Term Care Agency (MLTC Agency) representative stated that the Appellant has been enrolled in its Managed Long-Term Care Plan since January 2019 or February 2019. The MLTC Agency representative explained that the Appellant was advised in or around June or July 2019 that his enrollment with the Managed

Long Term Care Plan would be terminated due to the Appellant's failing to recertify for Medicaid eligibility in May 2019. The MLTC Agency representative explained that eligibility for Managed Long Term Care enrollment is determined by the Local County Department of Social Services.

The MLTC Agency representative indicated that the Managed Long Term Care Plan receives notice of the Medicaid enrollments and dis-enrollments through an electronic roster sent by the New York State Department of Health that are uploaded several times a month. The Managed Care Agency was alerted that the Appellant had not recertified for Medicaid eligibility and his Medicaid was subject to discontinuance effective July 3, 2019. The Appellant was verbally advised that he may be disenrolled from the Managed Long Term Care Plan as a result of his loss of Medicaid eligibility. The MLTC Agency representative did not indicate whether a written notice of disenrollment from Managed Long Term Care was issued. The uncontroverted record establishes that the Appellant requested this fair hearing July 17, 2019 after having been advised of a potential disenrollment and was granted aid continuing in respect of the Managed Long Term Care Plan enrollment.

At the fair hearing, a Representative from the local county Department of Social Services confirmed that on May 21, 2019, the Appellant was provided with a Notice stating that the Appellant's Medicaid coverage would be discontinued June 3, 2019 due to a failure to submit a Medicaid renewal form. During the pendency of this fair hearing, the Appellant submitted a recertification application for Medicaid in September 2019 and was approved for Medicaid coverage, including Medicaid Long Term Care Assistance, effective July 1, 2019.

The Managed Long Term Care Agency representative stated that the Appellant's enrollment with the managed long term care plan had not been interrupted since enrollment commenced from on or around January 2019 or February 2019. The representative testified based upon her personal review of enrollment records contained within Managed Long Term Care Agency's database but declined to submit documents on the fair hearing record.

It should be noted that, on the same day as this hearing, a separate Fair Hearing # [redacted] was held. During this hearing, the Representative for the local county Department of Social Services confirmed that the Appellant reapplied for Medicaid assistance and his eligibility was made effective July 1, 2019, resulting in a 27-day gap in Medicaid coverage from June 3, 2019 through June 30, 2019.

By Decision After Fair Hearing #[redacted], the Commissioner reversed the local department of social services' May 21, 2019 determination to discontinue the Appellant's Medicaid effective July 3, 2019. As a result, the Appellant's Medicaid and Managed Long Term Care assistance eligibility for the gap period June 3, 2019-June 30, 2019 was restored and the question under review as part of this fair hearing is moot.

Given the foregoing, there is no issue for the Commissioner to review as part of this fair hearing.

DECISION

There is no issue to be reviewed by the Commissioner regarding the Appellant being disenrolled from the Managed Long-Term Care Plan in which he has been participating.

DATED: Albany, New York
01/24/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Robert F. Gannon

Commissioner's Designee

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