STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 7, 2018
[redacted]
AGENCY: MAP
FH #: 7875814Z

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 10, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Medicaid Choice/ Conflict Free Resolution Center, the Agency's and the New York State Department of Health's Designated Agent

Ana Rodriguez, Quality Assurance Representative

ISSUE

Was the Agency's November 28, 2018, determination to involuntarily disenroll the Appellant from her Managed Long-Term Care Plan 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 73, has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living (hereinafter, the "MLTC Plan").

2. The Appellant has been in receipt of an authorization of Personal Care Services.

3. On March 5, 2018, a nurse-assessor completed an initial assessment of Appellant and completed a Uniform Assessment System-Comprehensive Community Assessment Report. The nurse-assessor determined Appellant needs daily assistance with activities of daily living (Level II personal care tasks).

4. On August 16, 2018, a nurse-assessor completed a reassessment of Appellant and completed a Uniform Assessment System-Comprehensive Community Assessment Report. The nurse-assessor determined Appellant does not need assistance with activities of daily living.

5. The Appellant's health conditions include, but not limited to, hypertension, gastro-esophageal reflux disease, pain, osteoarthritis and urinary incontinence.

6. The Appellant's needs daily assistance with meal preparations, cleaning, bathing, dressing as well as administration of medication.

7. The MLTC Plan submitted to the Agency an Involuntary Disenrollment Request Form and letter, wherein it informs the Agency that Appellant is no longer eligible for MLTC partial because he/she is assessed as no longer requiring community-based long-term care services or, for non-dual eligible Enrollees or PACE or MAP enrollees, assessed as no longer requiring community-based long-term care services and no longer meets the nursing home level of care.

8. By notice dated November 28, 2018, the Agency advised the Appellant of its determination to involuntarily disenroll the Appellant from the MLTC Plan, effective January 1, 2019, because "the Plan showed proof that [Appellant's] care needs have changed and [Appellant] no longer [qualifies] to stay in a long-term care plan."

9. On December 7, 2018, a request for a fair hearing was made on Appellant's behalf.

APPLICABLE LAW

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.

****

(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.

****

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.

****

(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, considering 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.

****

(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.

****

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

****

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.

***

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. 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.

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 6th 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.

Office of Health Insurance Programs, Division of Long Term Care, MLTC Policy 14.06: Implementation of the Conflict-Free Evaluation and Enrollment Center (CFEEC), Date of Issuance: September 30, 2014:

The purpose of this policy is to inform Managed Long-Term Care Plans (MLTCP) of a change in the enrollment process for individuals seeking Community Based Long Term Care (CBLTC) services.

***

The Department has established a system, in cooperation with Maximus, that all new MLTCP enrollees must have a Uniform Assessment System (UAS) on record prior to enrollment. The Department will develop a system edit to prevent individuals from enrolling into a plan without an UAS conducted by Maximus on file first.

****

MLTC Policy 13.03(A): Definition of Community Based Long Term Care (CBLTC) Services

The Department has repeatedly communicated with MLTC Plans and other stakeholders with regard to the definition of CBLTC Services as a primary condition of eligibility for enrollment in a Managed Long-Term Care plan. Consumers must demonstrate need for CBLTC Services for more than 120 days, and these services are defined as: Nursing Services in the home, Home Health Care (which is further defined as traditional Certified Home Health Agency (CHHA) services such as therapies or home health aide service in the home), Personal Care Services in the home (excluding Level 1), Consumer Directed Personal Assistance Services, Adult Day Health Care (ADHC), and Private Duty Nursing.
The demonstrated need for CBLTC Services for more than 120 days is the baseline requirement for enrollment in a Partially Capitated Plan, Nursing Home Level of Care is an additional condition of enrollment that is required for both the PACE and MAP products….

In a "Dear Managed Long-Term Care Plan" dated April 26, 2013, the Department advised in part that Plans must consider the individual needs of each enrollee during the assessment process and must clearly identify the need for social day care as a service in the plan of care. MLTC plans should not enroll a recipient in social day care unless the recipient has a functional or clinical need for community based long term care services (CBLTCS) – defined specifically as

personal care services in the home, home health care, private duty nursing, consumer directed personal assistance services, and adult day health care. The need for the CBLTCS must be documented during the initial assessment process, clearly identified in the plan of care, and evaluated on an ongoing basis during reassessments. Social day care can contribute to the total care plan but **cannot** represent the primary service provided to the enrollee as detailed in MLTC Policy 13.03: Community Based Long Term Care Services. Enrollees who no longer demonstrate a functional or clinical need for CBLTCS need must be disenrolled from their MLTC plan.

Section 505.14(a) of the Regulations provides in part that:

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations, they would be in receipt of inadequate service not meeting legal requirements. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services.

18 NYCRR Section 360-2.6 provides in part

(d) Whenever the social services district is informed of a change in a recipient's circumstances, it must review the recipient's need for other assistance or services. The district must inform the recipient of available assistance and services, and help the recipient in obtaining them.

DISCUSSION

The record in this matter establishes that the Appellant has been in receipt of Medicaid benefits and has been enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living (hereinafter, the "MLTC Plan"). The record also establishes that the Appellant has been in receipt of a Personal Care Services authorization. At the hearing the Plan presented evidence which shows that on March 5, 2018, a nurse-assessor completed an initial assessment of the Appellant and completed a Uniform Assessment System-Comprehensive Community Assessment Report. The nurse-assessor determined that the Appellant needs daily assistance with her activities of daily living (Level II personal care tasks). On August 16, 2018, a nurse-assessor completed a reassessment of the Appellant's Personal Care Service needs and completed a Uniform Assessment System-Comprehensive Community Assessment Report in which the nurse-assessor concluded that the Appellant is independent with regard to the activities of daily living.

The record also shows that the Plan submitted to the Agency an Involuntary Disenrollment Request Form and letter, wherein it informs the Agency that the Appellant is no longer eligible for Managed Long-Term Care because she longer requires community-based long-term care services or, for non-dual eligible Enrollees or PACE or MAP enrollees, was deemed as no longer requiring community-based long-term care services and no longer meets the nursing home level of care. Thereafter, by notice dated November 28, 2018, the Agency advised the Appellant of its determination to involuntarily disenroll the Appellant from the MLTC Plan, effective January 1, 2019, because "the Plan showed proof that [Appellant's] care needs have changed and [Appellant] no longer [qualifies] to say in a long-term care plan."

At the hearing the Appellant's daughter-in-law testified that there has been no improvement in the Appellant's care needs and that the Appellant continues to require assistance with her activities of daily living. The Appellant's daughter-in-law further testified she was present during the initial nurse assessment on March 5, 2018, and that the Appellant is not an accurate reporter of own her health conditions and care needs. The Appellant's daughter-in-law also testified that she herself was not present during the August 16, 2018 nurse assessor visit and that she had not even been aware that same had been scheduled for the Appellant. The Appellant's daughter-in-law also explained that the Appellant resides with her husband, who also receives personal care services.

In addition, the Appellant's daughter-in-law explained that the Appellant has been in receipt of an authorization of Personal Care Services in the amount of 28 hours per week (4 hours per day for 7 days per week). The Appellant's daughter-in-law also testified that

she herself visits the Appellant once a week and that she also as speaks to the Appellant with regard to the Appellant's health conditions and care needs. The Appellant's daughter-in-law further explained that she has assisted the Appellant with various of her tasks of daily living and that she has also observed the Appellant's aides similarly assist the Appellant.

The Appellant's daughter-in-law contends that, because the Appellant suffers from pain and osteoarthritis, the Appellant is unable to stand for long periods of time and that she cannot bend or raise her arms and hands. The Appellant's daughter-in-law testified that the Appellant needs assistance with transferring in/out of the bathtub, putting on pants, tying shoes, prompting to take medications, meal preparation and cleaning. The testimony of Appellant's daughter-in-law is credible as it was consistent, detailed, plausible and supported by documentation. The Agency, although duly notified of the date, time and location of the hearing as well as of the issue(s) to be addressed thereat, did not rebut the plausible and persuasive claims made by the Appellant's daughter-in-=law in this matter.

Also at the hearing the Appellant's legal counsel presented a letter from the Appellant's primary care physician which is dated January 3, 2019 and which states that the Appellant has a torn meniscus in her right knees and struggles with walking, dressing, and transferring in/out of bathtub. The letter also states that the Appellant cannot stand for long periods due to back issues and that she cannot fully lift her left arm due to cellulitis. Moreover, the letter further states that the Appellant is forgetful, easily disoriented, cannot manage going to medical appointments, and needs medication reminders.

The evidence as presented by the respective parties in this matter has been carefully reviewed and the contentions of the respective parties fully considered. The record establishes that the Appellant needs assistance with her activities of daily living for both level I and level II personal care tasks and services, particularly with regard to bathing, dressing and the administration of medications. The Agency's determination, therefore, is not correct and cannot be sustained.

DECISION AND ORDER

The Agency's November 28, 2018 determination to involuntarily disenroll the Appellant from her Managed Long-Term Care plan is not correct and is reversed.

The Agency is directed to:

1. Take no further action upon the November 28, 2018 notice.

2. Immediately restore the Appellant's Medical Assistance authorization of enrollment in the Managed Long-Term Care plan retroactive to the effective date, January 1, 2019.

3. Continue providing Medicaid coverage for the Appellant through her continued enrollment in a Managed Long-Term Care plan.

4. Continue the Appellant's enrollment in Centers Plan for Healthy Living unchanged.

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
01/23/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee