STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 13, 2018
[redacted]
AGENCY: MAP
FH #: 7859727Y

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 22, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan Centers Plan for Healthy Living

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was the Agency's December 18, 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. The Appellant, age 95 years resides alone. She has been in receipt of Medicaid benefits and has been enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living.

2. The Appellant has been in receipt of a Personal Care Services authorization: 12 -hour daily split-shift.

3. By Involuntary Intent Disenrollment letter dated December 18, 2018, the Agency informed that it has requested that the Appellant be involuntarily disenrolled from Managed Long-Term Care. because "Enrollee or family member engages in behavior that seriously impairs the Contractor's ability to furnish services for reasons other than those resulting from the Enrollee's special needs".

4. On November 13, 2018, the Appellant requested this fair hearing.

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.

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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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Section 4403-f of the New York State Public Health Law authorizes managed long-term care plans. “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 capitated basis for a population which the plan is authorized to enroll”.
GIS 11 MA/009 provides that effective August 1, 2011, personal care services for nondual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract.
Pursuant to Social Services Law §365-a(2)(e) Medicaid provides personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.
18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.
18 NYCRR 505.23 governs the scope of home health services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.
Section 42CFR438.56 of the Code of Federal Regulations includes Requirements and limitations regarding disenrollment:
(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 advises regarding 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 Managed Long -Term Care MODEL CONTRACT for partially capitated plans provides, in part, that:
ARTICLE IV
ELIGIBILITY FOR MANAGED LONG-TERM CARE
B. Eligibility Requirements
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
7. 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.
ARTICLE V
OBLIGATIONS OF THE CONTRACTOR

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D. Disenrollment Policy and Process

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. 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 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
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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.
The Department's New York State Consumer Guide to Managed Long- Term Care advises in part:
Can an MLTC Plan Disenroll Me Without My Permission?
A plan may disenroll you without your permission for certain reasons. These include, but are not limited to:
• moving outside the plan's service area;
• no longer requiring nursing home level of care;
• behaving in a way that prevents that plan from providing the care you need; or
• failing to pay money owed to the plan.
•
New York Medicaid Choice
Managed Long- Term Care (MLTC) Involuntary Disenrollment Request Procedures
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)
Proposed involuntary disenrollments identified as the member continuing to need/receive services are to be viewed by plans as transfers. These will typically be nonpayment of surplus and health and safety disenrollments. Plans must be prepared to communicate existing plans of care to receiving plans; in coordination with NYMC as necessary. PLEASE NOTE: This transfer does not apply to an Enrollee who is being involuntarily disenrolled due to service need

identified as only SADC or Level I Housekeeping.
All additional documentation provided by the plan and their subcontractors such as home care agencies to NYMC must be on Plan letterhead (dated and with legible signatures).
All documentation must be signed by the plan representative
Plans must submit any additional documentation requested by NYMC.
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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.
The Following Involuntary Disenrollment Reasons
1. Enrollee no longer lives in the plan service area.
2. Enrollee has been absent from the plan's service area for more than 30 consecutive days for Partial and Pace or 90 consecutive days for MAP.
3. Enrollee is hospitalized or enters an OMH, OPWDD or OASAS residential program for 45 consecutive days or longer.
4. Enrollee or family member engages in behavior that seriously impairs the Contractor's ability to furnish services for reasons other than those resulting from the Enrollee's special needs.
5. Enrollee fails to pay spend down fee or Net Available Monthly Income (NAMI) within 30 days after such amount comes due.
6. Enrollee knowingly fails to complete and submit any necessary consent or release.
7. Enrollee provides false information or otherwise engages in fraudulent conduct.
8. No longer in Medicare product (Only applicable to MAP).
9. Enrollee is Homeless
10. Dual Eligible Enrollee is no longer eligible for MLTC because he/she is assessed as no longer requiring community-based long- term care services, which may be identified at any reassessment or change to care plan.
Non-dual eligible Enrollee is no longer eligible for MLTC if he/she is assessed as no longer requiring community-based long- term care services, and no longer meets the nursing home level of care as determined using the last comprehensive assessment of the calendar year based on the assessment tool prescribed by the Department. Requiring CBLTC services may be identified at any reassessment or change to care plan. PACE participants who no longer meet NH LOC on annual reassessment, and cannot be deemed eligible for continued stay in the program, must de disenrolled. This applies to MAP members using that last comprehensive assessment of the calendar year.
11. Enrollee does not receive at least one of the following services:
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
APPENDIX B to the partially capitated MLTC model contract advises in part:

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).
Regulations at 505.14 provide, in part:
• (g) Case management.
• (1) All patients receiving personal care services must be provided with case management services according to this subdivision...
• (3) Case management includes the following activities...
• monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...
Reimbursement for Medical Expenditures
18 NYCRR section 360-7.5(a) provides in part as follows:
(3)(i) Payment may be made to a recipient or the recipient's representative for paid medical bills if:
(a) an erroneous MA eligibility determination is reversed (whether the reversal is due to the social services district discovering its own error or is the result of a fair hearing decision or court order), or the social services district fails to determine MA eligibility within the time periods set forth in section 360-2.4 of this Part; and
(b) the erroneous eligibility determination or the delay in determining eligibility caused the recipient or the recipient's representative to pay for medically necessary services which otherwise would have been paid for by the MA program.
(ii) Payment under this paragraph is not limited to the MA rate or fee in effect at the time the services were provided, but may be made to reimburse the recipient's or the recipient's representative's reasonable out-of-pocket expenditures. In addition, payment under this paragraph may be made with respect to services furnished by a provider who is not enrolled in the MA program, if such provider is otherwise lawfully qualified to provide the services, and had not been excluded or otherwise sanctioned from the MA program under Part 515 of this Title.
(iii) For purposes of subparagraph (ii) of this paragraph, an out-of-pocket expenditure will be considered reasonable if it does not exceed 110 percent of the MA payment rate for the service. If an out-of-pocket expenditure exceeds 110 percent of the MA payment rate, the social services district will determine whether the expenditure is reasonable. In making this determination, the district may consider the prevailing private pay rate in the community at the time services were rendered, and any special circumstances demonstrated by the recipient.

DISCUSSION

The record in this matter establishes that the Appellant, age 95 years 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: 12 -hour daily split-shift.

At the hearing, the Plan presented an Involuntary Intent Disenrollment letter dated December 18, 2018 wherein it informs that it has requested that the Appellant be involuntarily disenrolled from Managed Long-Term Care because "Enrollee or family member engages in behavior that seriously impairs the Contractor's ability to furnish services for reasons other than those resulting from the Enrollee's special needs". The Plan contends that the Appellant's daughter [redacted] engages in behavior that prevents the Contractor from rendering services to the Appellant. The Plan alleges racist behavior, constant complaints about and interference with the work of the aides, preventing the aides from eating their lunches, constantly requesting change of aides, failure to provide toilet paper, soap for the aides, etc.

The Appellant's daughter [redacted], the family member in question, testified and vigorously disputed the Plan's allegations. She testified that she oversees the Appellant's care, visits the Appellant daily, but does not reside with the Appellant. The record establishes and it is undisputed that the Appellant continues to need assistance with her activities of daily living.

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 regulations allow an MLTC to initiate involuntary disenrollment if 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". Based on the record presented some of the alleged actions by the family member [redacted] could seem questionable at times. For example, she admitted at the hearing that she did not provide soap for the aides to wash their hands but denied allegation that she does not provide toilet paper for the aides to use. The Plan, however, failed to establish that the alleged behavior in this case rose to the level that prevented the Contractor's ability to furnish services to the Appellant. The Plan's evidence does not establish a sufficient basis for the Appellant's disenrollment. Therefore, the Agency's determination to disenroll the Appellant cannot be sustained.

The Appellant's daughter is duly reminded that the aides must be provided the necessary tools at the Appellant's residence, such as hand soap for sanitary reasons; and must be allowed to carry out their mandated duties in a conducive environment.

DECISION AND ORDER

The Agency's December 18, 2018, determination to involuntarily disenroll the Appellant from her Managed Long-Term Care Plan was not correct and is reversed. The Agency is directed to:

1) Take no further action upon the December 18, 2018 notice.

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

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
03/13/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

C. C. Oluwesa.

Commissioner's Designee