STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 31, 2017
[redacted]
AGENCY: Westchester
FH #: 7543786P

In the Matter of the Appeal of

[redacted]

from a determination by the Westchester County 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 14, 2017, in Westchester County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Agency

No appearance by Agency

ISSUE

Did the Agency correctly deny the Appellant's request for an increase in Personal Care Services hours from 8 hours a day, 7 days a week to 12 hours a day, 7 days a week?

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 79, has been in receipt of Medicaid Managed Long Term Care (MLTC) Personal Care Services (PCS) benefits provided by Centers Plan for Healthy Living, LLC ("Agency").

2. The Appellant has had an ischemic stroke, is wheelchair bound and suffers from muscle spasms, asthma, vertigo, diabetes type 2, hypertension and hyperlipidemia. She also has a pacemaker.

3. Prior to May 8, 2017, the Appellant requested an increase in her PCS hours based on her deteriorating health. The Appellant requested an increase in PCS hours to 12 hours a day, 7 days a week.

4. On May 8, 2017, the Agency denied the Appellant's request for an increase in PCS hours

5. On May 9, 2017, the Appellant requested a fair hearing.

6. On May 12, 2017, the Appellant's treating physician completed form DOH-4359 in support of the Appellant's request for more PCS hours.

APPLICABLE LAW

Social Services Law section 365-a (8) provides:

> When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). 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).

Volume 42 of the Code of Federal Regulations, section 438.406, stating rules for Managed Long-Term Care appeals, including fair hearings, states in part that the participant or his representative must have access to his case record during the appeal (including documents and records considered when the Plan made its determination).

Regulations at 18 NYCRR 358-3.3(a)(1) states that, except as provided in subdivision (d) a recipient has a right to a timely and adequate notice when a social services agency:

(i) proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance Authorization or services.

The New York State Department of Health Publication "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care provides," in part:

> Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).
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> Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

Appendix F of the Mainstream Medicaid Managed Care Model Contract includes the following requirement as to giving of notice:

> When the Contractor intends to reduce, suspend, or terminate a previously authorized service within an authorization period, it must provide the Enrollee with a written notice at least ten (10) days prior to the intended Action.

The "MODEL MEMBER HANDBOOK GRIEVANCE AND APPEAL LANGUAGE" section of the Partial Capitation Managed Long-Term Care Model Contract includes the following:

> If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Pursuant to GIS Message 13 MA/015, at a fair hearing to review the district's denial of Medicaid coverage, the Medicaid applicant has the burden of proving that the district's denial

was incorrect. When the applicant prevails, the fair hearing decision will reverse the denial. The district cannot deny the application based on the reason that was set forth in the Agency's denial that was reversed. If no remaining eligibility factors need to be considered, the district must find the applicant eligible for Medicaid.

DISCUSSION

The Agency was duly notified of the time and place of the hearing. However, the Agency failed to appear or present any documentation concerning their denial notice dated May 8, 2017. The Office of Administrative Hearings verified the Agency had not submitted a waiver packet or asked that their personal appearance be waived. Therefore, the Agency failed to meet its obligations under 18 NYCRR 358-4.3(b), and failed to establish that its determination was correct pursuant to 18 NYCRR 358-5.9(a).

The Appellant requested additional hours PCS based on her diminished health. On May 12, 2017, the Appellant's treating physician completed form DOH-4359 in support of the Appellant's request for more PCS hours. The Appellant has had an ischemic stroke, is wheelchair bound and suffers from muscle spasms, asthma, vertigo, diabetes type 2, hypertension and hyperlipidemia. She also has a pacemaker. The Appellant's daughter indicated that the Agency's current PCS hours of 8 hours a day, 7 days a week only accounts for partial assistance in some tasks. The Appellant cannot prepare her meals and transport herself back into bed at night. The Appellant's treating physician noted that the Appellant cannot ambulate by herself, uses a wheelchair and needs to be accompanied at all times to her medical appointments. Based on the lack of Agency testimony and evidence and the Appellant's presented needs, the Agency's current allocation of 8 hours a day, 7 days a week is insufficient.

The Agency should re-assess the Appellant as soon as possible, take into consideration the Appellant's medical documentation and re-evaluate the Appellant's request for an increase in PCS to 12 hours a day, 7 days a week. The Agency will need to send a new notice to the Appellant reflecting their new evaluation.

During the new assessment, the Appellant's daughter must be present and the Appellant's primary language, Spanish, must be accommodated.

DECISION AND ORDER

The Agency's determination to deny the Appellant's request for an increase in Personal Care Services hours from 8 hours a day, 7 days a week to 12 hours a day, 7 days a week is not correct and is reversed.

1. The Agency is directed to cancel its May 8, 2017 Denial Notice.

The Agency is reminded of its obligations pursuant to GIS 13 MA 015.

FH# 7543786P

DATED: Albany, New York
08/21/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's
Designee