STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 10, 2016
[redacted]
AGENCY: MAP
FH #: 7320717P

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 27, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For NY State Dept. of Health/ Local Agency Contractor, Medicaid Choice

D. Caceres (7/25/2016, 9/6/2016, 12/13/2016, and 2/27/2017);
A. Rodriguez (7/25/2016, 9/6/2016, 12/13/2016)

ISSUE

Did the Appellant establish a good cause reason for failing to attend a hearing that was scheduled for November 9, 2016 to review the Agency's determination to involuntarily disenroll the Appellant from his Managed Long-Term Care Plan, Centers Plan for Healthy Living?

If the Appellant has established a good cause reason for failing to attend the November 9, 2016 scheduled hearing, was the Agency's determination to involuntarily disenroll the Appellant from his Managed Long-Term Care Plan, 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. Appellant, age 69 and legally blind, has been in receipt of Medical Assistance through a Managed Long-Term Care Plan operated by Centers Plan for Healthy Living, and has been in receipt of Personal Care Services in the amount of 16 hours per day, 7 days per week. He resides alone.

2. On December 22, 2014, a registered nurse completed an assessment of the Appellant's personal care services needs on behalf of Centers Plan for Healthy Living.

3. By notice dated January 23, 2015, Centers Plan for Healthy Living determined to reduce the Appellant's Personal Care Services hours from 112 hours per week (16 hours per day, 7 days per week) to 56 hours per week (8 hours per day, 7 days per week).

4. By notice dated February 27, 2015, Centers Plan for Healthy Living determined to uphold its initial adverse determination to reduce the Appellant's Personal Care Services hours from 112 hours per week to 56 hours per week.

5. The Appellant requested a fair hearing to contest the determination by Centers Plan for Healthy Living to reduce his Personal Care Services hours. That hearing (number 6952578N) was held on March 30, 2015, and resulted in a decision issued on April 10, 2015, finding that the Plan's determination to reduce the Appellant's Personal Care Services hours was not correct, and directed Centers Plan for Healthy Living to continue to provide the Appellant with Personal Care Services in the amount of 16 hours per day, 7 days per week.

6. By notice dated July 30, 2015, the Agency advised the Appellant of its determination to disenroll the Appellant from Centers Plan for Healthy Living, effective September 1, 2015.

7. On August 6, 2015, the Appellant requested a fair hearing to contest the Agency's determination to disenroll him from his Managed Long-Term Care Plan. Fair hearing number 7096205N was held on October 7, 2015, and resulted in a stipulation issued on October 21, 2015, whereby the Agency agreed to withdraw its July 30, 2015 notice, and to retroactively re-enroll the Appellant in his Managed Long-Term Care Plan with Centers Plan for Healthy Living.

8. By notice dated June 1, 2016, the Agency advised the Appellant of its determination to involuntarily disenroll the Appellant from his Managed Long-Term Care Plan, effective July 1, 2016, because the "Plan showed proof that they cannot provide their services to you".

9. By notice dated June 8, 2016, the Agency advised the Appellant of his "recent Plan transfer" scheduled to take effect on July 1, 2016.

10. On June 10, 2016, the Appellant requested a fair hearing to review the Agency's determination to involuntarily disenroll the Appellant from Centers Plan for Healthy Living.

11. By notice dated June 22, 2016, the Agency again confirmed the Appellant's "recent Plan transfer" scheduled to take effect on July 1, 2016.

12. The Appellant attended the first two scheduled dates of the present hearing (July 25, 2016 and September 6, 2016). However, on September 6, 2016, the Appellant requested an additional adjournment of the hearing because he did not receive the evidence packet in a format that would enable him to read the documents which the Agency intended to present at the hearing. As such, the third scheduled date for this hearing was November 9, 2016.

13. The Appellant did not attend the fair hearing that was scheduled for November 9, 2016, either in person or by representative, and at no time before the hearing did the Appellant request that such hearing be rescheduled.

14. Upon the Appellant's failure to appear at the scheduled fair hearing, either in person or by representative, the Office of Administrative Hearings of the New York State Office of Temporary and Disability Assistance issued a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing.

15. The Office of Administrative Hearings received a response from the Appellant, postmarked within ten days of such letter, requesting that the hearing be rescheduled.

16. The hearing date of December 13, 2016 was scheduled in response to such request for rescheduling. However, during the December 13, 2016 rescheduled hearing date, further adjournment was requested in order to afford the Appellant a full and fair opportunity to review the evidence that the Agency intended to present in support of its determination.

APPLICABLE LAW

Pursuant to the terms of the preliminary injunction in the federal class action entitled Fishman v. Daines (EDNY, 09CV5248, Bianco, J., March 6, 2016), if an applicant for or recipient of Medical Assistance requests a fair hearing to contest the adequacy, denial, reduction, restriction or termination of Medicaid benefits and fails to appear, either in person or by representative, at a fair hearing defaulted on or after April 11, 2016, the Office of Administrative Hearings will issue a "default letter" to the applicant or recipient's address of record asking if the fair hearing request has been abandoned. This letter advises the applicant or recipient that if he or she is requesting a rescheduled hearing date, he or she must provide a good cause reason for defaulting the hearing. The default letter also advises the applicant or recipient that if the Office of Administrative Hearings does not receive a response to such letter postmarked within ten days of the mailing date, the hearing request will be deemed abandoned.

The order further provides that, if the Office of Administrative Hearings receives a response from the applicant or recipient within ten days of the mailing date of the default letter and postmarked within ten days of the mailing date of such letter, requesting a rescheduled hearing date, the hearing will be rescheduled. At the rescheduled hearing, the good cause explanation for the failure to appear on the original hearing date will be addressed by the administrative law judge and, if necessary, the merits of the subject hearing request will thereafter be addressed by the administrative law judge.

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

(b)(i). The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to

require on or after April first, two thousand twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees simultaneously with their submission to the federal government.

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(v) The following medical assistance recipients shall not be eligible to participate in a managed long term care program or other care coordination model established pursuant to this paragraph until program features and reimbursement rates are approved by the commissioner and, as applicable, the commissioner of developmental disabilities:

(1) a person enrolled in a managed care plan pursuant to section three hundred sixty-four-j of the social services law;

(2) a participant in the traumatic brain injury waiver program;

(3) a participant in the nursing home transition and diversion waiver program;

(4) a person enrolled in the assisted living program;

(5) a person enrolled in home and community based waiver programs administered by the office for people with developmental disabilities.

(6) a person who is expected to be eligible for medical assistance for less than six months, for a reason other than that the person is eligible for medical assistance only through the application of excess income toward the cost of medical care and services;

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

(8) a person receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program;

(9) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the social services district;

(10) a person receiving family planning services pursuant to subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of the social services law;

(11) a person who is eligible for medical assistance pursuant to paragraph (b) of subdivision four of section three hundred sixty-six of the social services law; and

(12) Native Americans.

(vi) persons required to enroll in the managed long term care program or other care coordination model established pursuant to this paragraph shall have no less than thirty days to select a managed long term care provider, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider, the commissioner shall assign such participant to a managed long term care provider, taking into account quality, capacity and geographic accessibility.

(vii) Managed long term care provided and plans certified or other care coordination model established pursuant to this paragraph shall comply with the provisions of paragraphs (d), (i), (t), and (u) and subparagraph (iii) of paragraph (a) and subparagraph (iv) of paragraph (e) of subdivision four of section three hundred sixty-four-j of the social services law.

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(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:

Managed Long Term Care Partial Capitation Contract, FROM: September 1, 2012
TO: December 31, 2014

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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.

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.

DISCUSSION

By notice dated June 1, 2016, the Agency advised the Appellant of its determination to involuntarily disenroll the Appellant from his Managed Long-Term Care Plan, effective July 1, 2016, because the "Plan showed proof that they cannot provide their services to you" (Agency Exhibit 1). By notice dated June 8, 2016, the Agency advised the Appellant of his "recent Plan transfer" scheduled to take effect on July 1, 2016 (Agency Exhibit 2).

On June 10, 2016, the Appellant requested a fair hearing to review the Agency's determination to involuntarily disenroll the Appellant from Centers Plan for Healthy Living.

The Appellant attended the first two scheduled dates of the present hearing (July 25, 2016 and September 6, 2016). However, on September 6, 2016, the Appellant requested an additional adjournment of the hearing because he did not receive the evidence packet in a format that would enable him to read the documents which the Agency intended to present at the hearing. As such, the third scheduled date for this hearing was November 9, 2016.

The Appellant did not attend the fair hearing that was scheduled for November 9, 2016, either in person or by representative. In accordance with the above-cited terms of the preliminary injunction in the case of Fishman v. Daines, the Office of Administrative Hearings therefore sent a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing that was scheduled for November 9, 2016.

Thereafter, the Office of Administrative Hearings received a response from the Appellant, within ten days of such letter, requesting that the hearing be rescheduled. Based upon such request, the present hearing was scheduled, the threshold issue for which, pursuant to the Fishman preliminary injunction, is whether the Appellant had a good cause reason for failing to attend the originally scheduled fair hearing either in person or by representative.

At the hearing, the Appellant, who is legally blind, contended that he had fallen in the subway while travelling to the fair hearing location because he was unaccompanied by his Personal Care Services Aide. The Appellant's explanation is found credible, based upon the consistency of his statements, his overall demeanor, and his visual impairment. He has therefore

established good cause for failing to attend the November 9, 2016 rescheduled fair hearing date. The Agency's determination will now be reviewed on the merits.

As evidenced by the fact findings set forth above, and as confirmed by both the Appellant and the representatives for Centers Plan for Healthy Living, the Managed Long-Term Care Plan has not conducted an assessment of the Appellant's Personal Care Services needs since December 22, 2014, nearly two years before the Agency's June 2016 determinations to involuntarily disenroll the Appellant from Centers Plan for Healthy Living. However, also as evidenced by the fact findings above, Centers Plan for Healthy Living first sought to effectuate the Appellant's disenrollment from the Managed Long-Term Care Plan in July 2015, three months after a fair hearing decision was issued which reversed an attempted reduction (by 50%) of the Appellant's Personal Care services hours.

At the present hearing, representatives for Centers Plan for Healthy Living were asked why the Plan believes it is no longer able to provide services to the Appellant. The consistent response provided on all hearing dates was that the Appellant has not allowed Centers Plan for Healthy Living to conduct a new assessment of his personal care services needs. However, the evidence submitted to the Agency in support of the Plan's request for the Appellant's involuntary disenrollment reflects only one documented attempt by Centers Plan to reach out to the Appellant (on February 9, 2016), since the previous attempt to involuntarily disenroll the Appellant was withdrawn in October 2015 pursuant to stipulation after fair hearing number 7096205N.

Moreover, in its summary of the Appellant's email response to its attempted outreach, the Appellant's words were taken out of context selectively to demonstrate that the Appellant is uncooperative. Although the Appellant stated that he would prefer that an assessment be scheduled between 11:00 pm and 3:00 am, the Appellant did **not** state in his email that he refused to be re-assessed. At the hearing, the Appellant explained that his circadian rhythm is not attuned to Eastern Standard Time, and actually remains awake during overnight hours. Therefore, he must sleep during daytime hours. The Appellant asserted that Centers Plan for Healthy Living is fully aware of his sleeping hours, and the hours during which he is awake. Upon review of the Agency's documentation, the Appellant's contention is well-supported. In fact, a notation was made by Centers Plan for Healthy Living, in which the Plan was advised by the Agency to accommodate the Appellant's sleeping patterns and hours of wakefulness. Yet, the record fails to reflect that Centers Plan for Healthy Living has made such attempts.

Even more troubling is an unsigned copy of a "Behavioral Contract", which appears to have been prepared specifically for the Appellant (and not a document prepared for all members of Centers Plan for Healthy Living). After the single attempt at contacting the Appellant in February 2016 in order to schedule an assessment of the Appellant's personal care services needs, the record fails to reflect that Centers Plan for Healthy Living made further attempts to contact the Appellant in order to ascertain whether his medical needs and personal care services needs were adequately met until May 26, 2016, more than three months after the Plan's previous attempt to contact the Appellant, and over two months after Centers Plan had already submitted its paperwork to the Agency in order to effectuate the Appellant's involuntary disenrollment.

The Appellant confirmed that he had not received any further communication from Centers Plan for Healthy Living (via email, telephone, or in writing) before receiving the notices of involuntary disenrollment.

Upon review of the hearing record in its entirety, the evidence fails to reflect that Centers Plan for Healthy Living is "no longer able to provide services to" the Appellant. Therefore, the Agency's determination cannot be sustained.

DECISION AND ORDER

The Agency's determination to involuntarily disenroll the Appellant from his Managed Long-Term Care Plan, Centers Plan for Healthy Living, was not correct and is reversed. The Agency is directed to:

1. Withdraw its Notices of Intent dated June 1, 2016, June 8, 2016, and June 22, 2016.

2. Take no further action on its Notices of Intent dated June 1, 2016, June 8, 2016, and June 22, 2016.

3. Retroactively re-enroll the Appellant in Centers Plan for Healthy Living MLTC from the effective date of disenrollment, and to continue to allow the Appellant to be enrolled in Centers Plan for Healthy Living MLTC.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
03/14/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee