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Via first-class mail, facsimile, and email

May 20, 2014

The Honorable Andrew M. Cuomo
Governor of New York State
New York State Capitol Building
Albany, NY 12224
Fax: (518) 474-1513

Cindy Mann, Deputy Administrator & Director
Centers for Medicare & Medicaid Services
Center For Medicaid & CHIP Services
7500 Security Boulevard, MS S2-01-16
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cynthia.mann@cms.hhs.gov

Howard Zucker, M.D., Acting Commissioner
Jason Helgerson, Medicaid Director, Deputy Commissioner
(jah23@health.state.ny.us)
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Re: Time for Change in New York's Managed Long-Term Care

Dear Governor Cuomo, Ms. Mann, Dr. Zucker, and Mr. Helgerson:

We write to urge you to address the serious problems with Managed Long-Term Care (MLTC) in New York State. Many of our organizations have been warning government officials about these problems for years. As a matter of sound public policy, these problems can no longer be ignored.

A May 8, 2014 *New York Times* article (attached) highlights the human and financial costs of the key problem—MLTC plans are denying services to people who need them while aggressively recruiting clients who do not. The article juxtaposes the delay, disruption, and denial of community-based long-term care services to vulnerable New Yorkers who desperately need services with the MLTC plans' illegal marketing practices and enrollment of people who do not need those services.

The article illuminates the problematic financial incentives for MLTC plans and the providers associated with those plans: **"the more enrollees, and the less spent on services, the more money the**

companies can keep." These incentives encourage the provision of services to those who do not need them and reward plans that deny services to those who need them most.

The article also highlights the life-and-death consequences of these incentives. For example, cuts in certified home health agency reimbursement led to massive dumping of people like Ena Johnson, whose 24-hour care was immediately dropped and not restored until it was too late. **"By the time lawyers won her return home with 24-hour aides, she had a bone-deep 13-inch bedsore . . ."** Advocates have reported the same types of abuses by MLTC plans. Just last week New York Legal Assistance Group filed a complaint about an 85-year-old Bronx resident who needed 24-hour care due to a stroke, vascular impairments, diabetes, and other complex needs. Her care, previously stable for seven years, was reduced to 7 hours per day after her transition into MLTC from the personal care program. As has been all too common, the MLTC plan gave no written notice, no notice of appeal rights, and as a result, no right to "aid continuing."[1]

Once MLTC fully expands to include nursing homes, another vulnerable population will be at risk. Ignoring these problems will lead to bad public policy that will be harmful to seniors, people with disabilities, and their families for years to come. Policymakers can no longer tout the claimed budgetary successes of this new program without acknowledging the undeniable human costs.

New York State will fail to meet the goals of MLTC—to reduce waste and improve patient outcomes—unless these problems are addressed now. We call for the following changes to the MLTC program immediately:

- **Implement conflict-free assessments and coverage decisions.** The current MLTC program allows financially motivated MLTC plans to conduct the clinical assessments that determine who is eligible to receive services and who is not, thus placing the highest-need and potentially costly beneficiaries at extreme risk. Enrollment should be suspended or greater oversight implemented until conflict-free assessments are fully implemented.

- **Require arms-length contracting.** New York law allows the same organizations to own and operate both the MLTC plans and the long term care facilities and home care agencies funded by those organizations. This blatant conflict of interest is structurally poisonous to the entire system of care.

- **Ensure real due process protections for consumers.** MLTC services should not be reduced or terminated without procedures that meet due process standards of notice, aid continuing, and fair hearing rights. So far, New York State has failed to ensure continued provision of services and MLTC plans have cut services illegally. Standardized notices must be developed with

[1] The attached case example, described on page 3, further illustrates this problem.

consumer input. Providers found to have cut services without providing due process should be fiscally sanctioned and required to submit plans of correction to ensure future compliance.

- **End mandatory exhaustion of the internal appeal process.** The requirement that consumers "exhaust" internal appeals before requesting a fair hearing should be eliminated, because consumers are not notified of their appeal rights at all, let alone the obligation to request an internal appeal. Recourse to a fair hearing is essential. The attached case example shows how a consumer's services were cut from 12 to 8 hours per day for over five months until legal advocacy restored them last week. In the meantime, the 96-year-old man fell three times, requiring two hospitalizations. No notice was given, let alone notice of the requirement to request an internal appeal or the right to "aid continuing." *See* case example, attached.

- **Employ robust and effective surveillance.** Oversight of MLTC plans and providers is woefully inadequate and MLTC complaints, whether made through the MLTC complaint line or via other channels, are not adequately investigated and resolved. The State must invest more resources in surveillance. This could include:
    - expeditious implementation of the managed care ombudsman program with safeguards to ensure its independence from State and industry interference;
    - increased funding of the LTC Ombudsman Program, which will inevitably be a "first responder" on issues, particularly for consumers in residential care settings;
    - requiring an annual Office of Medicaid Inspector General audit of the MLTC program (including assessments of plans and providers);
    - using "secret shoppers" to look out for marketing fraud and monitor responsiveness of plan call centers;
    - training staff to identify fraudulent practices;
    - suspending enrollment for longer periods when plans engage in improper marketing and enrollment practices as well as other illegal practices such as due process violations; and
    - involving consumer advocates to identify best practices.

- **Weed out deficient MLTC plans.** The State should end its policy of letting any willing plan join the MLTC program and engage in an active procurement process. It should remove MLTC plans that violate the law or consistently fail to improve patient outcomes. The plans should be required to prove that complaints represent "one-off" incidents, by demonstrating actual compliance with adequate working systems and procedures. The State should periodically halt MLTC enrollment to assess plan performance with input from consumer advocates.

- **Ensure greater transparency and accountability**. There is no public information currently available on MLTC complaint and appeal rates.

Medicare beneficiaries can access information, through the star ratings system, about plan performance in dealing with complaints and appeals. The State Department of Financial Services' annual report on commercial insurers includes statistics on complaints and appeals. MLTC enrollees deserve at least the same level of transparency and accountability. The formal evaluation of MLTC plans must begin incorporating complaint and appeal information and such data must be made publicly available. Additionally, the State's MLTC reports must include plan-specific data on medical loss ratios, care management ratios, and the extent of provision of community-based services. The recent 2013 report presents only a partial picture of plan performance, much of it not plan-specific.

- **Protect nursing home residents in the enrollment process.** As the State rolls out expansion of MLTC to include nursing home care and residents, these vulnerable individuals must be protected. While existing residents will not be required to enroll in plans, they will be allowed to enroll in plans, and as such, will be vulnerable to marketing pressures. An enforceable informed consent requirement should be established, where plans must provide accurate and complete information about eligibility and choice and be able to document a consumer's consent to enrollment – or the consent of their designated representative for those who lack capacity. This is particularly important as the MLTC program begins taking on nursing home patients who are then passively enrolled into Fully Integrated Duals Advantage Plans. Additionally, DOH oversight of nursing homes must be more rigorous.[2]

- **Delay expansion of mandatory MLTC to new upstate counties and to the nursing home population** until the protections requested above are in place. In many upstate counties there are just one or two MLTC plans with only a handful of enrollees. No recipient of stable community-based services should be required to transition to these plans until their capacity is assured and the protections proposed above are incorporated.

With the deficiencies in the State's MLTC program clearly exposed, we ask you to take action so that the most vulnerable New Yorkers do not continue to suffer. We would welcome the opportunity to meet with you to discuss our proposals. Please contact Jota Borgmann at (212) 417-3717 or jborgmann@mfy.org if you would like to request a meeting with our group.

Sincerely,

Jota Borgmann, Senior Staff Attorney
MFY Legal Services, Inc.

[2] Other concerns regarding expansion of MLTC and mainstream managed care to include nursing home population are stated in a letter to CMS and DOH dated March 14, 2014, posted at http://www.wnylc.com/health/news/58.

On behalf of:

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cc (via email):

Hon. Richard N. Gottfried, Chair, New York State Assembly Health Committee

Hon. Kemp Hannon, Chair, New York State Senate Health Committee

Hon. Joan Millman, Chair, New York State Assembly Aging Committee

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The New York Times | http://nyti.ms/1j2derE

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Medicaid Shift Fuels Rush for Profitable Clients

By NINA BERNSTEIN MAY 8, 2014

When Hurricane Sandy flooded two adult homes in Queens, hundreds of disabled, elderly or mentally ill residents were caught in the surge. After weeks in public shelters, they were bused, over their objections, to a dilapidated four-story building called King's Hotel, in a crime-ridden section of Brooklyn.

Many had not showered in days. Crammed three cots to a room, they lacked basics like clean underwear. But in the parallel universe of New York's redesigned Medicaid program, they represented a gold mine.

Business managers from CenterLight Healthcare, a managed care company specializing in long-term services, huddled in a ground floor hotel room, poring over health data and spreadsheets that identified residents by name and room number. At the managers' direction, crews of enrollment nurses tracked down residents to pressure as many as possible to sign up with the company's long-term care plan, according to current and former CenterLight employees who were there.

To CenterLight, which had struck an unusual deal with the state to run the hotel as a temporary adult home, the evacuees were a captive audience, and each signature was worth $45,600 a year in fixed monthly Medicaid fees. To an agency supplying aides there, the signatures also meant more money.

But for taxpayers, the sign-up frenzy at King's Hotel points to hidden costs and potential abuses in an ambitious Medicaid overhaul in New York that has shifted $6 billion in public spending on long-term services for disabled and aged people to managed care companies like CenterLight. The state's goal was savings, but the changes set off a scramble among managed care companies and service providers to enroll clients requiring minimal care, including residents of adult homes who could be brokered in bulk, an investigation by The New York Times found. Many frail people with greater needs were dropped, and providers

jockeying for business bought, sold or steered cases according to the new system's calculus: the more enrollees, and the less spent on services, the more money the companies can keep.

Adult home residents, like those caught in the hotel, had long been victimized under the old fee-for-service Medicaid system, in which providers were paid for services rendered. Now, under managed care, they find themselves prey to new versions of old tactics, including intimidation to accept services they do not need.

"They came like vultures — 'Sign here, sign here!' — with their doughnuts and cookies," recalled Robert Rosenberg, 61, who has a spinal disorder and Crohn's disease, and, at 4 feet 4 inches tall, had waded through hip-high water to escape the flood at Belle Harbor Manor in Queens. "They coerced people. They told residents they would lose their Medicaid if they didn't sign."

Ronald White, 70, a former Marine now back at New Gloria's Manor, recalls refusing a $10 payment for his signature at the hotel ("a hellhole"), only to be awakened at night by a woman who said she was his aide. "I don't need an aide!" he said he had protested. "It sounded like a get-rich-quick scheme."

They were among many displaced residents whose accounts of the enrollment campaign were corroborated by CenterLight employees who were part of it. State officials had received similar complaints about the company's summer-long marketing push at Belle Harbor Manor before the storm, email exchanges show. Since then, other emails have reported enrollment violations involving other companies, including attempted bribes.

But state officials see no systemic problems with the shift to managed long-term care, which they call a popular success. They cite an 87 percent satisfaction rate in a mail survey of members. "Any suspected violations of the law or contracts with the state are investigated," Bill Schwarz, a State Health Department spokesman, said.

No complaints, he said, were reported from the hotel by state officials, who permitted the enrollment push and paid CenterLight about $350,000 for running the hotel for three weeks and supplying services. The state and the companies said they were proud of their work there and denied any improprieties.

"The driving factor," Mr. Schwarz said, "was to protect and serve the hundreds of vulnerable individuals impacted by this unprecedented natural disaster."

His statement was echoed by Constance Tejeda, a spokeswoman for CenterLight, who called its staff's work heroic. Colin Mahoney, a public affairs consultant for Edison Home Health Care, which supplied the aides, cited "unprecedented circumstances."

But the heavy-handed tactics revealed at the hotel are part of a larger pattern that emerges from interviews with industry insiders and patient advocates alike, and from court records, legislative hearings and emails obtained by The Times that discuss mass transfers of patients for money.

Michael Irvin, who was at the hotel as a marketing manager for CenterLight, said he complained to his supervisors and soon left for a better job. But he wound up working for a different managed care company where he fielded one offer to sell him cases by the thousand, and others that promised enrollees in exchange for money. He reported those illicit proposals to state officials, to little effect.

"It is a gold rush," Mr. Irvin said. "You've got the Wild West, where everybody can do everything to get a case, to the extent of bribing people to switch over cases."

The turbulence has intensified as the industry prepares for the next phase. Later this year, under a federal waiver obtained by Gov. Andrew M. Cuomo of New York, 25 Medicaid long-term care companies will also gain access to billions of dollars in federal Medicare payments. Companies can automatically enroll qualified members into combined plans that are supposed to yield greater government savings and more coordinated care. Whether those benefits are realized remains to be seen, but the change will mean even more revenue for the companies.

At the hotel, many residents had refused CenterLight's repeated sales pitches before the storm because they did not even need its services; some were clients of a rival company, ElderServe, which had already been sanctioned by the state for aggressive marketing; others did not have Medicaid, or were wandering the halls, disoriented.

But the nurses who cornered them had enrollment goals to meet — and authority to evaluate eligibility.

The threshold for enrollment in such plans is no longer a score on a numerical assessment of impairment, as before, but an ill-defined "need for 120 days of long-term care services" — services ranging from a few minutes' help from an aide

and a few hours at a social center, to round-the-clock home care or nursing home placement.

The biggest loophole, experts agree, is that New York's new system has no independent assessment of whether enrollees actually need services. Mr. Irvin, now a veteran of several companies' marketing efforts, was blunt: "Allowing the companies to perform their own assessments is like leaving a hungry dog to guard the meat shed."

Patient Selection

No group suffered more from the old system than the mentally ill residents of profit-making adult homes. Under fee-for-service Medicaid, many neglected residents were subjected to unnecessary treatment, even surgery.

Though disability money has long gone to the homes to supply meals and personal care, operators kept cutting services. They forced residents to use favored providers of home health care, who typically billed Medicaid at inflated rates, and paid inflated rent for access to the residents. Some of the same providers also pumped up Medicaid receipts outside adult homes by assigning low-paid aides to cases around the clock, at high profit, regardless of need.

Governor Cuomo's redesign was supposed to change all that. The first step, in April 2011, was to reformulate and shrink reimbursement for home care. Later, Medicaid beneficiaries already receiving more than 120 days a year of such services would be required to join a managed care plan that paid companies a fixed premium.

The state projected savings at more than $200 million annually, and says it succeeded. But a state plan obtained under the Freedom of Information Law noted a downside: "It may provide agencies an incentive to 'cherry pick' patients by serving only those with lower acuity and less intense needs."

That is just what happened.

Farrah Rubani, then senior vice president of Extended, a home health agency becoming a managed long-term care company, said she was told to get rid of clients receiving round-the-clock home care. "I said, 'What do you want me to do, load them up and drop them off at the Verrazano?' " Ms. Rubani said, adding: "They were bed-bound, they were desperate. We just chopped them up and threw them away."

The company denied Ms. Rubani's account, calling her a disgruntled former

employee.

It is uncertain if those clients were sent elsewhere. But in a class-action suit over patient dumping brought against five other agencies, the case of Ena Johnson, an 85-year-old Brooklyn grandmother, is instructive.

Bed-bound and incontinent after strokes, Mrs. Johnson received round-the-clock home care for years. But when the reimbursement changed, her home care agency, Personal Touch, sent her to the hospital for a two-day procedure, then refused to reinstate her care, the lawsuit says. By the time lawyers won her return home with 24-hour aides, she had a bone-deep 13-inch bedsore; she died two months later. “She suffered,” her daughter, Cecilia Johnson, said.

Personal Touch settled by paying $50,000 without admitting wrongdoing. It now operates a managed long-term care company called Integra with Medicaid revenue of $43 million a year.

While high-needs cases were shed, the race was on for cheap ones. In large adult homes, where one low-paid aide can serve many people, some of the same players who exploited the old Medicaid system found the residents were still a valuable commodity. Home operators, happy for managed care to shoulder their service costs, joined with certain companies and providers to pressure residents to sign for an aide and attend a social day center — that is, to accept the minimum services that could justify enrollment in a plan that collected $3,800 monthly per member.

“They told me the aide could hand me a towel when I came out of the shower, and I should sign up with ElderServe,” said James Ramdaou, an able-bodied resident of Park Inn Home in Queens who takes psychiatric medication. “I told them, I’m 34 years old, I don’t need elder-anything.”

Mr. Ramdaou complained last fall to Jota Borgmann, a lawyer with MFY Legal Services who has protested such marketing for two years, fruitlessly calling for an audit of potential fraud, and reporting specific complaints directly to Mark Kissinger, the state’s chief of long-term care, at Mr. Kissinger’s request.

In April 2012, the state suspended ElderServe’s enrollment for 45 days for marketing improprieties in adult homes. But CenterLight was also aggressive, said advocates who wrote Mr. Kissinger on Sept. 26, 2012, weeks before the storm, citing complaints by the Belle Harbor Manor residents’ council.

Complaints about both companies surfaced repeatedly at Garden of Eden, a

rundown adult home in Bensonhurst, Brooklyn, with a history of resident intimidation. In a 2011 case still awaiting an administrative judge's decision, the state sought removal of the operator, Martin J. Amsel, for threatening to evict mentally ill residents if they did not go to programs and doctors of his choosing, and get eyeglasses from his son-in-law's store. Now, many residents have been pushed to sign up with ElderServe or CenterLight, be bused to Inspire, a crowded social day care program managed by Mr. Amsel's relatives, and accept an aide from Edison home care, which is currently a defendant in a federal civil racketeering lawsuit over money allegedly siphoned from a hospital. (Edison has denied wrongdoing.)

"They're all going to work together to enrich each other," said Vincent Piazza, 67, a resident. "The government is still leaving us with the same people who have been abusing us."

At Belle Harbor, which collected evacuees' disability checks during the displacement, and received $1.5 million in hurricane grant money, residents say they were pushed between ElderServe and CenterLight, then into Aetna's plan, depending on deals.

In a recent reshuffle, Howard Kucine, 62, a Navy war veteran with diabetes, suddenly could not get his daily insulin shot from the sole nurse on site: He and his plan had been inadvertently dropped from contracts covering her services. Finally Mr. Kucine, who is in ElderServe, persuaded his roommate, Mr. Rosenberg, who is in CenterLight, to give him the injections.

Enrollees, for a Price

The architects of the new system have been slow to understand the interlocking financial interests that exploit it, some experienced health care professionals say.

"They're taking the price of a Mercedes and attaching it to each patient every single year, whereas before, with Medicaid fraud, you had to have all sorts of separate transactions," said a doctor who insisted on anonymity, after describing a business deal he rejected that would have funneled aged patients in his house-call practice to a managed care company through a home care agency. "The idea is to give them as little care as necessary."

On paper, consumer choice assures quality since members can switch plans every month. In reality, executives and consultants say, patients are being steered

and switched daily.

Providers, now unable to bill Medicaid directly, need cases from managed care companies, which also control hours and rates. But one hand washes another: The companies need enrollees, and providers with aides inside homes can deliver clients, or switch them from rival companies — for a price.

Managed care consultants say the trading extends from individual bribery to proposals like the anonymous email Mr. Irvin, the former CenterLight manager, received last fall when he was a full-time consultant for another managed care company, AlphaCare.

The email offered to sell AlphaCare a spreadsheet listing 20,000 members of the largest plan, VNSNY-Choice. No price was named, but in fixed monthly Medicaid payments, the list represented $1 billion, the message noted.

Although it was unclear if the sender actually had the data, Mr. Irvin alerted VNSNY and forwarded the message to government authorities. Three months ago, he also wrote Mr. Kissinger, the state's long-term care director, about being offered a $50,000 bribe by the owner of a home care agency, to switch hundreds of cases. Mr. Kissinger replied that the office of the Medicaid inspector general would contact him. No one has.

Another manager, insisting on anonymity for fear of retaliation, said he had rejected $500 per case. That is the going rate for an enrollment nurse to steer a case to a particular agency, other managers said. On a larger scale, agencies steer patients to managed care companies in exchange for higher rates per hour.

With Medicaid money going to such deals, said Ms. Rubani, who now runs Hopeton Home Care, even less is left where it is most needed: for wet, bedridden patients, "waiting for four hours for the next aide."

In contrast, robust adults with a psychiatric diagnosis are being drawn to centers like Alphabet Social Adult Day Care, which opened in February in the basement of a boutique condo building in the East Village, with pool tables, karaoke and casino trips. Such centers seek Medicaid enrollees for — and business from — managed care companies, but also suit real estate interests seeking commercial tenants.

Alphabet is owned by LicensePro, a health care start-up company whose broker, Olga Rice, assured a caller that Alphabet (asking price: $130,000) required no actual services. "Just occupy them," she said. "Read poems, sing music, play

some games."

"It's a money grab right now," said Chris Barrey, the deputy director of a psychiatric program nearby, who saw patients as young as 20 lured to Alphabet and required to stay for four hours — the billable minimum. "You don't have to have any licensed staff to run a program like that. You need a van and a basement."

Correction: May 17, 2014

A picture on May 9 with the continuation of an article about changes in New York's Medicaid policy, which have led managed care companies to enroll more adult home residents and low-maintenance patients at the expense of people with greater medical needs, was published in error. The photograph showed the Kings Hotel on 39th Street in Brooklyn, which did not house residents of adult homes affected by Hurricane Sandy. They were sent to a hotel with the same name at 2416 Atlantic Avenue.

Susan C. Beachy contributed research.

A version of this article appears in print on May 9, 2014, on page A1 of the New York edition with the headline: Medicaid Shift Fuels Rush for Profitable Clients.

Case Example Mr. S., Flushing NY - Senior Health Partners

Had 12 hours x 7 days personal care. Age 96. He had home care since 1997 through CASA, and then was mandatorily transitioned to MLTC. He has changed plans at least once – reasons are unclear as to why or how. He has dementia and his care is managed by family. He has been in the current plan since around July 2013.

11/19/2013 - Plan gave "Projected Service Plan for Member" with effective date the same as the date of the document – 11/19/13, stating recommend hours were 8 hours x 7 days. Member was asked to sign the plan – given that he has dementia and is Russian-speaking it is not clear that he understood what he signed. If this was supposed to be a notice of reduction, it fails in many respects – it was not given at least 10 days before the reduction, did not state that hours were being reduced and why, and lacked information on how to request an internal appeal and any explanation of "aid continuing" rights.

The plan provided an appeal form titled "Denial of Benefits under Managed Long Term Care" that gives instructions for requesting a Fair Hearing but says nothing about how to request an internal appeal, let alone the requirement that an internal appeal must be requested first. It is unclear if FH was requested, but if it was it would have been dismissed for failure to exhaust.

On Dec. 10, 2013, hours were cut to 8 hours x 7. Family called immediately to contest the reduction and submitted a medical letter in support. The plan failed to issue a decision on the appeal for over **three months**, leaving the member in limbo and with services cut the entire time. (The time limit for an internal appeal decision is 30 days, or only 3 days if appeal is expedited because of jeopardy to health).

By notice dated Mar. 19, 2014, plan denied the internal appeal with a "DENIAL OF BENEFITS." This notice does not even acknowledge that the issue involved a REDUCTION in hours, failing to explain why a reduction from 12 to 8 hours/day was justified, violating *Mayer v. Wing* as codified in 18 NYCRR 505.14(b)(5)(c).

Mr. S has multiple health diagnoses that necessitate 12 hours x 7 days of home care --chronic pneumonia, asthma, edema, and fluid retention in lungs. He has an unsteady gait and balance issues, requiring assistance with all ADLs. ***Since the reduction in his personal care hours, Mr. [redacted] has fallen three times when the aide was not present***. Two of these falls required medical attention. The family reports that Senior Health Partners was aware of at least one of these hospitalizations, but did not intercede to reverse the reduction in his plan of care. Due to his chronic pneumonia, asthma, and fluid retention in his lungs Mr. S must be reminded to use his nebulizer in the morning when he wakes up and again before he goes to bed. Prior to the reduction, his aide reminded him to use the nebulizer around 8 am and then before she left at 8 pm. After the reduction, the aide reminded him to use the nebulizer in the morning and again at 3:45 pm – four hours earlier than before --- which led to unnecessary buildup in his lungs.

Care was only restored after NYLAG filed a complaint with the State DOH on May 14th.

☐ Start of Enrollment
☑ Reassessment

Senior Health Partners
Managed Long-Term Care Plan
A Healthfirst Company

Projected Service Plan for Member

Name: [redacted] EMR # [redacted]

Projected Service Date: 11/19/13 Assessment Period from _____ to _____

Projected Services:

☑ Nursing Recommended frequency: q 6 month

Assess and monitor cardiopulmonary, neurovascular, musculoskeletal, gastrointestinal, genitourinary, cognitive, functional, skin integrity, nutrition and hydration status; instruct and supervise medications; instruct diet; provide support; reinforce home safety. Other: _____

☑ PCA/HHA Recommended days/hours: 7days x 3hrs

Name of vendor, if known: _____

Assist with personal care including bathing, dressing, grooming, toileting, skin care as needed; monitor skin integrity. Assist in ambulation and transfers as needed. Assist with meal preparation per recommended diet; medication reminders as needed; assist with shopping, accompany to MD appointments and errands. Perform light housekeeping. clean client's bathroom, kitchen bedroom and living areas; laundry, mop, sweep/vacuum floors.

☑ Nursing: q 6 month
☐ Housekeeping
☐ Initial Psychosocial Evaluation
☐ Physical Therapy Evaluation
☐ Speech Therapy Evaluation

☑ PCA/HHA: 7d x 3hrs
☐ Heavy Duty Housecleaning
☐ Home Repair
☐ Occupational Therapy Evaluation
☐ Nutrition Evaluation

☐ Adult Day Health Center: ☐ Social Day Center: ☐ Evaluation ☐ Currently attending
☐ Medical Model: ☐ Evaluation ☐ Currently attending

Name of Center if currently attending: _____

☐ PERS ☐ Safe Return Bracelet ☐ Medical ID Bracelet
☐ Transportation ☐ Audiology ☑ Dental ☑ Podiatry ☑ Optometry bath bench

☑ Medical Equipment: walker, cane, wheelchair, commode

☑ Medical Supplies: diapers, pull ups,

PCP Name: Klyayev, E Telephone # 718 576 4652

PCP Address: _____

NURSING

- [x] Member/Caregiver will reach optimal functioning
- [x] Member/Caregiver verbalize understanding and will follow medication regimen
- [ ] Member/Caregiver will demonstrate understanding of the disease process and treatment plan.
- [x] Member/Caregiver will keep an up to date list of current meds and verbalizes an understanding of the signs/symptoms related to the medication
- [x] Member/Caregiver will address individual barriers to improve overall well-being and meet personal health goals
- [x] Member/Caregiver will make and keep follow up appointments have annual health screening, counseling and immunizations
- [x] Member will inform the team if there are any health related changes

PCA

- [ ] HHA/PCA/ Housekeeping
- [x] Member will remain safe at home with supervision
- [x] Maintain a clean home
- [x] Provide medication reminders
- [x] Assist member with activity of daily living (i.e. bathing, grooming and transfer) and independent activities of daily living i.e. grocery shopping and laundry
- [x] Escorts to and from medical appointments
- [ ] If HHA: Assist with treatments as ordered

SOCIAL DAY

- [ ] Utilize community resources to enhance members socialization
- [ ] Member will receive Medical Treatment as needed while attending the Medical Model Day Center

PERS

- [ ] Member/caregiver verbalizes when and how to access emergency care

COVERED SERVICES

- [x] Member will receive an audiology evaluation
- [x] Member/caregiver verbalizes understanding of the importance of an annual audiology exam
- [ ] Member will receive needed hearing aids
- [x] Member will receive a podiatry exam
- [x] Member/caregiver verbalizes an understanding of the importance of a podiatry visits
- [x] Member will receive an annual eye exam
- [x] Member/caregiver verbalizes understanding of the importance of an annual eye exam
- [x] Member will receive an dental visit
- [x] Member/caregiver verbalizes understanding of the importance of annual dental visits

PHYSICAL THERAPY

- [ ] Member will show improved activity of daily living performance
- [ ] Member will show improved strength and coordination
- [ ] Evaluate appropriate medical equipment needs
- [ ] Educate member on fall precautions
- [ ] If eligible, enroll in SHP Fall Prevention Program
- [ ] Member will safely function in home with devices

OCCUPATIONAL THERAPY

- [ ] Member will show improved motor skills
- [ ] Evaluate the home and establish a plan for optimal functioning

PSYCHOSOCIAL

- [ ] Member will be provided with continued counseling

NUTRITIONAL ASSESSMENT

- [ ] Member will receive nutritional evaluation
- [ ] Verbal counseling needed

HEAVY DUTY HOUSEKEEPING

- [ ] Member's home will be eliminated of infestation and clutter
- [ ] Maintain a clean environment

SAFE RETURN BRACELET

- [ ] Identify member's with cognitive/memory deficits
- [ ] Promote safe return of member

TRANSPORTATION

- [x] Caregiver/Member will be provided safe transportation to all medical appointments
- [ ] Caregiver/Member will be provided safe transportation to Social/Medical Model Day Centers

Your finalized Service Plan will be mailed to you by your Care Management Team.

Member/Representative Signature: [redacted] Date: 11/19/13

Assessment Nurse Signature: [signature] Date: 11/19/13

DENIAL OF BENEFITS UNDER MANAGED LONG TERM CARE

SENIOR'S HEALTH PARTNER'S
MLTCP's Name

RIGHT TO A FAIR HEARING : If you believe that the action we have taken is wrong, you can ask for a State fair hearing by phone or by writing.

1. **TELEPHONE:** Statewide Toll Free 1-800-342-3334. Please have this notice with you when you call.
2. **FAX:** Fax a copy of all the pages of this notice to (518) 473-6735.
3. **WALK-IN:** Bring a copy of all the pages of this notice to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 330 West 34th Street, 3rd floor, New York, N.Y. – or - 14 Boerum Place, 1st floor, Brooklyn, New York.
4. **TO WRITE FOR A FAIR HEARING:** Fill in the space below and send a copy of all pages of this notice to:

   Fair Hearing Section
   NYS Office of Temporary and Disability Assistance
   Fair Hearings
   P.O. Box 22023
   Albany, N.Y. 12201-2023

   Please keep a copy for yourself.

5. **OR ONLINE ON THE INTERNET.** Complete the online request form at the following Web page:

   https://www.otda.state.ny.us/oah/oahforms/erequestform.asp

✓ **I want a fair hearing:** This action is wrong because The hours were taken away with out any reason or explanations.

Client Signature: (X) [redacted]

Client print name here: [redacted]

Client Address: [redacted] Flushing, N.Y. 11367

Phone Number: (718) [redacted] Case Number: _____ CIN Number : _____

MEMBER ID#: [redacted]

YOU MUST ASK FOR A FAIR HEARING WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE

IF YOU ASK FOR A FAIR HEARING, the State will send you a notice with the time and place of the hearing. You have a right to bring a person to help you like a lawyer, a friend, a relative or someone else. At the hearing, this person can give the hearing officer something in writing or just tell why the action should not be taken. This person can also ask questions of any other people at the hearing. Also you have the right to bring people to speak in your favor. If you have any papers that will help your case – pay stubs, receipts, health care bills, doctor's letters – bring them with you.

IF YOU NEED FREE LEGAL HELP, you may be able to get such help by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or call the number on the front of this notice.

(1)

YOU HAVE A RIGHT TO SEE YOUR CASE FILE to help you get ready for the hearing. If you call or write to us, we will give you free copies of other documents from your file, which you may want for your fair hearing. To ask for these documents or to find out how to see your file, call the general Help telephone on the front page or write to us at the address at the top of the front page. You should ask for these documents before the date of your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you ask that they be mailed.

FOR MORE INFORMATION ON YOUR CASE: If you want to see your file, to find out how to ask for a fair hearing or to find out how to ask for copies of your file, call the number or write to the address on the top of the front page of this notice.

(2)

March 19, 2014

(NYC – rev. 3/29/05)

Managed Long Term Care Plan Action Taken
Senior Health Partners
DENIAL OF BENEFITS

NOTICE DATE: 3/19/14	**NAME, ADDRESS AND TELEPHONE OF MLTCP:**
CASE NUMBER: / **CIN NUMBER:** VE[redacted]	Senior Health Partners 100 Church Street New York, NY 10007
ENROLLEE NAME AND ADDRESS: S[redacted]	**GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP (212) 324-2600**
[redacted] **FLUSHING, NY 11367**	

This is to inform you that your request for: **ADDITIONAL PATIENT CARE AIDE SERVICES.** has been denied by your Managed Long Term Care Plan through their appeals process on: **3/19/14** because: You are alert and oriented although forgetful at times and can perform your ADL's (Activities of Daily Living) with assistance. You were reported to have recently sustained falls where no injuries were noted and medical treatment was not required. In regards to your recent hospitalization, you were reported to have been treated and discharged home in stable condition with outpatient follow-up. You live with your daughter and have family support. The recommendation is for 7-days x 8-hours of Patient Care Assistant services per week. The Care Management Team with continue to assist you in your healthcare needs and monitor any changes in your status and adjust your services accordingly.

This action is taken under 42 CFR Part 438. If you think this action is wrong, you may ask for a "State Fair Hearing." To learn how to do this, please read the back of this sheet that says: "RIGHT TO A FAIR HEARING."

Distribution:
Client/Fair Hearing
Client copy
Managed Long Term Care Plan

(3)

y_NEW YORK STATE EXTERNAL APPEAL APPLICATION

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or out-of-network, complete and send this application to the above address within 45 days of the plan's final adverse determination. For help call 1-800-400-8882 or e-mail your questions to externalappealquestions@ins.state.ny.us.

TO BE COMPLETED BY ALL APPLICANTS

1. **Applicant Name:** _____

(Please check one) [V]Insured/Patient [ ]Patient's Designee [ ]Provider

2. **Patient Name:** [redacted]

3. **Patient Address:** [redacted]

Flushing NY, 11367

4. **Patient Phone Number:**
Home(718) [redacted] Work( ) _____

5. **Patient E-mail (if patient submits application and wants contact by e-mail):** _____

6. **Health Plan Name:** HealthFirst / Senior Health Partner

7. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination? (Please check one.)
[ ]Yes [ ]No [ ]Don't know

8. **Reason for Health Plan Denial:** (Please check one.)
[ ] Not medically necessary. [V] Experimental / investigational.
[ ] Clinical trial. [ ] The treatment is for a rare disease.
[ ] Out-of-network and the health plan proposed an alternate in-network service.

9. Describe the service and the date(s) of service. **Attach the final adverse determination from the first level of appeal with the health plan, or the health plan's letter waiving the appeal,** along with any other information you would like considered.
The patient had 7days x12 hours
Aide, services up until 12/10/13, and then the services were cut to 7days x8 hours without any explanations.
(authorizations to vendors attached)