STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 28, 2017
[redacted]
AGENCY: MAP
FH #: 7674172H

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 February 7, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For New York Medicaid Choice, the Agency's and New York State Department of Health's Designated Agent (hereinafter cited a "The Agency")

Ana Rodriguez, Fair Hearing Representative

ISSUE

Was the Agency's determination not to enroll the Appellant in a Managed Long Term Care Plan operated by [redacted], following the Appellant's involuntarily disenrollment from Centers Plan for Healthy Living, 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 41, is in receipt of authorization for Medical Assistance and is enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living ("the Plan").

2. The Appellant is in receipt of authorization for personal care services.

3. By letter dated November 21, 2017, the Plan advised the Appellant that it made a request to the Agency to have the Appellant involuntary disenrolled from its managed long term care plan.

4. On or about November 21, 2017, the Plan submitted a "Managed Long Term Care Involuntary Disenrollment Request Form" to the Agency, seeking to disenroll the Appellant because "Enrollee or family members engages in behavior that seriously impairs the Contractor's ability to furnish services for reasons other than those resulting from the Enrollee's special needs…"

5. By letter dated December 14, 2017, the Agency advised the Appellant that it authorized the Plan's request to involuntarily disenroll her from its managed long term care plan, because the Plan had established that it could not provide services to the Appellant. The letter stated that if the Appellant did not select a new plan, a plan would be chosen for her.

6. By letter dated December 21, 2017, the Agency advised the Appellant that she had been enrolled in another managed long term care plan, [redacted], effective January 1, 2018.

7. On December 28, 2017, this fair hearing was requested.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, or the source of funding and the amount deducted from the initial payment of supplemental security income as reimbursement of Public Assistance, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Regulations at 18 NYCRR 360-2.2(f) provides that an applicant or recipient of Medical Assistance has the responsibility to inform the Agency immediately of all changes in circumstances.

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

(g)(i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

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

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. Enrollments conducted by a

plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

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

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The Managed Long Term Care Model Contract provides, in part, that:

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D. Disenrollment Policy and Process
1. Disenrollment Policy
a. The Contractor shall comply with disenrollment policies and procedures developed by the Contractor as approved by the Department. Such written policies and procedures shall address all aspects of disenrollment processing and shall contain the disenrollment forms and materials used by the Contractor. The Contractor must submit any proposed material revisions to the policies and procedures for Department approval prior to implementation of the revised procedures.
b. The effective date of disenrollment shall be the first day of the month following the month in which the disenrollment is processed through eMedNY.
c. Disenrollment by the Contractor may not be based in whole or in part on an adverse change in the Enrollee's health or on the capitation rate payable to the Contractor. Disenrollment may not be initiated because of the Enrollee's high utilization of covered medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs except as may be established under section D.5.a of this Article.
d. The Contractor shall continue to provide and arrange for the provision of covered services until the effective date of disenrollment. The Department will continue to pay capitation fees for an Enrollee until the effective date of disenrollment.
e. In consultation with the Enrollee and other individuals designated by the Enrollee, prior to the Enrollee's effective date of disenrollment, the Contractor shall make all necessary referrals to the LDSS or entity designated by the Department, another MLTCP or alternative services for which the MLTCP is not financially responsible, to be provided subsequent to disenrollment, when necessary, and advise the Enrollee in writing of the proposed disenrollment date.
f. If an Enrollee is transferring from the Contractor's MLTCP to another MLTCP or Medicaid Managed Care plan, the Contractor must provide the receiving plan with the individual's current person centered service plan in order to ensure a smooth transition.
g. If an Enrollee is disenrolling from the Contractor's MLTCP to receive services through an Assisted Living Program (ALP), the Contractor must pay the applicable Medicaid rate for the level of care for which the Enrollee is assessed using the Patient Review Instrument (PRI) or successor tool until the disenrollment from the MLTCP is processed. The Contractor is responsible for all other medically necessary services covered by the MLTC benefit package that

are not included in the ALP rate until the disenrollment takes place.

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

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4. Reasons the Contractor Must Initiate Disenrollment

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

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

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

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

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

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

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

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

5. A Contractor May Initiate an Involuntary Disenrollment if:

a) An Enrollee or an Enrollee's family member or other person in the home engages in conduct or behavior that seriously impairs the Contractor's ability to furnish services to either that particular Enrollee or other Enrollees; provided, however, the Contractor must have made and documented reasonable efforts to resolve the problems presented by the individual. Consistent with 42 CFR 438.56(b), the Contractor may not request disenrollment because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs.

b) An Enrollee fails to pay for or make arrangements satisfactory to the Contractor to pay the amount, as determined by the LDSS or entity designated by the Department, owed to the Contractor as spenddown/surplus or NAMI within thirty (30) days after such amount first becomes due, provided that during that thirty (30) day period the Contractor first makes a reasonable effort to collect such amount, including making a written demand for payment and advising the Enrollee in writing of his/her prospective disenrollment.

c) An Enrollee knowingly fails to complete and submit any necessary consent or release.

d) An Enrollee provides the Contractor with false information, otherwise deceives the Contractor, or engages in fraudulent conduct with respect to any substantive aspect of his/her plan membership.

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.

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record establishes that the Appellant is in receipt of authorization for Medical Assistance and currently enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living ("the Plan"). The record further establishes that by letter dated December 14, 2017, New York Medicaid Choice (the "Agency") advised the Appellant that it had accepted the Plan's request to involuntarily disenroll the Appellant from its managed long term care plan. As a result of the disenrollment, by letter dated December 21, 2017, the Agency advised the Appellant that she had been enrolled in another managed long term care plan, [redacted], effective January 1, 2018.

At the time of the hearing the Appellant was enrolled with the Plan pursuant to an "Aid-to-Continue" order.

The record establishes that on or about November 21, 2017, the Plan submitted a "Managed Long Term Care Involuntary Disenrollment Request Form" to the Agency, seeking to disenroll the Appellant because "Enrollee or family members engages in behavior that seriously impairs the Contractor's ability to furnish services for reasons other than those resulting from the Enrollee's special needs…".

At the hearing, the Appellant's representative stated that the Appellant's involuntary disenrollment from the Plan was not in dispute. He stated the Appellant is disputing the Agency's subsequent enrollment of Appellant in the [redacted] managed long term care plan. He stated the Appellant was not aware that she had been involuntarily disenrolled until a representative from [redacted] contacted her to schedule an assessment.

The Appellant's representative contends the Appellant has transition rights, and since she has been involuntarily "kicked out" of the Plan, she has the right to choose her new plan, and has the right to keep her current level of care until such time as a timely and adequate notice advises that her services will be changed. The Appellant's representative stated that while the Appellant had received a letter from the Plan in November 2017 advising that it had made a request to involuntarily disenroll her, she had not received the Agency's December 14, 2017 letter advising that it had accepted the Plan's request for involuntarily disenrollment, which also advised that if she did not select a new managed long term care plan, one would be chosen for her. Therefore, since the Appellant had not received the Agency's December 14, 2017 notice, he contends she should now be able to select the managed long term care plan of her choice, which is [redacted]

[redacted], and the Agency should enroll her in that plan.

In addition to non-receipt, the Appellant's representative asserts that the December 14, 2017 letter constituted a defective notice because it was mailed to the wrong address.

In response, the Agency contends that the December 14, 2017 letter was mailed to the Appellant's address of record, and since the Appellant had not responded to it, she was enrolled in the plan selected for her, thereby completing the involuntary disenrollment process. According to the Agency's representative, if the Appellant now wants to be enrolled with [redacted], it will be considered a request for a "voluntary transfer," which would include a pre-enrollment assessment.

The Appellant's representative stated that because the Appellant had not received notice of the involuntary disenrollment, she should be placed back in the same position she was in on December 14, 2017 and be allowed to transition to the plan of her choice, which would include her current plan of care being forwarded to the plan of her choice for continued service at the current level. He stated that a pre-enrollment assessment associated with a "voluntary transfer" would unfairly expose the Appellant to the risk of being authorized for fewer personal care services hours than she had at the time of the involuntary disenrollment.

After thorough consideration and review of the record, the Agency's determination will be sustained.

The central issue for this hearing is whether the Agency followed proper involuntary disenrollment procedures. The position of the Appellant's representative is that the Agency did not, as the December 14, 2017 letter constituted a defective notice because it was mailed to the wrong address, therefore the Appellant did not receive it and did not have timely and adequate notice of the disenrollment, thereby depriving her of the opportunity for placement in the managed long term care plan of her choice. The Agency's December 14, 2017 and December 21, 2017 letters were addressed to the Appellant at "[redacted]". Appellant's representative states that she lives at "[redacted]". The Agency's representative stated that the Appellant's address was obtained from the New York City Human Resources Administration Medical Assistance Program (MAP). MAP documents in the hearing record ("Turn Around Document" and "eMedNY" screens) reflect the Appellant's mailing and residential addresses as "[redacted]", as of January 29, 2018 and January 30, 2018, respectively. Upon review of this information at the hearing, the Appellant's representative produced a copy of a letter dated February 5, 2018, in which the Appellant stated she has lived at the [redacted] Avenue address since October 2015, repeatedly reported her change of address "to Medicaid" by telephone and at recertification, and faxed proof of her residence to her public assistance worker which was updated in "NYC's WMS system". There was no documentation submitted in support of this letter (e.g., a copy of correspondence addressed to her current address from HRA's Medical Assistance Program; a copy of a submitted recertification form - or any other document - reflecting notice to HRA's Medical Assistance Program of a change in address; a fax confirmation page regarding what was allegedly sent to the public assistance

worker; or evidence that her address was updated in NYC's WMS system). This copy of a letter, by itself, is deemed unpersuasive. The Agency is not at fault for addressing its correspondence to the Appellant at the address of record which still appears in the MAP database, more than two years after the date Appellant stated she moved. As a recipient of Medical Assistance, the Regulations provide it is the Appellant's responsibility to provide MAP with all changes in circumstances, including change of address. It has not been sufficiently established at this hearing that the Appellant had done so, or alternatively, that MAP failed to process a timely request. Thus, the record does not support a finding that the December 14, 2017 notice was defective, nor does it provide a context within which a claim of non-receipt can be reasonably considered. The record does not reflect any error in the Agency's involuntary disenrollment process, which in this case, was completed with Appellant's subsequent enrollment in [redacted] managed long term care plan.

The Appellant may contact HRA's Medical Assistance Program to resolve any outstanding issues regarding her residential and mailing addresses of record, and request a Fair Hearing, in the event those issues are not resolved to her satisfaction.

DECISION

The Agency's determination not to enroll the Appellant in a Managed Long Term Care Plan operated by [redacted], following the Appellant's involuntarily disenrollment from Centers Plan for Healthy Living, was correct.

DATED: Albany, New York
03/06/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee