STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 17, 2017
[redacted]
AGENCY: MAP
FH #: 7535571R

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 June 9, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Provider

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, dated May 9, 2017, to reduce the Appellant's Medical Assistance authorization for Personal Care Services from 42 hours weekly, 7 hours daily, Monday through Saturday, to 39 hours weekly, 6.5 hours daily, 6 days weekly 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, aged 77, resides alone and has been enrolled in a Medicaid Managed Long Term Care plan through Centers Plan for Healthy Living "Centers Plan".

2. The Appellant has been in receipt of Personal Care Services of 42 hours weekly, 7 hours daily, Monday through Saturday.

3. On March 31, 2017, the MLTCP obtained a Uniform Assessment System – New York Assessment Report for Appellant, hereinafter, "UAS of March 31, 2017."

8. By Initial Adverse Determination, dated May 9, 2017, hereinafter the "Initial Adverse Determination," the MLTCP advised the Appellant of its determination to reduce the Appellant's Medical Assistance authorization for Personal Care Services from 42 hours weekly, 7 hours daily, Monday through Saturday to 39 hours weekly, 6.5 hours daily, 6 days weekly.

9. On May 17, 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.

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 438.236 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.

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. The Court found that prior to issuing any reduction notice, the Agency must first identify some development that justifies altering a recipient's level of services. Specifically, the Agency was enjoined from reducing recipient's home care services unless the Agency's notice states that a reduction is justified because of any of a series of listed reasons. Effective October 31, 2001, relevant sections of 18 NYCRR 505.14(b) were amended to include the following requirements, consistent with the Mayer decision, for Agency determinations and notices of determination to reduce, discontinue, or deny Personal Care Services, as to reasons for the Agency to select from when issuing relevant notices. The Regulations mention the following approved reasons for taking such action, to be written on the notice:

> (1) the client's medical, mental, 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 than they were previously;
>
> (2) a mistake occurred in the previous personal care services authorization;
>
> (3) the client refused to cooperate with the required assessment of services;
>
> (4) a technological development renders certain services unnecessary or less time consuming;

(5) the client can be more appropriately and cost-effectively served through other Medicaid programs and services;

(6) the clients health and safety cannot be assured with the provision of personal care services;

(7) the clients medical condition is not stable;

(8) the client is not self-directing and has no one to assume those responsibilities;

(9) the services the client needs exceed the personal care aides scope of practice; and

(10) the client resides in a facility or participates in another program or receives other services which are responsible for the provision of needed personal care services.

GIS 01 MA/044 states in pertinent part:

The purpose of this GIS message is to advise social services districts of new personal care services regulations that the Department has adopted to comply with Court rulings in Mayer v. Wing and to remind districts of State requirements affecting client notices and districts' assessments of recipients whom districts determine require 24-hour care.
In accordance with Mayer, the Department adopted regulations effective November 1, 2001, that apply to social services districts' client notices and use of task based assessment plans. A copy of these regulations is attached to this GIS message. These are not new requirements. These regulations generally reflect prior instructions that the Department has issued with respect to the Mayer case (See GIS 96 MA/019 and GIS 97 MA/033).
Among other things, the new regulations provide that the district's "determination to reduce, discontinue or deny a client's prior authorization must be stated in the client notice." The regulations set forth several examples of appropriate reasons and notice language to be used when reducing, discontinuing or denying services.
[18 NYCRR 505.14(b)(5)(v)(c)(1)-(10)].
For example, the new regulations provide that one reason for reducing or discontinuing personal care services is "the client's medical, mental, 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 than they were previously" [18 NYCRR 505.14 (b)(5)(v)(c)(1)]. Consistent with the Court ruling in Mayer, the State requires that client notices citing this reason for reducing or discontinuing services must identify the specific medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction or discontinuation in services. The client notice must explain why the change in the client's circumstances results in the need for fewer hours of services.

DSS-4357EL
WGIUPD GENERAL INFORMATION SYSTEM 12/24/01
DIVISION: Office of Medicaid Management **PAGE 2**
GIS 01 MA/044
Districts are reminded that State policy, as reflected in the new regulations, requires that when districts determine to reduce, discontinue or deny personal care services, the client notice must identify the specific reason (whether a prior mistake in the authorization, the client's refusal to cooperate with the required assessment or other specific reason set forth in the regulations) that justifies the action. The client notice must also explain why the cited circumstance or event necessitates the reduction, discontinuance or denial of services.

* Section 358-5.9.* Fair hearing procedures.

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements 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 or is exempt from work requirements pursuant to Part 385 of this Title. Except, where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of public assistance, medical assistance, SNAP benefits or services, the social services agency must establish that its actions were correct.

DISCUSSION

The record establishes that the Appellant, age 77, was authorized to receive Personal Care Services of 42 hours weekly, 7 hours daily, Monday through Saturday. By Initial Adverse Determination, the MLTCP determined to reduce the Appellant's Personal Care Services from 42 hours weekly, 7 hours daily, Monday through Saturday to 39 hours weekly, 6.5 hours daily, 6 days weekly, stating in pertinent part that the plan is taking this action because the health care service is not medically necessary. The notice further stated:

> "…Based on the comprehensive NYS Department of Health UAS-NY conducted on March 31, 2017 and the Plan Client Tasking Tool you have demonstrated the following in your abilities to perform your Activities of Daily Living and Instrumental Activities of Daily Living Based:
> - Dressing upper body: extensive assistance where 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 task by yourself.
> - Bathing, dressing lower body, locomotion, transfer to toilet, toilet use: maximal assistance. You need physical help to complete most parts of this task, like someone to lean on or help you lift a body part. However, you can complete most parts of this task by yourself.
> - Bed Mobility and Eating: limited Assistance. You need some physical touch and direction throughout the task, but you can complete the task without someone to lean on or help you lift any body parts.…"

The notice further stated that the current UAS-NY assessment and the plan's client tasking tool showed that the Appellant needs six and a half hours a day/ 6 days a week (a total of 39 hours a week) of Level II Personal Care Aide services to complete the above tasks.

At the hearing the Appellant credibly testified that the nurse who completed the UAS form did not stay at her home more than ten minutes and had difficulty conversing in English. The Appellant further testified that she has medical conditions including arthritis in 85% of her body, one torn rotator cuff in her right shoulder, three torn rotator cuffs in her left shoulder, carpal tunnel syndrome in both wrists, COPD, sciatica, and is oxygen dependent 24 hours a day 7 days a week. The Appellant ambulates with a walker indoors and uses a wheelchair wheeled by others outdoors. A review of the UAS establishes that the Plan found that the Appellant is totally dependent for functional needs such as meal preparation, housework, finances and transportation.

The evidence establishes that the Initial Adverse Determination, which is the adverse determination notice upon which this fair hearing has been requested, does not adequately identify an appropriate reason to justify its action to reduce the Appellant's Medical Assistance authorization for Personal Care Services, 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. The MLTCP's Determination is therefore improper.

In accordance with the Mayer decision, the MLTCP is required to provide appropriate grounds to justify a reduction of Appellant's Personal Care Services. However, the MLTCP fails to provide such grounds and failed to submit any credible evidence to establish a basis for the reduction. Thus, the MLTCP has not met its burden of proof consistent with the Mayer decision and subsequent policy provisions. Based on the foregoing, the MLTCP's determination to reduce the Appellant's Personal Care Services was not proper.

For the foregoing reasons, the determination by the MLTCP to reduce the Appellant's Medical Assistance authorization for Personal Care Services from 42 hours weekly, 7 hours daily, Monday through Saturday to 39 hours weekly, 6.5 hours daily, 6 days weekly, cannot be sustained.

DECISION AND ORDER

The MLTCP's May 9, 2017 determination to reduce Appellant's Personal Care Service hours from 42 hours, weekly, 7 hours daily, Monday through Saturday to 39 hours weekly, 6.5 hours daily, 6 days weekly is not correct and is reversed.

1. The MLTCP is directed to withdraw its notice, dated May 9, 2017, with respect to the reduction of the Appellant's Personal Care Services authorization.

2. The MLTCP is directed to restore the Appellant's Personal Care Service authorization to 42 hours weekly, 7 hours daily, Monday through Saturday unchanged.

As required by 18 NYCRR 358-6.4, the MLTCP must comply immediately with the directives set forth above.

DATED: Albany, New York
06/29/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee