STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 27, 2017
[redacted]
AGENCY: MAP
FH #: 7523265J

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 May 22, 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)

Alicia Jacobs, Fair Hearing Representative

ISSUE

Was the Appellant's Managed Long Term Care Plan's determination dated April 18, 2017 to reduce the Appellant's Personal Care Services authorization from 52 hours per week (8 hours per day, 5 days per week and 6 hours per day, 2 days per week) to 45.5 hours per week (6.5 hours per day, 7 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 sixty-one, resides alone and has been enrolled in a Medicaid Managed Long Term Care Plan through Centers Plan for Healthy Living.

2. The Appellant has been in receipt of an authorization for 52 hours per week of Personal Care Services (8 hours per day, 5 days per week and 6 hours per day, 2 days per week) as a continuity of a pre-existing Personal Care Aide (PCA) service plan prior to her enrollment with Centers Plan for Healthy Living on February 1, 2017.

3. On March 28, 2017, a nursing assessor completed a Uniform Assessment System (UAS) evaluation of the Appellant's personal care needs.

4. On March 28, 2017, a nursing assessor completed an aide task service plan (ATSP) as to the Appellant's personal care needs recommending 45.5 hours per week of Personal Care Services.

5. On April 18, 2017, Centers Plan for Healthy Living issued to the Appellant a written Initial Adverse Determination which advises the Appellant of Centers Plan for Healthy Living's determination to reduce the Appellant's Personal Care Services authorization from 52 hours per week to 45.5 hours per week. The notice stated, in part, that "The plan is taking this action because the health care service is not medically necessary. Based on the Comprehensive NYS Department of Health Uniformed Assessment System UAS-NY conducted on 03/28/2017 you have demonstrated the following level of care service is not medically necessary.

> Bathing and Dressing lower body Extensive Assistance and you need physical help to complete some parts of this task, like someone to lean on or help you lift a body part, however you can complete most parts of this yourself
> Personal Hygiene and dressing upper body Extensive Assistance where you needed physical help to complete some parts of this task like someone to lean on or help you lift a body part, however you can complete most parts of this yourself…

6. On April 27, 2017, the Appellant requested this fair hearing

APPLICABLE LAW

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 438.210 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 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

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.

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

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home…

Section 505.14(a) of the Regulations provides in part that:

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(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions…

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions shall include some or total assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(8) feeding;

(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the

patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(10) providing routine skin care;

(11) using medical supplies and equipment such as walkers and wheelchairs; and

(12) changing of simple dressings.

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

Pursuant to recently revised 18 NYCRR § 505.14(b)(5)(v)(c)(2):

Appropriate reasons and notice language to be used when reducing or discontinuing

personal care services include but are not limited to the following:

> (i) **the client's medical or mental condition or economic or social circumstances have changed** and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. **The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;**
>
> (ii) **a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;**
>
> (iii) the client refused to cooperate in the required reassessment;
>
> (iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
>
> (v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
>
> (vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify.

Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The uncontroverted evidence establishes that the Appellant, age sixty-one, 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 of 52 hours per week.

On March 28, 2017, a nursing assessor completed a UAS evaluation of the Appellant's personal care needs. On March 28, 2017, a nursing assessor completed an ASTP as to the Appellant's personal care needs recommending 45.5 hours per week of Personal Care Services.

On April 18, 2017, Centers Plan for Healthy Living issued to the Appellant a written Initial Adverse Determination which advises the Appellant of Centers Plan for Healthy Living's determination to reduce the Appellant's Personal Care Services authorization from 52 hours per week to 45.5 hours per week. The notice indicated, in part, that that "The plan is taking this action because the health care service is not medically necessary. Based on the Comprehensive NYS Department of Health Uniformed Assessment System UAS-NY conducted on 03/28/2017 you have demonstrated the following level of care service is not medically necessary.

> Bathing and Dressing lower body Extensive Assistance and you need physical help to complete some parts of this task, like someone to lean on or help you lift a body part, however you can complete most parts of this yourself
> Personal Hygiene and dressing upper body Extensive Assistance where you needed physical help to complete some parts of this task like someone to lean on or help you lift a body part, however you can complete most parts of this yourself…."

Centers Plan for Healthy Living's notice was carefully reviewed at the hearing as to the specific stated reason to justify its action to reduce the Appellant's Personal Care Services authorization, such as a change in the Appellant's medical, mental, or social circumstances, or if a mistake occurred in the previous personal care services authorization. Centers Plan for Healthy Living's notice dated April 18, 2017 does not identify the **specific reason** to justify its action to reduce the Appellant's Personal Care Services authorization, such as specific changes in the Appellant's medical, mental, or social circumstances. Additionally, at the hearing, Centers Plan for Healthy Living failed to provide any information regarding the Appellant's prior Personal Care Aide (PCA) service plan which existed prior to enrollment in Center Plan for Healthy Living. Thus, there is no way to compare the two assessments in order to determine whether there has been a change in the Appellant's medical, mental, or social circumstances.

Although the notice describes the Appellant's current condition, it does not state that her condition has improved or the way it has changed. The notice does not state that a mistake occurred in the previous personal care services authorization. If the notice is based on particular changes in the Appellant's circumstances, it does not provide an explanation as to why the changes result in the need for fewer hours of Personal Care Services.

As Centers Plan for Healthy Living's notice does not provide the **specific** reason for the reduction in hours, such as a change in circumstances or an error in a prior assessment, and does not state why a reduction in hours is necessary, Centers Plan for Healthy Living's determination to reduce the Appellant's Personal Care Services authorization from 52 hours per week (8 hours per day, 5 days per week and 6 hours per day, 2 days per week) to 45.5 hours per week (6.5 hours per day, 7 days per week) cannot be sustained.

DECISION

Centers Plan for Healthy Living's determination to reduce the Appellant's Personal Care Services authorization from 52 hours per week (8 hours per day, 5 days per week and 6 hours per day, 2 days per week) to 45.5 hours per week (6.5 hours per day, 7 days per week) is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to continue to authorize Personal Care Services to the Appellant in the amount of 52 hours per week (8 hours per day, 5 days per week and 6 hours per day, 2 days per week).

Should Centers Plan for Healthy Living 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 required, the Appellant must provide it to Centers Plan for Healthy Living promptly to facilitate such compliance

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

DATED: Albany, New York
07/13/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee