**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** November 30, 2015
[redacted]
**AGENCY:** MAP
**FH #:** 7185080Z

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

## JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on December 23, 2015, 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

Jillian Hinkson, Fair Hearing Representative

## ISSUE

Was the Managed Long-Term Care Plan's determination to reduce the Appellant's Personal Care Services (PCS) Authorization from nine hours per day, seven days per week to five hours per day, five days per week (Monday to Friday) and four hours, two days a week (Saturday to Sunday) 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 forty-five, has been enrolled in a Medicaid Managed Long Term Care plan ((hereinafter, the "MLTC Plan") through Centers Plan for Healthy Living.

2. The Appellant had been in receipt of a Personal Care Services authorization in the amount of nine hours per day, seven days per week.

3. On November 11, 2015, the plan completed a Uniform Assessment System - New York Assessment (Comprehensive) Report (UAS).

4. On November 23, 2015, the plan issued a written Notice which advised the Appellant of its determination to reduce the Appellant's Personal Care Services authorization from nine hours per day, seven days per week to five hours per day, five days per week (Monday to Friday) and four hours, two days a week (Saturday to Sunday) on the grounds that the health care service is not medically necessary.

5. On November 30, 2015, 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 Appellant has been enrolled in a Medicaid Managed Long Term Care plan through Centers Plan for Healthy Living and has been in receipt of a Personal Care Services authorization in the amount nine hours per day, seven days per week. By notice dated November 23, 2015, the plan determined to reduce the Appellant's Personal Care Services authorization from nine hours per day, seven days per week to five hours per day, five days per week (Monday to Friday) and four hours, two days a week (Saturday to Sunday). The notice advised the Appellant that the reduction in services was because the health care service was not medically necessary.

At the hearing, the Appellant testified that her medical condition has not improved to warrant a reduction to the Appellant's Personal Care Services. The Appellant's testimony based on the evidence presented in this hearing was found to be credible and persuasive.

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 or does not meet specific benefit coverage criteria. 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 November 23, 2015 notice does not adequately identify the specific reasons to justify the MLTC Plan's action to reduce the Appellant's Personal Care Services authorization. Furthermore, the MLTC Plan's November 23, 2015 notice fails to comply with 18 NYCRR 358-2.2, inasmuch as it fails to cite the law or regulation upon which its action is based.

Therefore, the MLTC Plan's determination to reduce the Appellant's Personal Care Services authorization nine hours per day, seven days per week to five hours per day, five days per week (Monday to Friday) and four hours, two days a week (Saturday to Sunday) 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 nine hours per day, seven days per week to five hours per day, five days per week (Monday to Friday) and four hours, two days a week (Saturday to Sunday) is not correct and is reversed.

1. The MLTC Plan is directed to immediately restore the Appellant's Personal Care Services authorization to nine hours per day, seven 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 nine hours per day, seven 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
01/08/2016

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee