STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 19, 2017
[redacted]
AGENCY: MAP
FH #: 7555015N

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 24, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

New York Medicaid Choice

Denise Caceres, Representative
Ana Rodriguez, Representative

ISSUE

Was the determination of New York Medicaid Choice to involuntarily disenroll the Appellant from Centers Plan for Healthy Living correct?

FACT FINDING

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, who is 70 years old, has been in receipt of Medical Assistance for himself only.

2. The Appellant has been enrolled in a managed long term care plan, and had either selected, or been assigned to, Centers Plan for Healthy Living, a partially capitated Managed

Long Term Care plan.

3. The Appellant has been in receipt of a Personal Care Services authorization for 112 hours weekly, at a rate of 16 hours per day, 7 days per week.

4. On May 5, 2017, Centers Plan for Healthy Living made a referral to New York Medicaid Choice (Maximus), requesting approval for the involuntary disenrollment of the Appellant because a NYS Department of Health Assessment System (UAS-NY) is a Medicaid requirement of Managed Long Term Care Plans, and the Appellant has been uncooperative and has not allowed Centers Plan for Healthy Living to have a UAS-NY assessment conducted.

5. By notice dated May 30, 2017, New York Medicaid Choice (Maximus) informed the Appellant that he was being disenrolled from Centers Plan for Healthy Living, effective July 1, 2017, on the grounds that Centers Plan for Healthy Living showed proof that they cannot provide their services to the Appellant.

6. On June 19, 2017, this hearing was requested.

7. As a result of the matter of Varshavsky v. Perales, this fair hearing was rescheduled to be heard in the Appellant's home.

APPLICABLE LAW

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. n adequate, though not timely, notice is required where the Agency has accepted or denied an application for Public Assistance, Medical Assistance or Services; or has increased the Public Assistance grant; or has determined to change the amount of one of the items used in the calculation of a Public Assistance grant or Medical Assistance spend down; or has determined that an individual is not eligible for an exemption from work requirements. 18 NYCRR 358-3.3(a).

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

(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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(viii)

(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.

Section 42CFR438.56 of the Code of Federal Regulations provides for the requirements and limitations regarding disenrollment from a managed long term care plan:

(a) Applicability. The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) Disenrollment requested by the MCO, PIHP, PAHP, or PCCM. All MCO, PIHP, PAHP, and PCCM contracts must

(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM 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 or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and

(3) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

Section 42 CFR 438.62 states that, for continued services to recipients, the State agency must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of an MCO, PIHP, PAHP, or PCCM whose contract is terminated and for any Medicaid enrollee who is disenrolled from an MCO, PIHP, PAHP, or PCCM for any reason other than ineligibility for Medicaid.

The eligibility requirements for Managed Long Term Care for partially capitated plans under the Managed Long Term Care Model Contract, art. IV, section B, are:

Except as specified in section C of this Article, an Applicant who completes an enrollment agreement shall be eligible to enroll under the terms of this Contract if he/she:

1. meets the age requirements identified in Appendix F;

2. is a resident in the Contractor's service area;

3. is determined eligible for Medicaid by the LDSS or entity designated by the Department;

4. is determined eligible for MLTC by the MLTCP using an eligibility assessment tool designated by the Department;

5. is capable, at the time of enrollment, of returning to or remaining in his/her home and community without jeopardy to his/her health and safety, based upon criteria provided by the Department; and

6. is expected to require at least one (1) of the following services covered by the MLTCP for more than 120 days from the effective date of enrollment:

    a. nursing services in the home;

    b. therapies in the home;

    c. home health aide services

    d. personal care services in the home;

    e. adult day health care;

f. private duty nursing; or

g. Consumer Directed Personal Assistance Services

1. The potential that an Applicant may require acute hospital inpatient services or nursing home placement during such 120 day period shall not be taken into consideration by the Contractor when assessing an Applicant's eligibility for enrollment.

The Managed Long Term Care Model Contract, art.V, section D, provides for the disenrollment policy and procedure:

1. Disenrollment Policy

(a.) The Contractor shall comply with disenrollment 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 or her special needs except as may be established under section D.5a 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.

2. Enrollee-Initiated Disenrollment

(a.) An Enrollee may initiate voluntary disenrollment at any time for any reason upon oral or written notification to the Contractor. The Contractor must provide written confirmation to the Enrollee of receipt of an oral request and maintain a copy in the Enrollee's record. The Contractor shall attempt to obtain the Enrollee's signature on the Contractor's voluntary disenrollment form, but may not delay the disenrollment while it attempts to secure the Enrollee's signature on the disenrollment form. The effective date of disenrollment must be no later than the first day of the second month after the month in which the disenrollment was requested.

(b.) An Enrollee who elects to join and/or receive services from another managed care plan capitated by Medicaid, a 1915(c) waiver program or OPWDD Day Treatment program is considered to have initiated disenrollment from the MLTCP.

(c.) The Contractor must provide information and referral to Enrollees who are requesting disenrollment without a transfer to another MLTCP, managed care plan capitated by Medicaid or alternative service who require such services in order to be safely maintained. Such assistance could include, but not be limited to, referral to the Enrollment Broker or Adult Protective Services (APS), if necessary.

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).

4. 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 or 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.

E. Enrollee Protections

1. The Contractor shall have and comply with Department-approved written policies and procedures regarding internal grievances, grievance appeals and appeals processes, that are consistent with the Department's grievance, grievance appeals and appeals policies contained in Appendix K of this Agreement. These include notifying Enrol1ees who receive an adverse appeal resolution about their right to a Medicaid Fair Hearing and/or an External Appeal through the Department of Financial Services, where applicable. The Contractor must submit any proposed material revisions to the approved policies and procedures for Department approval prior to implementation of the revised policies and procedures.

New York Medicaid Choice provides detailed instructions to Managed Long-Term Care Plans regarding involuntary disenrollment requests which include, in part, that:

> 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.

Appendix B to the partially capitated Managed Long Term Care model contract advises, in part, that MCOs must have in place adequate case management systems to identify the service needs of all Enrollees, including Enrollees with chronic illness and Enrollees with disabilities, and ensure that medically necessary covered benefits are delivered on a timely basis. These systems must include procedures for standing referrals, specialists as PCPs, and referrals to specialty centers for Enrollees who require specialized medical care over a prolonged period of time (as determined by a treatment plan approved by the MCO in consultation with the primary care provider, the designated specialist and the Enrollee or his/her designee), out-of-network referrals and continuation of existing treatment relationships with out-of-network providers (during transitional period).

DISCUSSION

By notice dated May 30, 2017, New York Medicaid Choice (Maximus) informed the Appellant that he was being disenrolled from Centers Plan for Healthy Living, effective July 1, 2017, on the grounds that Centers Plan for Healthy Living showed proof that they cannot provide their services to the Appellant.

The record establishes that the Appellant has been enrolled in Centers Plan for Healthy Living since May 2014. The record also establishes that the Appellant has been in receipt of a Personal Care Services authorization for 112 hours weekly, at a rate of 16 hours per day, 7 days per week. The record further establishes that Centers Plan for Healthy Living has not conducted a UAS-NY of the Appellant's Personal Care Services since December 22, 2014.

Centers Plan for Healthy Living contended that NYS Department of Health Assessment System (UAS-NY) is a Medicaid requirement of Managed Long Term Care Plans, and the Appellant has been uncooperative and has not allowed Centers Plan for Healthy Living to have a UAS-NY assessment conducted since December 22, 2014.

The Appellant claimed that he has a medical condition that prevents him from being awake during the day. The Appellant testified that he had been in receipt of Personal Care Services from 6:30 p.m. to 10:30 a.m. daily, but that he now receives the Personal Care Services from 5:00 p.m. to 9:00 a.m. The Appellant claimed that he was informed by Centers Plan for Healthy Living that a UAS-NY assessment can only be conducted during the business hours of 9:00 a.m. and 5:00 p.m., and that Centers Plan for Healthy Living would not accommodate him by conducting an assessment outside of the usual business hours. The Appellant claimed that is unable to complete an assessment during the hours of 9:00 a.m. and 5:00 p.m. due to his medical condition.

The record establishes that Centers Plan for Healthy Living attempted to accommodate the Appellant by scheduling an assessment on Sunday, April 30, 2017, at 6:00 a.m. The record also establishes that an assessment was not completed on April 30, 2017. The Appellant claimed that although he was notified of the April 30, 2017 visit by Centers Plan for Healthy Living, he was not informed that the visit was for the purpose of an assessment, and that he refused to allow Centers Plan to conduct a "surprise" assessment.

The Appellant testified that he was not willing to agree to complete a UAS-NY assessment at 9:00 a.m. because he has a right to complete an assessment when he is alert, dressed, and ready. However, the Appellant also testified that he receives visits from his medical doctor at 9:00 a.m., which contradicts his claim that he would not be able to conduct an UAS-NY assessment from Centers Plan for Healthy Living at 9:00 a.m. The Appellant's testimony that he cannot be awake or alert during the day in order to complete a Medicaid required assessment is also inconsistent with the fact that the Appellant was able to participate in this hearing from 1:00 p.m. to 3:31 p.m., a period of over two and a half hours.

In weighing the evidence, the contentions of Centers Plan for Healthy Living are persuasive. The Appellant's own testimony establishes that the Appellant has engaged in conduct or behavior that seriously impairs the ability of Centers Plan for Healthy Living to furnish services to the Appellant. The record establishes that Centers Plan for Healthy Living is unable to provide services to the Appellant.

It is noted that the Appellant claimed that the notice to disenroll the Appellant from Centers Plan for Healthy Living is defective because the word "involuntary" is not included in the notice. However, the regulations do not provide that the word "involuntary" must be used in the notice. The regulations provide for the conditions under which a person may be involuntarily disenrolled from a managed long term care plan, and the record establishes that NY Medicaid Choice and Centers Plan for Healthy Living have complied with the disenrollment policy and procedure.

It is also noted that the Appellant claimed that the determination of NY Medicaid Choice to disenroll the Appellant from Centers Plan for Healthy Living was unfair because he was not given the opportunity to have a conference with My Medicaid Choice. However, the Appellant failed to establish that he requested a conference with My Medicaid Choice.

DECISION

The determination of New York Medicaid Choice to involuntarily disenroll the Appellant from Centers Plan for Healthy Living is correct.

DATED: Albany, New York
02/12/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee