Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Notice of Determination and Fair Hearing Policy for Health Home and HCBS

Intended Population: Health Home Serving Adults and Children

Department: Health Home

Effective Date: 4/1/2019

Date Revised: 5/14/2019, 10/1/2021;11/1/2022; 1/1/2023; 2/1/2024; 12/1/2024; 1/1/2025

DOH Policy: HH0004
DOH Policy: CW0009

Purpose of Policy

To inform Health Home Service Providers the policy regarding issuing of notices and disseminating the Notice of Determination forms and the Fair Hearing process for members who are referred to Health Home, enrolled in Health Home, disenrolled from Health home, and whom may also be is receipt of HCBS Waiver. Adherence to these requirements is the responsibility of Health Homes, Care Management Agencies/Care Managers by the implementation date noted above.

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director.
3. All questions regarding this policy or its implementation may be directed to the AHI Health Home Director.

Statement of Policy

AHI shall develop, disseminate, and review at least annually a Notice of Determination and Fair Hearing Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Notice of Determination and Fair Hearing Policy.

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Definitions

AHIHH: AHI Health Home, a designated lead Health Home by the New York State Department of Health

Health Home Service Provider: An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

Health Home Candidate: a person who is potentially eligible to become a Health Home Participant and is assigned by an MCO or NYSDOH to AHI or is referred by an organization.

Member/Participant: The individual (both adults and children/youth) enrolled in the Health Home program or enrolled for the Children's Waiver. The term includes, parent, guardian, legal authorized representative of the member, as applicable. These terms can be used interchangeably.

OTDA: Office of Temporary Disability Assistance

Aid Continuing: The right of a Health Home enrollee to have services continue unchanged until the Decision After Fair Hearing is issued; Aid Continuing directives are issued by OTDA.

Agency Conference**:** An informal meeting that may be requested by the member in addition to requesting a Fair Hearing in which the member may submit additional information in support of their disagreement with the determination on enrollment or continued enrollment in the NYS Health Home Program**.**

Evidence Packet**:** Documentation supporting enrollment/disenrollment determinations can include and is not limited to: the signed consent form; the updated Plan of Care (POC); care record notes; appropriateness; eligibility assessments, documentation and medical documentation; written summary of the case; the applicable Health Home policy(s) governing the program; and, a copy of the notice being challenged. Additionally, the Children's Waiver Eligibility Determination or attempts to complete such Eligibility Determination is included for children under Home and Community Based Services (HCBS).

Fair Hearing**:** A proceeding before an Administrative Law Judge that provides an opportunity for a member and the agency to present evidence in support of a determination that the member does not agree with.

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Fair Hearing Notice: Notifications sent from Office of Temporary and Disability Assistance (OTDA) to the Department which identify when a Health Home (HH) or Children's Waiver member requests a Fair Hearing and all subsequent activities to include, date Fair Hearing is scheduled for, request for reschedule of the Fair Hearing date, Decision After Fair Hearing, etc.

Successful Completion: Occurs when a member has met all of the goals in the Plan of Care and no longer meets the appropriateness criteria for participation in a Health Home or HCBS.

Notice Date: The date the Notice of Determination is issued.

Notice of Determination/Decision: A written notice to a member or potential member of the Health Home's determination of eligibility for enrollment or continued enrollment in the NYS Health Home Program.

Timely Notice: Per 18 NYCRR § 358-2.23, a timely notice is one that is mailed at least ten days before the date upon which the proposed action is to become effective.

HARP: Health and Recovery Plan

SNP: Special Needs Plan

HCBS: Home and Community Based Services

***Children and Youth Evaluation Service (C-YES)*:** The State-designated Independent Entity that conducts the Home and Community Based Services (HCBS) Eligibility Determination for children/youth who need or want HCBS and are not enrolled in Medicaid. The Children and Youth Evaluation Service (C-YES) develops and manages the Home and Community Based Services (HCBS) plan of care for children/youth enrolled in the 1915(c) Children's Waiver Home and Community Based Services who also elect to opt out of comprehensive Health Home (HH) care management and will only receive Home and Community Based Services (HCBS) care management services.

Effective Date: the date in which the Health Home will take action as described in the Notice of Decision/Determination (see Definition for Timely Notice).

Home and Community Based Services (HCBS)/Level of Care (LOC) Eligibility Determination: A tiered assessment where multiple factors must be met for child's HCBS/LOC eligibility to be determined. To access Children's HCBS, a child must meet target population, risk factors, and functional criteria as described in the Children's Waiver. The HCBS/LOC Eligibility Determination is housed within the Uniform Assessment System (UAS).

Adequate Notice: Notice issued that meets the specifications of 18 NYCRR § 358-2.22; adequate notice is given when an application for Health Home (HH) or Children's Waiver enrollment is accepted or denied.

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Background

The Notice of Determination and Fair Hearing Program Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

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AHIHH requires that the Health Home Service Providers notify Health Home Enrollees and/or Health Home Candidates, and those who enroll or who are denied enrollment in the children's HCBS Waiver program, of their Fair Hearing rights and participate in the Fair Hearing process should it be requested by the Heath Home Enrollee, Children's Waiver Participant, Children's Waiver Candidate, or Health Home Candidate. Care managers will understand and follow the process for Fair Hearings including who to contact in the event the member/potential member is interested in pursuing a Fair Hearing. Care Management Agencies (CMA) will review the Notice of Decision form in its entirety, including Fair Hearing rights within the Notice of Determination/Decision document, with the member and their family.

The New York State Department of Health has developed several types of Notice of Determination forms to be used to notify Health Home Candidates of their Enrollment in Health Home, Denial of Enrollment in Health Home, their Disenrollment from Health Home, or acceptance or denial in the Children's HCBS Waiver. The forms also notify the Candidate's rights to a Fair Hearing should they disagree with their Enrollment, Denial of Health Home, their involuntary Disenrollment from Health Home, or denial or acceptance into the Children's HCBS Waiver program.

Notice of Determination:

Health Home Services Providers are responsible for issuing the below documentation to the Health Home Candidate or Enrollee within the specified timeframes listed in the Policy.

Notice of Determination DOH 5236 – Notice of Denial of Enrollment in Health Home

Health Home eligibility must be verified before enrolling in the program, including proper Medicaid coverage, diagnostic, and appropriateness criteria. If a Health Home Candidate is determined to be ineligible for Health Home during the Outreach and Engagement process due to not meeting the Health Home Eligibility criteria, the referral source must be contacted and notified of the denial. The Health Home Service Provider is responsible for issuing the **DOH 5236** to the Health Home Candidate, Legal Guardian, or Legal Authorized Representative within 5 business days of determination. A copy of the notice must be uploaded in the AHIHH care management record. Possible reasons for denial of enrollment or disenrollment from the Health Home Program include:

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- Ineligible for Medicaid – Medicaid is required for enrollment in Health Homes
- Member has Medicaid coverage that is not compatible with Health Home (Emergency Coverage only, Family Planning only, Essential Plan etc.)
- Member does not meet diagnostic criteria
- Member does not meet the appropriateness criteria
- Member currently resides in an excluded setting (Residential Treatment Facility, Nursing Home, Incarceration etc.)
- Member is concurrently enrolled in another Health Home

If the Health Home Candidate, Legal Guardian, or Legal Authorized Representative, is not in agreement they may contact the Health Home to request a conference regarding the denial. The Health Home will request to review any additional information to re-determine eligibility; the Health Home candidate, Legal Guardian, or Legal Authorized Representative will be notified by the Health Home within 10 days following the conference. If the Health Home finds the denial valid the Health Home Candidate, Legal Guardian, or Legal Authorized Representative can request a Fair Hearing within 60 days.

Notice of Determination DOH 5234 – Notice of Enrollment in Health Home

If the Health Home Candidate meets the eligibility criteria for Health Home and has consented to enroll the Health Home Service Provider is responsible for issuing the **DOH 5234** and uploading a copy of the notice in the AHIHH care management record system within 5 calendar days of enrollment. The notice must clearly indicate the date of enrollment and must be issued with the member's welcome letter and Health Home Rights and Responsibilities.

Notice of Determination DOH 5235 – Disenrollment from Health Home

If the Health Home Enrollee is going to be Disenrolled from the Health Home program and they disagree with the decision or cannot have a conversation with the Care Manager regarding the disenrollment, the Health Home Service Provider must provide the member timely notice, which is a *minimum of 10 days' notice (based on Date Mailed) prior to the proposed action.* HHSP's should review and complete the discharge plan prior to disenrollment. In addition, the Health Home Service Provider is responsible for issuing the **DOH 5235** and uploading a copy in the AHIHH Care Management Record System. The Health Home Service Provider should mail or give the enrollee the DOH 5235 prior to disenrollment.

If the ten (10) calendar days carry over into the following month, then the disenrollment date is identified and written as the last day of that following month. Any Health Home Care Management (HHCM) core services conducted during this time are billable. All documentation must be up to date in order to Bill for these services.

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In cases of a member being transferred to a different HHSP, the DOH 5235 is not required as the member will continue to receive Health Home services.

Under circumstances where the member voluntarily disenrolls from the Health Home program, the HHSP *will not* issue the DOH 5235 and the enrollee *will not* have the right to request a fair hearing.

A disenrollment letter on agency letterhead must be Issued to all disenrolling members. The letter must include the date of disenrollment, reason, and how to re-enroll. If the member is voluntarily disenrolling, then the member does not need the DOH 5235 issued, but the letter must state that of this effective date the member's signed Health Home consents are no longer valid. ***Please see Health Home Disenrollment Policy for more information***

Children's HCBS Waiver Participants

Health Home Care Manager and Supervisor Responsibilities:

- Ensure that the CMA has a process in place to immediately notify the members or potential members and their parent/guardian upon enrollment, denial of enrollment, or disenrollment from the Health Home program/Children' s waiver.
- Issues the appropriate notice of determination/notice of decision as follows:
    - .. adequate notice of a determination/notice of decision to accept or deny an application for enrollment, within five (5) calendar days of determination or,
    - .. timely and adequate notice of a disenrollment within five (5) calendar days of determination;
- maintains a copy of such notice in the member's record;
- holds an informal Agency Conference with the member and their representative upon request of the member and/or their parent/caretaker/guardian/legally authorized representative;
- maintains well documented evidence to support enrollment/disenrollment determinations when a Fair Hearing is scheduled including, but not limited to, the signed consent form; the updated Plan of Care (POC); Children's Waiver Eligibility Determination or attempts to complete such Eligibility Determination; care record notes; medical documentation, as well as a written summary of the case; the applicable program policy upon which the decision is based; and a copy of the notice sent to the member;
- provides a copy of the evidence packet to the member or their legally authorized representative and provide copies of other documents from the member's case file upon request from the member and/or their parent/caretaker/guardian/legally authorized representative prior to the hearing;
- attends the Fair Hearing, be familiar with the case, and have the authority to make binding decisions at the hearing including the authority to withdraw the decision; and,
- complies with the Decision after Fair Hearing as to enrollment in or disenrollment from the New York State Health Home (HH) Program and Children's Waiver.

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Notice of Decision for eligible or ineligible children/youth DOH-5287:

While eligibility determination for the Children's Waiver HCBS is separate and distinct from Health Home (HH) eligibility, the process for issuing a Notice of Decision is the same. Children/Youth may be found to be ineligible for Children's Waiver HCBS but remain eligible for Health Home (HH). Upon receiving a Children's Waiver HCBS service request/referral, the Health Home the care manager needs to determine if the child/youth meet the Children's Waiver HCBS eligibility requirements. If the child/youth does not meet any of the HCBS eligibility exclusion reason (i.e., over the age of twenty-one (21), expected to reside in an inpatient setting for ninety (90) days or more, enrolled in another Home and Community Based Services (HCBS) waiver, etc. as noted on DOH 5287) then the Children's Waiver HCBS Determination assessment will be conducted to determine if the child/youth meet the Level of Care (LOC) criteria. Upon signing and finalizing the Children's Waiver HCBS Determination within the Uniform Assessment System for New York (UAS-NY), the Health Home Care Manager (HHCM) will be presented with an outcome confirming if the child/youth is HCBS eligible or ineligible for the identified Target Population.

If a youth that has had a Level of Care completed by the Health Home Service provider to participate in the Children's Wavier, the family must be issued the **DOH-5287** notice of Decision for Enrollment or Denial of Enrollment in the NYS 1915(c) Children's Waiver. The Notice of Decision must be completed each time a Level of care is completed (every 365 days) for the member and issued within 5 business days.

If the child/youth is determined eligible and there is a Children's Waiver slot available per Capacity Management, the HHCM will send the child/youth a Notice of Decision Enrollment (DOH-5287) form. The Notice of Decision (NOD) will document the outcome of the HCBS/LOC Eligibility Determination.

The same form, Notice of Decision for Enrollment or Denial of Enrollment in the New York State 1915 Children's Waiver (DOH 5287), is sent for both enrollment and denial of enrollment. The Health Home care manager will send the notice form within five (5) calendar days from the completion of the Children's Waiver HCBS Eligibility Determination to the child/family which documents the outcome of Children's Waiver HCBS Eligibility Determination. For children/youth found eligible, the Children's Waiver HCBS Eligibility Determination is valid for one (1) year (three-hundred and sixty-five (365) days) from the date of the signed/finalized assessment, which is outlined in the form Notice of Decision for Enrollment or Denial of Enrollment in the New York Children's Waiver (DOH 5287).This Notice is sent for initial assessments for all children and for children that remain eligible when a reassessment occurs, which will include a new three-hundred and sixty-five (365) days of eligibility.

If the child/youth is determined Home and Community Based Services (HCBS) eligible; however, a waiver slot is not available per Capacity Management:
The child/family will still receive a notice from the Health Home care manager of eligibility. Once a slot becomes available, the Department of Health (DOH) Capacity Management will notify the Health Home care manager and then the Health Home Care Manager will issue an updated DOH 5287 to the

child/family indicating that a slot is available or will need to conduct a new Home and Community Based Services (HCBS) Eligibility Determination if the family wishes to pursue Home and Community Based Services (HCBS) and the Eligibility Determination was signed/finalized over six (6) months. For further information and guidance, please refer to the Children's Home and Community Based Services Manual.

Notice of Decision for Disenrollment DOH5288:

The Children's Waiver HCBS Eligibility Determination is valid for one year (365 days). If the child/youth no longer meets the Home and Community Based Services (HCBS) Eligibility Criteria or is found ineligible during the annual Children's Waiver HCBS Eligibility Determination, then the HHCM sends a Notice of Decision (NOD) for Discontinuance in the New York State Children's Waiver (DOH 5288) within five (5) calendar days from the ineligibility determination to the child/family and (10) calendar days (based on date mailed) prior to the action of disenrollment from the Children's Waiver.

NOTE: If an annual Children's Waiver HCBS Eligibility Determination cannot be completed due to lack of documentation, a DOH 5288 is sent at least ten (10) calendar days prior to the annual reassessment due date.

When a member has been enrolled in the 1915(c) and is now being disenrolled from the Wavier the **DOH-5288** Notice of Decision for Discontinuance in the NYS 1915 (c) Children's Waiver must be issued. The DOH 5288 must be issued 5 days after the date of ineligibility and the family given 10 days (based on post mark) prior to action to disenroll being taken.

** For more information on the Children's Waiver please see the HHSC Waiver and HCBS Policy and the HHSC HCBS Waiver Disenrollment and Discharge Policy**

HARP / HIV Special Needs Plans Home and Community Based Services for Adults

The Health and Recovery Plans (HARP) or Special Needs Plans (SNP) are responsible for issuing the determination regarding eligibility for Home and Community Based Services. Health Homes must comply with requests from Health and Recovery Plans (HARP) or Special Needs Plans (SNP) to participate in the Fair Hearing process.

Fair Hearing Process:

If a Health Home Enrollee is not in agreement with their denial of enrollment or disenrollment from Health Home, they can request a Fair Hearing. The Health Home Enrollee will need to complete the back of the DOH 5236, DOH 5235, DOH 5287, or DOH 5288 and submit for review to OTDA. The HHSP should immediately alert the Health Home when a candidate/member has requested a fair hearing if they are aware. The member can also request a conference with the Lead Health Home in lieu of or concurrently with the Fair Hearing.

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The member has sixty (60) calendar days from the date of the Notice of Determination/Notice of Decision to request a Fair Hearing from the Office of Temporary and Disability Assistance (OTDA). When a Fair Hearing is requested, the Office of Temporary and Disability Assistance's (OTDA) Office of Administrative Hearings (OAH) will issue issues form OAH-4420 (Acknowledgement of Fair Hearing Request (OAH-4420), the Fair Hearing number assigned, and Confirmation of Aid Status. Office of Temporary and Disability Assistance's (OTDA) Office of Administrative Hearings (OAH) will then issue form Notice of Fair Hearing (OAH-457) to the member and the New York State Department of Health's Health Home Team who sends the Fair Hearing notice to the Health Home (HH) and the member as applicable. This form notice will also provide provides the Fair Hearing number that has been assigned by Office of Temporary and Disability Assistance (OTDA), as well as the date, time, and location of the hearing. The Notice of Fair Hearing (Form OAH-457) will also indicate the Aid status and if the Health Home (HH) is being directed to provide Aid Continuing, i.e., to continue providing services unchanged until the Decision After Fair Hearing Notice is issued.

The member has the right to be represented by legal counsel, a relative, a friend or other person, or to represent themselves. At the hearing the member, their attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, the member has a right to bring witnesses to speak in their favor.

AHI Health Home will ensure that an appropriate representative is present at the Fair Hearing. They will attend the Fair Hearing on the scheduled date, time, and location directed on form the Notice of Fair Hearing (Form OAH-457). If the Health Home has a valid reason, they may request an adjournment by contacting Office of Temporary and Disability Assistance (OTDA) as listed within the Notice.

PLEASE NOTE: Simply needing more time may not be sufficient for Office of Temporary and Disability Assistance (OTDA) to grant an adjournment.
Fair Hearings may be expedited, usually at the request of the member, depending on the urgency of the issue(s), and may be held within three days or sooner.
1 18 CRR-NY 358-5.7 Defines who may be present at the Fair Hearing.

<u>Aid Continuing</u>

If the Health Home Enrollee requests a Fair Hearing before the effective date on a Notice of Determination the Health Home Enrollee can continue to receive Health Home Care Management Services until the Fair Hearing decision is given to the Health Home Enrollee. If the Health Home Enrollee does not wish to stay with their Current Health Home Service Provider AHI HH will transfer the Health Home Enrollee to another Health Home Service Provider.

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If the Health Home Enrollee checks the *box "I agree to have the action taken on my Medical Assistance benefits, as described in the notice, prior to the issuance of the fair hearing decision"* under the continuing your benefits, AHIHH may Pend the Health Home Enrollee in MAPP until a decision is made during the Fair Hearing process.

When a Notice of Determination/Decision is issued to the member, they have the right to determine whether they want to request a Fair Hearing and whether the selection of Aid Continuing is right for them. If Office of Temporary and Disability Assistance (OTDA) orders Aid Continuing before the effective date stated in the notice, the member continues to receive Health Home Care Management services and/or Children's Waiver Home and Community Based Services until the final outcome of the Fair Hearing is determined.

NOTE: Children/youth enrolled in the Children's Waiver who request a Fair Hearing with Aid Continuing must continue to have Care Management as part of the waiver requirements.

AHI Health Home can file a challenge to the Aid Continuing if evidence supports the decision.

Right to a Conference

The Health Home Enrollee may have a conference with AHIHH to review these actions. If the Health Home Enrollee requests a conference, they should ask as soon as possible. During the conference if AHIHH discovers the wrong decision was made or, if information the enrollee provides AHIHH determines to change the initial decision, AHIHH will take corrective action and inform the Health Home Enrollee in writing. The Health Home Enrollee can request a conference by calling AHIHH directly at 518-480-0111. If AHIHH upholds the decision to disenroll, the Health Home Enrollee is still entitled to a Fair Hearing.

Waiver of Appearance

Under certain circumstances the Health Home can request a waiver of appearance from the OTDA five days before the hearing date and only submit a written evidence packet. The requests will be reviewed by OTDA on a case-by-case basis. The request must include the primary contact person and a backup contact person. Also included in the request must be the fair hearing number, date of the hearing, and a summary of the specific facts relevant to the case under review at the hearing.

If Office of Temporary and Disability Assistance's (OTDA) grants this request, the Health Home can submit a written evidentiary evidence packet instead of appearing at the hearing location. Waiver requests will be reviewed and granted on a case-by-case basis. At this time, Blanket waivers of appearance will not be granted; however, if the agency contact does not receive a telephone call from the Office of Administrative Hearings (OAH) prior to the hearing date indicating otherwise, it will be presumed that a waiver has been granted.

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The waiver request contains the primary and back-up contact person's names and telephone number/s. The waiver request also contains the fair hearing number, date of hearing, and a summary of the specific facts relevant to the issue under review at the hearing.

For proper inclusion in the fair hearing record, the waiver request and evidentiary evidence packet should be submitted immediately upon notification of the hearing request.

Evidence Packet

Within a reasonable timeframe prior to the hearing, the Health Home Enrollee can request a copy of the case file. The Health Home will provide the Health Home Enrollee with copies of the case file that may be needed for the fair hearing review. The Health Home will send copies of the evidence packet within 10 business days of receiving notice from OTDA of the Fair Hearing date. Evidence Packets are sent via the secure portal at Office of Temporary Disability Assistance (OTDA) through Upload.NY.gov

The evidence packet will include information that the Health Home used to make their decision about the Health Home Enrollees enrollment in the program. Included in the packet will be all signed DOH forms applicable to Health Home, the most recent Comprehensive Assessment as well as the most recent Plan of Care. Also included are case notes, medical documentation, and a case summary.

If the member or their authorized representative needs additional documentation to prepare for the Fair Hearing, the Health Home will provide the requested documentation within a reasonable time prior to the fair hearing date. If the member's request is made less than five (5) business days before the hearing, the Health Home provides such copies no later than at the time of the hearing. Case file documents should be mailed only if the member specifically asks that they be mailed. If there is insufficient time for such documents to be mailed and received before the scheduled date of the Fair Hearing, the documents may be presented at the hearing instead of being mailed.

Decision After Fair Hearing

When the Decision after Fair Hearing is issued, it is binding upon the Health Home and must be complied with.

Decision is in Favor of the Member

If the decision after the Fair Hearing is in favor of the Health Home Enrollee, the Health Home will need to end the pended segment in MAPP (if applicable) and begin a new enrollment segment to be effective the first of the month following disenrollment to ensure no lapse in the segments. The Health Home Enrollee can request a new Health Home Service Provider as well and the Health Home will complete the transfer.

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If the Decision after Fair Hearing is in favor of the member with Aid to Continue, then services continue to be provided to the member and the Health Home continue to follow program policies.

If the decision is made in favor of disenrolled member a new segment will be opened for the by on the first of the month following the decision and resume serving the member.

- If the last POC was completed within the last 365 days then the CMA should use that Plan Of Care
- Initial appropriateness must be re-recorded within 28 days
- A new CES Tool will be required in 365 days (Adult members)
- A new LOC for HCBS Enrolled youth will be required at 365 days from the previous LOC regardless of if the outcome was ineligible or eligible.

NOTE: In instances when the decision after the Fair Hearing is in the member's favor but the reason for the Notice to have been issued to the member was due to lack of appropriateness criteria for continued Health Home (HH) enrollment, the Health Home (HH) must notify the Department in writing via the Health Home BML subject: Health Home Policy for guidance on next steps.

Decision Not in Favor of the Member

If the decision is not in favor of the member and they have Aid to Continue the CMA will notify all parties involved of the disenrollment from Health Home. *Please refer to the Disenrollment Policy.* The care manager notifies all involved professionals of the disenrollment from the Children's Waiver Home and Community Based Services, if applicable.

If the member is disenrolled then the case will remain closed, and documentation of the Fair Hearing is maintained in the member's record.

Either party may request that OTDA reconsider the decision after the Fair Hearing if they feel there has been an error in law or fact. A request for reconsideration must be sent to the OTDA Litigation Mailbox. During this time the Fair Hearing decision remains in effect.

Maintaining Members' Status in the Tracking System for Health Home and HCBS Waiver for HHSC

The member's segment in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) is adjusted according to whether the member requests a Fair Hearing with or without Aid Continuing (AC). If DOH receives notification from the Office of Temporary and Disability Assistance (OTDA) of an order for a Fair Hearing with Aid Continuing (AC) while the member's segment is still active (typically within ten (10) days from postmark of the Health Home notice to the member and before the Health Home (HH) disenrolls the member) the Department will notify the Health Home (HH) and pend the segment with 'Pended for HH Fair Hearing Aid Continuing' effective the first day of the month following the date on which the order was received. If the Department receives notification of a member's request

for a Fair Hearing with Aid Continuing (AC) after the segment has been closed (typically more than (10) days after the Health Home notice to the member) the Department modifies (reopens) the closed segment and then pends the member's segment 'Pended for HH Fair Hearing Aid Continuing.

NOTE: Segments that are 'Pended for HH Fair Hearing Aid Continuing' can only be changed by DOH and cannot be changed by the Health Home (HH).

Care Management Agencies are to continue to serve members that are 'Pended for HH Fair Hearing Aid Continuing' and the pended segments are structured to allow AHI to bill for services which are provided as required by the Office of Temporary and Disability Assistance (OTDA) between the time their Fair Hearings (FH) with Aid Continuing is ordered and the determination by the Administrative Law Judge is issued. Care Management Agencies may only bill if they provide at least the minimum necessary core services in accordance with the Health Home, Health Home Plus, and/or High-Fidelity Wrap policies. Annual Appropriateness (for children) and Continued Eligibility for Services (CES) Tool (for adults) do not need to be completed for segments the Department pends with 'Pended for HH Fair Hearing Aid Continuing.' The Plan of Care is to be completed and uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).

DOH monitors the outcome of Fair Hearings. Upon receipt of the Decision After Fair Hearing, DOH adjusts the pended segment in MAPP to reflect the outcome of the Fair Hearing. The adjusted pend reason codes may then be changed by the Health Home and DOH instructs AHI Health Home accordingly. The following lists the procedures associated with Decisions After Fair Hearing and the responsibility of the Health Home and Department.

- If the Decision after Fair Hearing is in favor of a member with Aid Continuing, DOH creates a new 'Pended for Approved Fair Hearing' segment with a pend start date that equals the first of the month during which the Decision after Fair Hearing was received and notifies AHI of this change. AHI will end this segment on the last day of the month in which the Decision After Fair Hearing was received and then creates a new active enrollment segment dated the first day of the month after which the Decision is received and continues to serve the member. This action triggers the system to end the 'Pended for Approved Fair Hearing' segment.
- If the Decision after Fair Hearing is not in favor of a member with Aid Continuing, or if the member withdraws the Fair Hearing Request, the Department will create a new 'Pended for Denied Fair Hearing' or 'Pended for Withdrawn Fair Hearing' segment with a pend start date that equals the first of the month during which the Decision after Fair Hearing was received and notifies the Health Home of this change. AHI will end that segment on the last day of the month after the month in which the Decision is received.
- If something changes with the member's status while 'Pended for HH Fair Hearing Aid Continuing' that would normally result in the Health Home closing the member's segment, the Health Home contacts the Department via the Fair Hearing Bureau Mail Log before taking any action. If the Department agrees that the member's segment should be closed prior to the member's Fair Hearing disposition, the Department creates a new 'Pended for Administrative

Change' segment with a pend start date that equals the first of that month. AHI then ends that segment on the last day of the month in which the notice is received.

If the member requests a Fair Hearing and the Office of Temporary and Disability Assistance (OTDA) does not order Aid Continuing (AC), the Health Home is not required to provide services to the member while the member is waiting for their Fair Hearing. If the Decision After Fair Hearing finds in favor of the member, AHI follows the final decision of the Administrative Law Judge. DOH instructs the Health Home to create an active segment on the first day of the month after which the Decision After Fair Hearing (FH) is issued.

In these instances, the existing consent remains valid. If the previous Plan of Care was completed within the last three hundred and sixty-five (365) days, it is still active. Initial Appropriateness must be recorded within twenty-eight calendar (28) days of the new active segment (adults and children/youth). If the Health Home is unable to identify an applicable Initial Appropriateness criterion, the Health Home is to contact the Department for guidance via the Fair Hearing Bureau Mail Log. A new Continued Eligibility for Service (CES) Tool is required three hundred and sixty-five (365) days after opening the new segment (adults). For children/youth, annual appropriateness must be documented in the member's record. For the Children's Waiver Home and Community Based Services, the Eligibility Determination must be completed within three-hundred and sixty-five (365) days from the previous Children's Waiver Home and Community Based Services, Eligibility Determination, regardless of whether it was an ineligible determination. If the original Notice was issued because the member no longer met continuing eligibility criteria, the Health Home contacts the Department Fair Hearing Bureau Mail Log for guidance on completing Initial Appropriateness for the new active segment.

POLICY AND PROCEDURE

Quality and Performance Improvement

AHI HH will periodically review records to ensure compliance with the procedures and standards set forth in this policy. Quality indicators will include but may not be limited to:

- Evidence in the AHIHH care management record system to support the decision/determination
- Proper and timely issuance of the appropriate notice of determination form
- The Health Home (HH) issued a correct and complete, timely and adequate notice to the member.
- The Health Home (HH) tracks and monitors Fair Hearings requests filed against the Health Home (HH)/Care Management Agency (CMA):
    - Fair Hearing Requests with Aid Continuing
    - Fair Hearing Request without Aid Continuing
- The Health Home followed protocol regarding member disenrollment or continued enrollment determination
- The Health Home tracks the number of decisions after Fair Hearings:
    - in favor of the Health Home (HH)/Care Management Agency (CMA)
    - in favor of the member
    - Reason for unfavorable decision
    - Are there similar issues that prompt a Fair Hearing that require technical assistance to the Care Management Agency (CMA)?
- The Health Home (HH) provided the evidence packet to the member and/or their authorized representative upon their request.
- The Health Home (HH) provided additional information to the member or their authorized representative upon their request.

Agencies found to be non-compliant with this policy may be required to engage in the corrective action process and/or be imposed other sanctions.

AHI Health Home will review the status and outcomes of filed Fair Hearings quarterly at the Compliance Committee meetings.

POLICY AND PROCEDURE

Training

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of the initial policy training a future in-depth training will be developed to understand notice procedures and management of the Fair Hearing process. AHI will provide training to Care Management Agencies (CMA) and care managers on the Fair Hearing process are to include, but are not limited to:

- Health Home (HH)/Care Management Agency (CMA) Care Manager roles and responsibilities in the Fair Hearing process
- Notices of Decision/Determination issued
- Agency Conferences
- Fair Hearing Requests
- Aid Continuing
- Disenrollment/Continued Enrollment procedures
- Documentation needed to support enrollment/disenrollment determinations/Decision after Fair Hearing

Contact Person: Assistant Director, Health Home

Responsible Person: Health Home Service Provider

Reviewed By: Director, Care Management and Health Home

Approved By: Chief Compliance Officer

POLICY AND PROCEDURE

Appendix A

Desk Guide: Notice of Determination Forms

Notice of determination forms can also be found in 7 languages by following the link: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Type of Notice	Description and Location
DOH 5236 – Notice of Denial of Enrollment in Health Home	This Notice of Determination will inform the potential member that they do not meet the eligibility criteria for enrollment into the Health Home Program and the reason for denial of enrollment. *Must be provided and uploaded within 5 days of the determination*
DOH 5234 – Notice of Enrollment in Health Home	This Notice of Determination will inform the member that they have been enrolled into the Health Home program with the effective date of enrollment and the commencement of care management services. *Must be provided uploaded within 5 days of enrollment*
DOH 5235 – Disenrollment from Health Home	This Notice of Determination will inform the member that they have been disenrolled from the Health Home Program and the reason for the disenrollment. *Members must be given a minimum of 10 days' notice (date of postmark) prior to disenrollment and a discharge plan should be completed* *** This only needs to be issued if the member has not consented or been informed of the discharge***
DOH 5287 – Notice of Decision for Enrollment or Denial of Enrollment	This Notice of Decision will inform the member/family that they have been found eligible or ineligible for the 1915(c) Children's Waiver. Must be provided and uploaded within 5 days of the determination
DOH 5288 – Notice of Decision for Discontinuance in the Children's Waiver	This Notice of Decision will inform the member/family that they have been disenrolled from the 1915(c) Children's Waiver *Members must be given a minimum of 10 days' notice (date of postmark) prior to disenrollment and a discharge plan should be completed*

Adirondack Health Institute

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POLICY AND PROCEDURE

Appendix B
Sample Welcome Letter

Welcome to Adirondack Health Institute Health Home!

We are excited to welcome you to the Adirondack Health Institute's Health Home program. Health Home is a Medicaid service, not a physical place. **These services are available to eligible Medicaid individuals at no cost to you**. Our mission is to serve as a bridge that connects our members to essential resources in your community in hopes of improving quality of life. We look forward to working with you.

Through this program, a Care Coordinator will work with you to **coordinate and link you to services such as:**

- Medical and mental health care
- Community resources
- Advocate needs and barriers with your care team
- Connect you to services that address social determinants of health such as; food insecurity, access to education and job opportunities, transportation, barriers to accessing medications
- Link to resources that can assist with locating and applying for safe and affordable housing

Your care coordinator is _____from the AHI Community Access Team. They can be reached during normal business hours, Monday – Friday 8am to 4pm, at _____. A representative from AHI's Community Access Team can be reached 24/7 via phone at 518-769-4230.

If you have any concerns about the care coordination services you are receiving, Adirondack Health Institute's leadership team can be reached at 1-866-708-2912; office hours are Monday – Friday 8am to 4pm or in writing to AHI Health Home Care Management; 100 Glen St., Glens Falls, NY 12801. Or you may call the Medicaid Help Line at 1-800-541-2831.

We hope our program serves you well. If you have any questions or concerns, please call or write. **We will be happy to help you!**

We look forward to serving you!

POLICY AND PROCEDURE

Appendix C

Rights and Responsibilities

CLIENT'S RIGHTS & RESPONSIBILITIES

EACH CLIENT HAS THE RIGHT TO:

Services:

- Receive a timely response to requests for help and information.
- Receive considerate and respectful services.
- Receive services without regard to race, color, creed, gender, sexual orientation, religion, age, disability, marital status, national or ethnic origin.
- Take an active part in the planning of services.
- Receive accurate and up to date information.
- Refuse services.
- Terminate services at any time.

Confidentiality:

- Have all records and information kept private and confidential
- Receive a copy of, and have explained to you, the HIPAA Notice of Privacy Practices.
- Provide written, signed consent if information is to be released.
- Revoke consent at any time.

Feedback:

- Provide feedback regarding the services you receive, including the right to make a complaint if warranted
- Utilize the Complaint Procedure if services are not to your satisfaction.
- Participate in surveys to let the agency know how we can better serve you.

EACH CLIENT HAS THE RESPONSIBILITY TO:

Services:

- Schedule appointments before coming in to the office.
- Keep scheduled appointments.
- Develop and work towards agreed upon goals.

Confidentiality:

- Maintain confidentiality of other clients.

Agency Policies:

- Observe agency policies.
- Abstain from any harassing and/or violent behavior (verbal, written or physical) towards agency staff or clients.
- Treat other clients and staff with courtesy and respect.
- Refrain from being under the influence of alcohol or illegal substances when attending appointments/ events (office visits, home visits, support groups, medical appointments when accompanied by staff, etc.).

Adirondack Health Institute

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POLICY AND PROCEDURE

COMPLAINT PROCEDURE

When you have a problem, issue, or major difference of opinion about treatment through this agency, you have the right to report your complaint. You may follow the below steps:

1. Contact your/ your child's care coordinator for assistance in resolving the issue
2. If no resolution can be reached, the client/guardian/designee should inform the care coordinator that he/she would like to meet with the agency's supervisor of the Health Home program. This meeting will take place within 10 days of request.
3. If you are not satisfied, you may contact the Director of the agency.

You may also contact the below organizations for grievances related to the Health Home program:

AHI Health Home: 1-866-708-2912

New York State Medicaid Helpline: 1-800-541-2831

You may request a State Fair Hearing. A Fair Hearing is a chance for you to tell an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings, why you think a decision about your/your child's/your designee's case made by a local social services agency is wrong. The Office of Temporary and Disability Assistance will then issue a written decision which will state whether the local agency's decision was right or wrong. The written decision may order the local agency to correct the case.

To request a Fair Hearing, you may call 1 (800) 342-3334,
fax the Fair Hearing Request Form to 518-473-6735, or mail it to:
New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
P.O. Box 1930
Albany, NY 12201-1930

Your/your child's care coordinator will provide you a copy of the Fair Hearing Request Form upon request.

Your/ your child's care coordinator will assist in connecting you with resources to help you with filing complaints, including requests for Fair Hearings. These resources can include, but are not limited to, hearing and vision assistance and language interpretation.

By signing this form, you understand that you/your child have rights and responsibilities as a Health Home Participant, including the right to make a complaint about the Health Home services received. You will receive a copy of this form once you have signed it.

_____	_____	_____
Health Home Participant- Print Name Health Home Participant's Parent/Guardian	Health Home Participant- Sign Name Health Home Participant's Parent/Guardian	Date
_____	_____	_____
Care Coordinator- Print Name	Care Coordinator- Sign Name	Date