STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 1, 2018
[redacted]
AGENCY: MAP
FH #: 7800968R

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 August 27, 2018, 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)

Julia Rolffot, Fair Hearing Representative

ISSUE

Was the Managed Long-Term Care Plan's determination, dated July 27, 2018, to reduce the Appellant's Personal Care Services (PCS) authorization from 32.5 hours per week (6.5 hours per day, 5 days per week) to 22.5 hours per week (4.5 hours per day, 5 days 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 67, has been enrolled in a Medicaid Managed Long Term Care (MLTC) plan through [redacted].

2. The Appellant had been in receipt of a Personal Care Services authorization in the amount of 6.5 hours per day, 5 days per week (32.5 hours per week).

3. On June 13, 2018, the plan completed a Uniform Assessment System (UAS) - New York Comprehensive Community Assessment Report and a Client Task Sheet.

4. On June 22, 2018, the Plan issued an Initial Adverse Determination which advised the Appellant of its determination to reduce the Appellant's Personal Care Services authorization from 32.5 hours per week to 22.5 hours per week based primarily on the June 13, 2018 UAS report.

5. On July 27, 2018, the Plan issued a Final Adverse Determination upholding its adverse determination of June 22, 2018.

6. On August 1, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

In general, a recipient of Medical Assistance or Services has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Medical Assistance or Services; or has determined to change the amount of one of the items used in the calculation of a Medical Assistance spenddown. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Medical Assistance in another district.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

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.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

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**...

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

DISCUSSION

The record establishes that the Appellant, age 67, has been enrolled in a Medicaid Managed Long Term Care (MLTC) plan through Centers Plan for Healthy Living (the Plan). The Appellant had been in receipt of a Personal Care Services authorization in the amount of 6.5 hours per day, 5 days per week (32.5 hours per week).

On June 13, 2018, the plan completed a Uniform Assessment System (UAS) - New York Comprehensive Community Assessment Report and a Client Task Sheet and on June 22, 2018, the Plan issued an Initial Adverse Determination which advised the Appellant of the Plan's determination to reduce the Appellant's Personal Care Services authorization from 32.5 hours per week to 22.5 hours per week, a determination which the Plan upheld in its Final Adverse Determination of July 27, 2018.

The Appellant suffers from Pyriformis Syndrome (primary diagnosis), sciatica, chronic headaches, diabetes mellitus, heart failure, hypertension, coronary artery disease, osteoporosis, anxiety and chronic pain, among other things, including early dementia. These diagnoses were documented in a letter dated April 30, 2018 from Dr. [redacted] of [redacted].

The Appellant's representative argued against a reduction in the authorized hours of care and testified that the Appellant, her mother, was found outside in July of this year and did not know how to get home. She also testified that her mother's forgetfulness has gotten worse

recently. She cited an example by explaining how her mother left the stove on, without realizing what she had done.

In a letter dated June 26, 2018, Appellant's doctor, [redacted], states Appellant is being treated for mixed vascular/Alzheimer's dementia. He further opines that, if unsupervised, the Appellant can be a danger to herself and others; she requires assistance with her medications; and a reduction of hours of care would not be recommended.

The Plan contends that the decision to reduce the Appellant's Personal Care Services (PCS) hours is "because the service is not medically necessary." The Plan points out in its determination that the Appellant resides with her granddaughter, husband and great granddaughter; the recent UAS report indicates improvement in Appellant's abilities to perform physical functioning; and Appellant showed improvement related to dressing, personal hygiene, eating, toilet transfer, bed mobility, bathing, meal preparation, housework and medication management. Consequently, the Plan reduced the number of hours of Personal Care Services from 32.5 per week to 22.5 per week.

The Client Task Sheet of December 18, 2017 indicates total hours per week should be 37.5 while the Client Task Sheet of June 12, 2018 indicates, based on Appellant's improved functionality, that total hours per week should be 22.5.

As per the cited regulations a denial or reduction in PCS services must clearly establish a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary. If the determination results in a termination or reduction, the reason must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

The record at the hearing establishes that the rationale presented by the MLTC Plan is conclusive and does not contain the specific facts and criteria in support of the reduction of hours of Personal Care Services from 32.5 per week to 22.5 per week.

Comparing the December 18, 2017 UAS report to the June 13, 2018 UAS report, the Plan decreased the level of service from maximal assistance to limited assistance for several ADL's citing Appellant 's improvement as the basis for the decrease. The summary for Functional Status (Section F of the UAS) is essentially the same for the wo UAS report being compared except for the omission of the word "maximal" in the description of the level of service needed per the June 2018 report.

The largest changes in the hours of care, as indicated in respective Client Task Sheets were for bed mobility, walking and toilet transfers. Bed mobility was assigned 45 minutes per day in December 2017, but zero minutes were assigned for this function in June 2018, despite the necessity for limited assistance. Walking was reduced from maximal assistance at 28 minutes per day to limited assistance at 12 minutes per day. Toilet transfer was reduced from maximal assistance at 60 minutes per day to limited assistance at 21 minutes per day.

The calculation of the number of minutes assigned for each function is unclear and was not established by the Plan. For example, there was no change in the assigned minutes per day from December 2017 to June 2018 for medication management (performance) and medication management (capacity) even though they went from maximal assistance to supervision and from extensive assistance to supervision, respectively, despite the progressive nature of the Appellant's dementia diagnosis.

Therefore, based on the above, the MLTC Plan's determination to reduce the Appellant's Personal Care Services authorization from 32.5 hours per week to 22.5 hours per week cannot be sustained.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination to reduce the Appellant's Personal Care Services (PCS) authorization from 32.5 hours per week (6.5 hours per day, 5 days per week) to 22.5 hours per week (4.5 hours per day, 5 days per week) is not correct and is reversed.

1. The MLTC Plan is directed to immediately restore the Appellant's Personal Care Services authorization back to 32.5 hours per week (6.5 hours per day, 5 days per week).

2. The MLTC Plan is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 32.5 hours per week (6.5 hours per day, 5 days per week) for the duration of the Appellant's current certification period.

Should the MLTC Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's representative must provide it to the MLTC Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
10/16/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee