STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 8, 2017
[redacted]
AGENCY: MAP
FH #: 7549869P

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 July 25, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the determination of the Managed Long Term Care Plan to reduce the Appellant's Personal Care Services authorization from 70 hours per week to 35 hours per week 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 77, has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long Term Care plan operated by Centers Plan for Healthy Living (hereinafter, the Plan).

2. The Appellant has been in receipt of personal care services in the amount of 70 hours per week.

3. On May 15, 2017, a nurse, on behalf of the Plan, completed a Uniform Assessment System – Comprehensive Assessment (UAS) as well as a Level of Care Report.

4. On May 30, 2017, the Plan issued to the Appellant a written notice of "Initial Adverse Determination" which advises the Appellant of the Plan's determination to reduce the Appellant's Personal Care Services authorization from 70 hours per week to 35 hours per week effective June 13, 2017.

5. On June 19, 2017, the Plan issued to the Appellant an amended written notice of "Initial Adverse Determination" which advises the Appellant of the Plan's determination to reduce the Appellant's Personal Care Services authorization from 70 hours and to 35 hours per week effective June 13, 2017.

6. On June 8, 2017, this fair hearing was requested on behalf of Appellant.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or Services, the Appellant must establish that the Agency's denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits

Section 358-2.21 states that a "social services agency" means the State, county, city, town official or town agency, social services district or HEAP certifying agency responsible for making the determination or for the failure to act, which is the subject of review at the fair hearing.

Section 358-3.1 of the Regulations provide:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a right to a fair hearing if:

(1) your application has been denied by a social services agency, or you have agreed in writing that your application should be withdrawn but you feel that you were given incorrect or incomplete information about your eligibility for the covered program or service...

(3) your public assistance, medical assistance, SNAP benefits or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP, SNAP or services are inadequate...

(f) As an applicant or recipient you do not have the right to a fair hearing in all situations...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

As per MLTC policy 15.03 for all managed long term care partial capitation plan decisions made on or after July 1, 2015, that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing immediately without exhausting the plan's internal appeal process.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.236 of 42 CFR Subpart D provides, in pertinent part, that each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines. In addition, it provides that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. The New York State Department of Health Office of Health Insurance Programs established the "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care".

With respect to notice requirements, Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(c) Notice of adverse action. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of Sec. 438.404, except that the notice to the provider need not be in writing.

(d) Timeframe for decisions. Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) Standard authorization decisions. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service…

Section 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) The reasons for the action...

Regulations at 18 NYCRR 358-3.3(a)(1) states, in relevant part, a recipient has a right to a timely and adequate notice when a social services agency proposes to take any action to discontinue, suspend, or reduce a Medical Assistance Authorization or services. A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

In Mayer et al. v. Wing et al. (S.D.N.Y.), Plaintiffs challenged New York City's efforts to reduce their personal care services, authorized under fee-for-service Medicaid. The Court found that a reduction notice must state any of a series of listed reasons to justify its action. Effective October 31, 2001, relevant sections of 18 NYCRR 505.14(b) were amended to include the requirements consistent with the Mayer decision for Agency determinations and notices of determination to reduce Personal Care Services.

The Guidelines for the Provision of Personal Care Services in Medicaid Managed Care, released on May 31, 2013, also includes notice requirements consistent with the Mayer decision and it provides, in part:

III. e. Terminations and Reductions…

iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;

3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice.

DISCUSSION

In this matter, the evidence establishes the Appellant, age 77, has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long Term Care plan operated by Centers Plan for Healthy Living (hereinafter, the Plan). It further establishes the Appellant has been in receipt of personal care services in the amount of 70 hours per week. Additionally, on May 15, 2017, a nurse, on behalf of the Plan, completed a Uniform Assessment System – Comprehensive Assessment (UAS) as well as a Level of Care Report.

The evidence also establishes that on May 30, 2017, the Plan issued to the Appellant a written notice of "Initial Adverse Determination" which advises the Appellant of the Plan's determination to reduce the Appellant's Personal Care Services authorization from 70 hours per week to 35 hours per week effective June 13, 2017. Thereafter, on June 19, 2017, the Plan issued to the Appellant an amended written notice of "Initial Adverse Determination" which advises the Appellant of the Plan's determination to reduce the Appellant's Personal Care Services authorization from 70 hours and to 35 hours per week effective June 13, 2017. The June 19, 2017 written notice states "This is an amended letter from your previously dated letter on May 30, 2017".

Pursuant to Mayer, 18 NYCRR 505.14(b) and The Guidelines for the Provision of Personal Care Services in Medicaid Managed Care, the Plan must state any of a series of listed reasons to justify its action. After careful review of the May 30, 2017 and June 19, 2017 written notices, it is the finding that the Plan did not state a reason for its action consistent with Mayer, 18 NYCRR 505.14 (b) or The Guidelines for the Provision of Personal Care Services in Medicaid Managed Care. The Plan only stated, in both of the written notices, that Appellant's personal care services in the amount of 70 hours per week is not medically necessary and provided a summary of a physical assessment performed on April 27, 2017. The Plan's cited reason for its determination, "not medically necessary", is not a specific and appropriate substantive basis that justifies its action. It must also be noted that the June 19, 2017 written notice is not timely as it was not mailed ten days prior to the Plan's proposed action. Therefore,

Plan's May 30, 2017 and June 19, 2017 written notices are void and its determination must be reversed.

DECISION AND ORDER

The determination of the Managed Long Term Care Plan to reduce the Appellant's Personal Care Services authorization from 70 hours per week to 35 hours per week was not correct and is reversed.

1. The Plan is directed to restore/continue the Appellant's Personal Care Services authorization at the rate of 70 hours per week.

Should the Plan 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 plan promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, the Plan must comply immediately with the directives set forth above.

DATED: Albany, New York
08/04/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee