MLTC Involuntary Disenrollment Process

BUREAU OF MANAGED LONG TERM CARE

APRIL 13, 2026

WEBINAR LOGISTICS

- Phone numbers must be associated with an attendee in the participant list.
- Participants will remain muted throughout the presentation.
- Questions can be submitted through the Q&A function **at the end of the presentation** and will be answered as time permits.
- The slides and recording will be shared after the webinar.

AGENDA

- MLTC Involuntary Disenrollment Overview
- Plan Responsibilities
- Changes to the MLTC Involuntary Disenrollment Request Form
- Involuntary Disenrollment Package
- Notices
- Requests to Continue MLTC Enrollment
- Transition of Care Responsibilities
- Questions & Answers
- Appendix

MLTC INVOLUNTARY DISENROLLMENT OVERVIEW

- The Managed Long Term Care (MLTC) Involuntary Disenrollment Policy has been updated to reflect the implementation of Minimum Needs Requirements, including the newly associated involuntary disenrollment reasons and clarification to existing reasons.
- Effective **June 1, 2026**, MLTC plans, including Partial Capitation (MLTCP), Programs of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus (MAP) plans, must follow MLTC Policy 26.01 for involuntary disenrollments.

Plan Responsibilities

MLTC INVOLUNTARY DISENROLLMENT OVERVIEW

- A Plan initiated MLTC involuntary is a disenrollment initiated by the MLTC plan without agreement from the Enrollee. The disenrollment is submitted when the Enrollee no longer meets the conditions for continued enrollment.
- The Plan must submit the disenrollment request to New York Medicaid Choice (NYMC), the Department's enrollment broker, as specified by the Department in the MLTC Involuntary Disenrollment policy.
- The Plan must submit the disenrollment request to NYMC in the required time, form, and with the required documentation, as specified by the Department.

PLAN INTENT TO DISENROLL LETTER

MLTC INTENT TO INVOLUNTARY DISENROLL LETTER (VERSION 04/2026)

Template begins below this line

[MLTC Plan Name]
[MLTC Plan Mailing Address]
[1-800-MCO-PLAN]

IMPORTANT INFORMATION ABOUT PLAN ENROLLMENT
INTENT TO DISENROLL

[Letter Date]

[Recipient]
[Recipient's Address]
[Recipient's City, State Zip]

Enrollee Name: [Enrollee]
Enrollee Number: [Plan Identification Number]
Medicaid ID: [Medicaid Identification Number or CIN]

Dear [Enrollee]:

This is an important letter about your enrollment in [Insert MLTC Plan Name]. This letter is to let you know that we informed New York Medicaid Choice (NYMC) that you can no longer remain enrolled in [Insert MLTC Plan Name] because [Insert Involuntary Disenrollment Reason].

What Happens Next?

NYMC must review and agree with [Insert MLTC Plan Name]'s involuntary disenrollment request before you can be disenrolled. If NYMC agrees, you will no longer be enrolled in [Insert MLTC Plan Name] as of [Anticipated Effective Date]. If your involuntary disenrollment is approved by NYMC, the following will occur:

- You will be provided a disenrollment confirmation notice from NYMC which will include fair hearing rights.
- If you disagree with the disenrollment reason you will be able to request a fair hearing once you have received the disenrollment confirmation notice from NYMC.
- We will continue to provide you with the services you are now receiving until you are disenrolled.

Your [Insert MLTC Plan Name] Care Manager will work with you to transfer your care prior to the disenrollment effective date.

What You Can Do Now?

Please contact us immediately if you have any questions about this letter. Your Care Manager may be able to assist you if you would like to stay enrolled. You can call us at [1-800-MCO-PLAN] for TTY, call [TTY Number], [Hours of Operation].

Note: You must remain continuously enrolled in a Managed Long Term Care plan to qualify for services under the current criteria. If you are disenrolled from Managed Long Term Care and seek to re-enroll, you will be required to meet the assessment criteria as outlined in Public Health Law 4403-f.

Other Help:

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

Sincerely,

[MLTC Plan Representative]

[Plans must send a copy of this notice to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist]

[At your request, a copy of this notice has been sent to:
[First name Last name]

[Insert: Language Assistance Notice]

SAMPLE

MLTC INVOLUNTARY DISENROLLMENT OVERVIEW

Once the Plan has completed all required actions including outreach attempts, then the next step in the involuntary disenrollment process is to send the Enrollee the applicable *Intent to Disenroll letter*. The Plan must send the approved *Intent to Disenroll letter* to the Enrollee **and** their authorized representative(s) prior to submitting the involuntary disenrollment package for the Enrollee to NYMC.

There are two types of involuntary disenrollment reasons, mandatory or optional:

- A **mandatory** involuntary disenrollment reason is a required action that the Plan **MUST** take following a specific triggering event. The Plan **MUST** initiate an involuntary disenrollment within five (5) business days of the date the Plan knows of the triggering event.
- An **optional** involuntary disenrollment reason is an action where under limited circumstances the Plan **MAY** initiate an involuntary disenrollment process.

Changes to the MLTC Involuntary Disenrollment Request Form

Managed Long Term Care Involuntary Disenrollment Request Form

Please Print

PLAN'S IDENTIFYING INFORMATION

Plan Name ______________________________

Plan Representative's Name ______________________ Telephone # (___) ___-____ (Area Code)

Signature ______________________ Date ___/___/_____

☐ MAP ☐ PACE ☐ MLTC Partial (MLTCP)

ENROLLEE'S IDENTIFYING INFORMATION

Last Name ______________________ First Name ______________________

DOB (MM/DD/YYYY) ___/___/_____ Medicaid CIN ________

MLTC Plan Legacy Status: ☐ MLTC Plan Legacy ☐ Non Legacy

The Plan must select one disenrollment reason and include the required supporting documentation outlined in the corresponding section, along with a copy of the Plan's Intent to Disenroll letter that was sent to the Enrollee. Plans must also refer to the MLTC Involuntary Disenrollment Form Work Instructions when completing this form.

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
☐ Enrollee no longer resides in the Plan's service area.	All	Date HRA/LDSS was notified: ___/___/_____ Enrollee's New Address: ______________________
☐ Enrollee has been absent from the Plan's service area for more than 30 consecutive days.	All	Start date of Enrollee's absence from the service area: ___/___/_____ Statement from the Enrollee's Home Care Agency, or other pertinent evidence, that efforts were made in accordance with the policy to contact the Enrollee.
☐ Enrollee enters an OMH, OPWDD, or OASAS residential program that is not an MLTC plan covered benefit for 45 consecutive days or longer.	All	Name of Residential Program: ______________________ Type of Program (check one): ☐ OMH ☐ OPWDD ☐ OASAS Date of admission: ___/___/_____
☐ Enrollee is hospitalized for 45 days or longer.	MLTCP	Name of Hospital: ______________________ Date of admission: ___/___/_____ ☐ Enrollee does not have a discharge plan.
☐ Enrollee is no longer enrolled in the Plan's aligned Medicare Advantage product.	MAP	Medicare Disenrollment Date: ___/___/_____
☐ Enrollee is not enrolled in the aligned Medicare health plan, if applicable.	PACE	Medicare Disenrollment Date: ___/___/_____
☐ Enrollee refused to cooperate or was unable to be reached to complete the required assessment.	All	Written statement (on Plan Letterhead) indicating all efforts used to gain the Enrollee's cooperation with scheduling and completing the required assessment.
☐ Enrollee does not receive at least one of the CBLTSS within the previous month.	All	Written statement (on Plan letterhead) indicating the reason the Enrollee is not receiving one of the listed services and evidence of all outreach attempts, along with a description of the safe discharge plan and/or any referrals. ☐ Contact ☐ No Contact
☐ Enrollee no longer meets the nursing home level of care.	PACE	Date of Community Health Assessment ___/___/_____ • NHLOC Score: ________
☐ Enrollee no longer in need of CBLTSS for more than 120 days.	All	Date of Community Health Assessment: ___/___/_____ • NHLOC Score: ________ • Need for 120 days continuous CBLTSS ☐ Yes ☐ No

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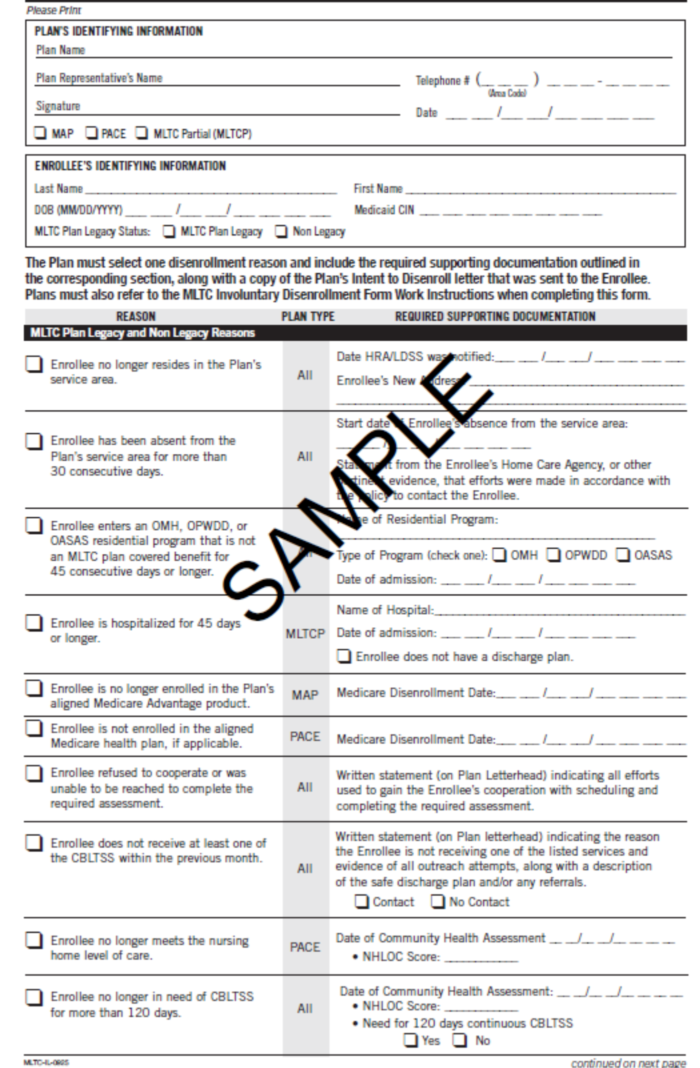
SAMPLE

MLTC INVOLUNTARY DISENROLLMENT FORM CHANGES

The *Managed Long Term Care Involuntary Disenrollment Form* has been updated to align with the Minimum Needs Requirements and changes to the process, including new fields, new reasons and updates to prior reasons.



Managed Long Term Care Involuntary Disenrollment Request Form

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Please Print

PLAN'S IDENTIFYING INFORMATION

Plan Name

Plan Representative's Name ____ Telephone # (___) ___-____ (Area Code)

Signature ____ Date ___/___/_____

❑ MAP ❑ PACE ❑ MLTC Partial (MLTCP)

ENROLLEE'S IDENTIFYING INFORMATION

Last Name ____ First Name ____

DOB (MM/DD/YYYY) ___/___/_____ Medicaid CIN ________

MLTC Plan Legacy Status: ❑ MLTC Plan Legacy ❑ Non Legacy

The Plan must select one disenrollment reason and include the required supporting documentation outlined in the corresponding section, along with a copy of the Plan's Intent to Disenroll letter that was sent to the Enrollee. Plans must also refer to the MLTC Involuntary Disenrollment Form Work Instructions when completing this form.

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
❑ Enrollee no longer resides in the Plan's service area.	All	Date HRA/LDSS was notified: ___/___/_____ Enrollee's New Address: ____
❑ Enrollee has been absent from the Plan's service area for more than 30 consecutive days.	All	Start date of Enrollee's absence from the service area: ___/___/_____ Statement from the Enrollee's Home Care Agency, or other pertinent evidence, that efforts were made in accordance with the policy to contact the Enrollee.
❑ Enrollee enters an OMH, OPWDD, or OASAS residential program that is not an MLTC plan covered benefit for 45 consecutive days or longer.	All	Name of Residential Program: ____ Type of Program (check one): ❑ OMH ❑ OPWDD ❑ OASAS Date of admission: ___/___/_____
❑ Enrollee is hospitalized for 45 days or longer.	MLTCP	Name of Hospital: ____ Date of admission: ___/___/_____ ❑ Enrollee does not have a discharge plan.
❑ Enrollee is no longer enrolled in the Plan's aligned Medicare Advantage product.	MAP	Medicare Disenrollment Date: ___/___/_____
❑ Enrollee is not enrolled in the aligned Medicare health plan, if applicable.	PACE	Medicare Disenrollment Date: ___/___/_____
❑ Enrollee refused to cooperate or was unable to be reached to complete the required assessment.	All	Written statement (on Plan Letterhead) indicating all efforts used to gain the Enrollee's cooperation with scheduling and completing the required assessment.
❑ Enrollee does not receive at least one of the CBLTSS within the previous month.	All	Written statement (on Plan letterhead) indicating the reason the Enrollee is not receiving one of the listed services and evidence of all outreach attempts, along with a description of the safe discharge plan and/or any referrals. ❑ Contact ❑ No Contact
❑ Enrollee no longer meets the nursing home level of care.	PACE	Date of Community Health Assessment ___/___/_____ • NHLOC Score: ____
❑ Enrollee no longer in need of CBLTSS for more than 120 days.	All	Date of Community Health Assessment: ___/___/_____ • NHLOC Score: ____ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No

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SAMPLE

Managed Long Term Care Involuntary Disenrollment Request Form *Continued*

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REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	PACE	Date of Community Health Assessment: ___/___/_____ • NHLOC Score: ____ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No
❑ Enrollee or Enrollee's family member or other person in the home engages in behavior that seriously impairs the Plan's ability to furnish services for reasons other than those resulting from the Enrollee's special needs.	All	Written statement from the Plan (on plan letterhead) describing the case situation, including the names of different home care agencies utilized and results of service attempts. Adult Protective Services (APS) reference is needed for safety issues.
❑ Enrollee fails to pay 'spend down' fee or Net Available Monthly Income (NAMI) within 30 days after such amount becomes due.	All	Copies of multiple letters/invoices sent to consumer (on Plan letterhead) requesting payment.
❑ Enrollee knowingly provides false information, otherwise deceives the Plan, or engages in fraudulent conduct with respect to any substantive aspect of their plan membership	All	Documented proof that indicates the Enrollee is engaged in fraudulent behavior (e.g., police reports or legal documentation).
❑ For PACE only, PACE Direct Eligibility Enrollment was found invalid.	PACE	Written statement (on Plan letterhead) indicating the PACE plan agrees that the Enrollee does not meet the requirements to remain enrolled in the plan, along with a description of the safe discharge plan and/or any referrals.
MLTC Plan Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care.	MAP MLTCP	Date of Community Health Assessment: ___/___/_____ • NHLOC Score: ____ • MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment: ___/___/_____ • NHLOC Score: ____ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years
Non Legacy Reasons		
❑ Enrollee no longer meets the Minimum Needs Requirement.	MAP MLTCP	Date of Community Health Assessment: ___/___/_____ Minimum Needs Requirements • More than 2 ADL's at Limited Assistance level or above ❑ Yes ❑ No • Diagnosis of Alzheimer's disease or dementia and Supervision with more than one ADL or above ❑ Yes ❑ No If Yes, DOH-5821 ❑ Yes ❑ No ❑ N/A If Yes, Date Form Completed: ___/___/_____
❑ Enrollee no longer meets the Minimum Needs Requirement **and** is no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment: ___/___/_____ Need for 120 days continuous CBLTSS ❑ Yes ❑ No Minimum Needs Requirements • More than 2 ADL's at Limited Assistance level or above ❑ Yes ❑ No • Diagnosis of Alzheimer's disease or dementia and Supervision with more than one ADL or above ❑ Yes ❑ No If Yes, DOH-5821 ❑ Yes ❑ No ❑ N/A If Yes, Date Form Completed: ___/___/_____

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SAMPLE

MLTC INVOLUNTARY DISENROLLMENT FORM

The 'Plan Identifying Information' Section has been updated.

The Plan is now required to select plan type. The plan type selected **must** align with the 'Plan Type' for the reason that is selected.

PLAN'S IDENTIFYING INFORMATION

Plan Name ______________________________

Plan Representative's Name ______________________ Telephone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ (Area Code)

Signature ______________________ Date ___ ___ /___ ___/___ ___ ___ ___

❑ MAP ❑ PACE ❑ MLTC Partial (MLTCP)

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	PACE	Date of Community Health Assessment: ___ ___/___ ___/___ ___ ___ ___ • NHLOC Score: ___________ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No

NEW INVOLUNTARY DISENROLLMENT FORM CHANGES- MLTC PLAN LEGACY STATUS

- The '**Enrollee's Identifying Information**' section has been updated to include the Enrollee's '**MLTC Plan Legacy Status**'.
- Prior to initiating an involuntary disenrollment, the Plan must first determine the MLTC Plan Legacy status and check the applicable box on the form.

ENROLLEE'S IDENTIFYING INFORMATION

Last Name ________________________ First Name ________________________

DOB (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___ Medicaid CIN ___ ___ ___ ___ ___ ___ ___ ___

MLTC Plan Legacy Status: ❑ MLTC Plan Legacy ❑ Non Legacy

FORM CHANGES- MLTC LEGACY STATUS

The Involuntary Disenrollment reasons on the form were divided into three sections based on the individuals MLTC Plan Legacy status:

1. **MLTC Plan Legacy or Non Legacy Reasons:** Involuntary Disenrollment reasons are applicable to all Enrollee's regardless of their MLTC Plan Legacy Status.
2. **MLTC Plan Legacy Reasons:** Involuntary Disenrollment reasons applicable to Enrollee's with MLTC Plan Legacy.
3. **Non Legacy Reasons:** Involuntary Disenrollment reasons applicable to Enrollee's without MLTC Plan Legacy.

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Managed Long Term Care Involuntary Disenrollment Request Form *Continued*

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REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	PACE	Date of Community Health Assessment: __ __/__ __/__ __ __ __ • NHLOC Score: ___________ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No
❑ Enrollee or Enrollee's family member or other person in the home engages in behavior that seriously impairs the Plan's ability to furnish services for reasons other than those resulting from the Enrollee's special needs.	All	Written statement from the Plan (on plan letterhead) describing the case situation, including the names of different home care agencies utilized and results of service attempts. Adult Protective Services (APS) reference is needed for safety issues.
❑ Enrollee fails to pay 'spend down' fee or Net Available Monthly Income (NAMI) within 30 days after such amount becomes due.	All	Copies of multiple letters/invoices sent to consumer (on Plan letterhead) requesting payment.
❑ Enrollee knowingly provides false information, otherwise deceives the Plan, or engages in fraudulent conduct with respect to any substantive aspect of their plan membership	All	Documented proof that indicates the Enrollee is engaged in fraudulent behavior (e.g., police reports or legal documentation).
❑ For PACE only, PACE Direct Eligibility Enrollment was found invalid.	PACE	Written statement (on Plan letterhead) indicating the PACE plan agrees that the Enrollee does not meet the requirements to remain enrolled in the plan, along with a description of the safe discharge plan and/or any referrals.
MLTC Plan Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ • NHLOC Score: ___________ • MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ • NHLOC Score: ___________ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years
Non Legacy Reasons		
❑ Enrollee no longer meets the Minimum Needs Requirement.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ Minimum Needs Requirements • More than 2 ADL's at Limited Assistance level or above ❑ Yes ❑ No • Diagnosis of Alzheimer's disease or dementia and Supervision with more than one ADL or above ❑ Yes ❑ No If Yes, DOH-5821 ❑ Yes ❑ No ❑ N/A If Yes, Date Form Completed: __ __/__ __/__ __ __ __
❑ Enrollee no longer meets the Minimum Needs Requirement **and** is no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ Need for 120 days continuous CBLTSS ❑ Yes ❑ No Minimum Needs Requirements • More than 2 ADL's at Limited Assistance level or above ❑ Yes ❑ No • Diagnosis of Alzheimer's disease or dementia and Supervision with more than one ADL or above ❑ Yes ❑ No If Yes, DOH-5821 ❑ Yes ❑ No ❑ N/A If Yes, Date Form Completed: __ __/__ __/__ __ __ __

SAMPLE

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FORM CHANGES- MLTC LEGACY STATUS

- If the individual is enrolled in a PACE plan and no longer meets the nursing home level of care and is no longer in need of CBLTSS for more than 120 days, the Reason under the MLTC Plan Legacy and Non-Legacy Reasons will be used when submitting the form.
- If the individual has MLTC Plan Legacy and is in either enrolled in MAP or MLTCP, the Reason under MLTC Plan Legacy Reasons will be used when submitting the form.

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	PACE	Date of Community Health Assessment: __ __/__ __/__ __ __ __ • NHLOC Score: ___________ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ • NHLOC Score: ___________ MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ • NHLOC Score: ___________ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years

FORM CHANGES REQUIRED SUPPORTING DOCUMENTATION

- Once the Involuntary Disenrollment Reason is selected, the Plan must complete the Required Supporting Documentation fields on the form.
- The Plan must include any additional supporting documentation indicated in on the form for the Involuntary Disenrollment Reason selected, if applicable.
- For all reasons, the Plan must include the Intent to Disenroll Letter.

The Plan must select one disenrollment reason and include the required supporting documentation outlined in the corresponding section, along with a copy of the Plan's Intent to Disenroll letter that was sent to the Enrollee. Plans must also refer to the MLTC Involuntary Disenrollment Form Work Instructions when completing this form.

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
☐ Enrollee no longer resides in the Plan's service area.	All	Date HRA/LDSS was notified:___ ___ /___ ___/ ___ ___ ___ ___ Enrollee's New Address: ___________________________

FORM – ASSESSMENT REASONS

With the implementation of the Minimum Needs Requirements, new disenrollment reasons were added to the MLTC Involuntary Disenrollment Request Form to capture individuals who are no longer eligible based on their plan reassessment.

- All assessment reasons are now separated by Population (Dual Eligibility and Age), Plan Type (MAP, MLTCP and PACE), and for individuals with and without MLTC Plan Legacy (refer to MLTC Policy 25-04 Tables A and B).

NEW REASONS

REASON	PLAN TYPE	REQUIRED SUPPORTING DOCUMENTATION
MLTC Plan Legacy and Non Legacy Reasons		
Enrollee no longer in need of CBLTSS for more than 120 days.	All	Date of Community Health Assessment: __ __/__ __/__ __ __ __ •NHLOC Score: ___________ •Need for 120 days continuous CBLTSS ☐ Yes ☐ No
Enrollee no longer meets the nursing home level of care and no longer in need of CBLTSS for more than 120 days.	PACE	Date of Community Health Assessment: __ __/__ __/__ __ __ __ •NHLOC Score: ___________ •Need for 120 days continuous CBLTSS ☐ Yes ☐ No
MLTC Plan Legacy Reasons		
Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment: __ __/__ __/__ __ __ __ •NHLOC Score: ___________ •Need for 120 days continuous CBLTSS Yes ☐ No ☐ MLTCP only: ☐ Non-duals ☐ Duals 18 – 20 years

NEW REASONS CONTINUED

<table>
<tr><th>REASON</th><th>PLAN TYPE</th><th>REQUIRED SUPPORTING DOUCMENTATION</th></tr>
<tr><td colspan="3">Non Legacy Reasons</td></tr>
<tr><td>Enrollee no longer meets the Minimum Needs Requirement.</td><td>MAP
MLTCP</td><td>Date of Community Health Assessment: __ __/__ __/__ __ __ __
Minimum Needs Requirements
• More than 2 ADL's at Limited Assistance level or above
☐ Yes ☐ No
•Diagnosis of Alzheimer's disease or dementia and Supervision with more than one ADL or above
☐ Yes ☐ No
If Yes, DOH-5821 ☐ Yes ☐ No ☐ N/A
If Yes, Date Form Completed: __ __/__ __/__ __ __ __</td></tr>
<tr><td>Enrollee no longer meets the Minimum Needs Requirement and no longer in need of CBLTSS for more than 120 days.</td><td>MAP
MLTCP</td><td>Date of Community Health Assessment: __ __/__ __/__ __ __ __
Need for 120 days continuous CBLTSS
☐ Yes ☐ No
Minimum Needs Requirements
• More than 2 ADL's at Limited Assistance level or above
☐ Yes ☐ No
•Diagnosis of Alzheimer's disease or dementia and Supervision with more than one ADL or above
☐ Yes ☐ No
If Yes, DOH-5821 ☐ Yes ☐ No ☐ N/A
If Yes, Date Form Completed: __ __/__ __/__ __ __ __</td></tr>
</table>

DUAL AND NON-DUAL POPULATIONS

The following Involuntary Disenrollment reasons require Plans to identify the specific population type of the Enrollee depending on Plan type. **These reasons are applicable to MLTCP dual eligible enrollees aged 18 to 20, MLTCP non-dual eligible enrollees and all MAP enrollees.** Refer to Table B in MLTC Policy 25.04 for enrollees with MLTC Plan Legacy Status.

- Plans must select the appropriate **checkbox** identifying if the Enrollee is in an **MLTCP and Non-Dual or Dual Eligible and aged (18-20).**

MLTC Plan Legacy Reasons		
❑ Enrollee no longer meets the nursing home level of care.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ • NHLOC Score: ___________ MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years
❑ Enrollee no longer meets the nursing home level of care **and** no longer in need of CBLTSS for more than 120 days.	MAP MLTCP	Date of Community Health Assessment:__ __/__ __/__ __ __ __ • NHLOC Score: ___________ • Need for 120 days continuous CBLTSS ❑ Yes ❑ No MLTCP only: ❑ Non-duals ❑ Duals 18 - 20 years

ADDITIONAL UPDATES

- For certain reasons, the documentation required for submission will be the Involuntary Disenrollment form and Intent to Disenroll letter. Examples:
  - Plans are required to include the date of the Community Health Assessment and enter key data points, such as the NHLOC Score.

❑ Enrollee no longer meets the nursing home level of care.	PACE	Date of Community Health Assessment __ __/__ __/__ __ __ __ • NHLOC Score: ___________

  - Plans are required to enter the Medicare disenrollment date.

❑ Enrollee is no longer enrolled in the Plan's aligned Medicare Advantage product.	MAP	Medicare Disenrollment Date:___ ___ /___ ___/ ___ ___ ___ ___
❑ Enrollee is not enrolled in the aligned Medicare health plan, if applicable.	PACE	Medicare Disenrollment Date:___ ___ /___ ___/ ___ ___ ___ ___

Involuntary Disenrollment Package

INVOLUNTARY DISENROLLMENT PROCESSING CALENDARS

- Plans are reminded to always adhere to the work instructions below when submitting form.

Plan Instructions for MLTC Involuntary Disenrollment

- Plans must submit Involuntary Disenrollment packages **by 12:00PM** to be considered as submitted for the same day. Packages submitted **after 12:00PM** are considered as submitted for the **next business day.**

2026 MLTC PLAN INVOLUNTARY DISENROLLMENT PROCESSING SCHEDULE	
PLAN SUBMISSION WINDOW	DISENROLLMENT EFFECTIVE DATE
11/7/2025 - 12/9/2025	1/1/2026
12/10/2025 - 1/8/2026	2/1/2026
1/9/2026 - 2/4/2026	3/1/2026
2/5/2026 - 3/6/2026	4/1/2026
3/7/2026 - 4/7/2026	5/1/2026
4/8/2026 - 5/8/2026	6/1/2026
5/9/2026 - 6/5/2026	7/1/2026
6/6/2026 - 7/7/2026	8/1/2026
7/8/2026 - 8/7/2026	9/1/2026
8/8/2026 - 9/4/2026	10/1/2026
9/5/2026 - 10/7/2026	11/1/2026
10/8/2026 - 11/5/2026	12/1/2026
11/6/2026 - 12/9/2026	1/1/2027

INVOLUNTARY DISENROLLMENT SUBMISSION PROCESS

Plans should submit the Involuntary Disenrollment package using **CISCO** - The NYMC Secure Encryption Service (https://res.cisco.com).

The Plan must submit an involuntary disenrollment package to the NYMC Health Plan Affairs Department via the NYMC secure portal. The package **must** include the following:

- A completed *Managed Long Term Care Involuntary Disenrollment Request Form*,
- The required supporting documentation for the selected disenrollment reason,
- The *Intent to Disenroll letter*, and
- The transmittal form requested from NYMC.

Notices

INVOLUNTARY DISENROLLMENT NOTIFICATION

Individuals will be notified of their involuntary disenrollment by NYMC via an Involuntary Disenrollment Confirmation Notice. Fair Hearing rights will apply to this notice from NYMC including Aid to Continue. The involuntary disenrollment confirmation notice has contact information if the individual has questions regarding the disenrollment.

Mandatory: Individuals that remain eligible and meet the Minimum Need Requirements will be informed that they **must** choose a plan. If they do not choose a plan, they will be **auto transferred** into a MLTCP plan.

Voluntary:

- Individuals **without** MLTC Plan Legacy, who remain eligible for MLTC and meet the Minimum Need Requirements will be informed they **can** choose a Plan. If they choose a Plan, they will be transferred. If they do not choose a Plan, they will be disenrolled to FFS Medicaid.
- Individuals **with** MLTC Plan Legacy, who remain eligible for MLTC enrollment and meet the Legacy Criteria as outlined in MLTC Policy 25.04 will be informed they **can** choose a Plan. If they choose a Plan, they will be transferred. If they do not choose a Plan, they will be disenrolled to FFS Medicaid.

Excluded/Ineligible:

Individuals that are ineligible for continued enrollment in MLTC will be disenrolled to Fee for Service Medicaid.

INVOLUNTARY DISENROLLMENT NOTICE EXAMPLES

Important Notice of Managed Long Term Care Plan Disenrollment

Dear <Consumer Name>: <CIN>

This notice is to let you know that you will no longer remain enrolled in <**Current Health Plan Name**> starting <effective date>. You will no longer be enrolled in <**Plan Name**> because your assessment outcome showed:

- You do not need help with **more than two** activities of daily living, such as bathing or getting dressed. You also do not need supervision with **more than one** activity of daily living if a diagnosis of Alzheimer's Disease or dementia was confirmed during the assessment; **and**
- You do not need **at least one** community based long term service and support for more than 120 days.

This means you do not meet these assessment requirements to remain enrolled in a Managed Long Term Care (Medicaid) plan.

INVOLUNTARY DISENROLLMENT NOTICE EXAMPLES

Mandatory Language

What happens next:

- Included is a **Managed Long Term Care Plan List**. Call New York Medicaid Choice at **1-888-401-6582** for information about the plans that are available to you and work with your current providers. We can help you choose a plan.
- If you do not choose an **MLTC Medicaid plan,** one will be selected for you.
- Your plan will continue providing your current services until you are enrolled in an **MLTC Medicaid plan**.

Voluntary Language

What happens next:

- Included is a **Managed Long Term Care Plan List**. Call New York Medicaid Choice at **1-888-401-6582** for information about the plans that are currently available to you and work with your current providers. We can help you choose a plan.
- If you do not choose a plan, you will be disenrolled to fee-for-service (FFS) Medicaid on **<effective date>**. You can contact your Local Department of Social Services to discuss your care needs. Call us at 1-888-401-6582 and we will give you their phone number.
- If you are disenrolled to FFS Medicaid, the way you receive services will change. You will receive health care by using your NY State Benefit Identification card (Medicaid card). You will no longer use your plan card or receive coverage through **<Plan Name>**.
- Your plan will continue providing your current services until you transfer to a new plan or are disenrolled to FFS Medicaid on **<effective date>**.

Excluded/Ineligible Language

What happens next:

- You will be disenrolled to fee-for-service (FFS) Medicaid. You must contact your Local Department of Social Services to discuss your care needs. Call us at 1-888-401-6582 and we will give you their phone number.
- After <**effective date**>, the way you receive services will change. You will receive health care by using your NY State Benefit Identification card (Medicaid card). You will no longer use your plan card or receive coverage through <**Plan Name**>.
- Your plan will continue providing your current services until you are disenrolled to FFS Medicaid on <**effective date**>.
- If your situation changes or if you have questions about what plan options may be available to you, call New York Medicaid Choice.

INVOLUNTARY DISENROLLMENT NOTICE EXAMPLES

- **Frequently Asked Questions** section was added to the Involuntary Disenrollment Notice to improve understanding and address the most common questions associated with each involuntary disenrollment reason.

Frequently Asked Questions

What is an assessment?

An assessment is a meeting with a nurse to discuss your health care needs and to help determine if you are eligible to remain enrolled in the Managed Long Term Care plan.

What assessment requirements do I need to meet to remain enrolled in a Managed Long Term Care (Medicaid) plan?

To remain enrolled in a Managed Long Term Care (Medicaid) plan:

- You need help with **more than two** activities of daily living, or you need supervision with **more than one** activity of daily living if a diagnosis of Alzheimer's Disease or dementia was confirmed during your assessment; **and**
- You need **at least one** of these community based long term services and supports for more than 120 days:
  - Nursing services in the home
  - Home health aide services
  - Private duty nursing
  - Personal care services in the home
  - Adult day health care
  - Consumer directed personal assistance services
  - Therapies in the home (physical, occupational, respiratory and speech pathology)

What are activities of daily living?

Activities of daily living are basic tasks related to your self-care. These tasks can include:

- Bathing or showering
- Personal hygiene such as hair, tooth, and nail care
- Getting dressed
- Eating your meals
- Getting in and out of bed or getting up from a chair
- Walking and getting around in your home
- Using the bathroom

Requests to Continue MLTC Enrollment

REQUESTS TO CONTINUE MLTC ENROLLMENT

Following the initiation of the involuntary disenrollment process, where the MLTC plan has completed the required Plan actions, there are certain instances when the Enrollee is able to maintain their enrollment by remedying the involuntary disenrollment issue. To initiate this process the Enrollee must contact the MLTC plan to continue the enrollment prior to the involuntary disenrollment effective date. The MLTC plan must act to facilitate the continuation of the enrollment by working with NYMC and the Enrollee.

When the Enrollee has addressed the involuntary disenrollment reason prior to the involuntary disenrollment effective date and is eligible to continue their enrollment, the Plan must provide an updated enrollment letter to the Enrollee. When NYMC processes the re-enrollment, the Enrollee will receive an enrollment confirmation notice.

REQUESTS TO CONTINUE MLTC ENROLLMENT

The scenarios below are a **few examples** of actions that the Enrollee may take to continue their enrollment in the MLTC plan. Continuous enrollment can be applied if the Enrollee has addressed the involuntary disenrollment issue prior to the involuntary disenrollment effective date:

- **Enrollee has been absent from the Plan's service area for 30 consecutive days.**
  The Enrollee must contact the MLTC plan after returning to the service area to request to continue their enrollment. The Plan must document the continued enrollment request as an occurrence in the monthly Care Management record including any changes to the existing PCSP.

- **Enrollee does not receive at least one CBLTSS in the previous month.**
  The Enrollee must contact the MLTC plan and reinstate their PCSP including the CBLTSS. The CBLTSS must be scheduled and resumed according to the standard timeframes for service authorization requests. The Plan must document the continued enrollment request as an occurrence in the monthly Care Management record, which may include any changes to the existing PCSP.

REQUESTS TO CONTINUE MLTC ENROLLMENT

Individual Initiated Request:

- If an individual calls NYMC requesting to re-enroll into their MLTC plan **prior** to the disenrollment effective date, NYMC conducts a conference call to the MLTC plan.
- The MLTC plan must review the individual's status and determine if a continuous re-enrollment is appropriate as outlined in the MLTC Involuntary Disenrollment policy located here.

REQUESTS TO CONTINUE MLTC ENROLLMENT

Prior to Pulldown:

- If the individual is eligible for continuous enrollment and it is **prior to MLTC pulldown**, Plans must submit a new **Upload File (U-File)** to their Secure File Transfer Protocol (SFTP) server or within their Plan folder in the Axway Secure portal.

After Pulldown:

- If the individual is eligible for continuous enrollment and it is **after MLTC pulldown**, but **prior to the disenrollment effective date,** Plans must **reach out securely via the CISCO Encryption Service or their own secure platform to their NYMC Health Plan Affairs (HPA)** contacts for immediate assistance.
- As a reminder, pulldown is the enrollment deadline date.

REQUESTS TO CONTINUE MLTC ENROLLMENT

- To initiate re-enrollment, the Enrollee must contact the MLTC plan **prior to the involuntary disenrollment effective date**. The MLTC plan must act to facilitate the continuation of the enrollment by working with NYMC and the Enrollee.
- When the Enrollee has addressed the involuntary disenrollment reason **prior to the involuntary disenrollment effective date** and is eligible to continue their enrollment, the Plan must provide an updated enrollment letter to the Enrollee.
- When NYMC processes the re-enrollment, the Enrollee will receive an enrollment confirmation notice.

Transition of Care Responsibilities

TRANSITION OF CARE RESPONSIBILITIES

Prior to the effective date of the disenrollment, the MLTC Plan must work with the Enrollee and other individuals designated by the Enrollee, to make all necessary referrals to the LDSS, another Plan, other community resources, health care providers, alternative service providers and/or programs to facilitate a transition of care for services identified in the Enrollee's PCSP.

Note: Individuals with MLTC Plan Legacy status, who are transferred to another MLTC plan as result of an involuntary disenrollment, will maintain their MLTC Plan Legacy status. For more information, refer to MLTC Policy 25.04 - *Minimum Needs Requirement Update to the Eligibility Requirements for Managed Long Term Care Enrollment*.

CONTACT

For inquiries or assistance, please contact: **Bureau of Managed Long Term Care - New York State Department of Health** at mltcinfo@health.ny.gov.

Appendix

ACRONYMS

ADL – Activities of Daily Living

CBLTSS – Community Based Long Term Services and Supports

CHA – Community Health Assessment

FFS – Fee-for-Service Medicaid

HPA – Health Plan Affairs

LDSS – Local Department of Social Services

LTNHS – Long Term Nursing Home Stay

PACE – Program of All-Inclusive Care for the Elderly

PCSP – Person-Centered Service Plan

SFTP – Secure File Transfer Protocol

ACRONYMS

MAP – Medicaid Advantage Plus

MLTC – Managed Long Term Care

MLTCP – Managed Long Term Care Partial

MMIS – Medicaid Management Information System

NHLOC – Nursing Home Level of Care

NYMC – New York Medicaid Choice

OASAS – Office of Addiction Services and Supports

OMH – Office of Mental Health

OPWDD – Office of People with Developmental Disabilities

NEW
YORK
STATE
Department
of Health