STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 5, 2015
[redacted]
AGENCY: MAP
FH #: 6952578N

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 March 30, 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)

G. Sirota, Fair Hearing Representative
L. Ruvinova, Fair Hearing Representative
N. Arzi, Fair Hearing Representative

ISSUE

Was the Appellant's Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 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, age 67, has been in receipt of Medical Assistance benefits, is enrolled in a 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 16 hours daily, 7 days weekly.

2. On December 22, 2014, a nursing assessor completed a Uniform Assessment System evaluation of the Appellant's personal care needs.

3. On December 22, 2014, a nursing assessor completed a client task sheet as to the Appellant's personal care needs.

4. By notice dated January 23, 2015, the Managed Long Term Care Plan determined to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 days weekly.

5. On January 23, 2015, the Appellant requested an internal appeal.

6. On February 5, 2015, this fair hearing was requested.

7. By notice dated February 27, 2015, the Managed Long Term Care Plan determined to uphold its determination to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 days weekly.

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.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

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

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III. 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.

DISCUSSION

The evidence establishes that the Appellant has been in receipt of Medical Assistance benefits, is enrolled in a 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 16 hours daily, 7 days weekly. The evidence further establishes that by notice dated January 23, 2015, the Managed Long Term Care Plan determined to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 days weekly.

The Managed Long Term Care Plan's notice of reduction dated January 23, 2015, 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, etc. The Managed Long Term Care Plan's notice dated January 23, 2015, provided as follows:

> "Based on the most recent face to face clinical assessment performed by Centers Plan for Healthy Living Nurse, it was determined that your clinical and or functional needs

> no longer require a level of service that you were previously receiving, thus your Personal Care Attendant services will be reduced from 112 hours/week to 56 hours/week beginning on 2/4/2015."

The credible evidence establishes that the Managed Long Term Care Plan's notice dated January 23, 2015, does not adequately identify an appropriate 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. The Managed Long Term Care Plan's notice dated January 23, 2015, was not proper.

The evidence establishes that on January 23, 2015, the Appellant requested an internal appeal. By notice dated February 27, 2015, the Managed Long Term Care Plan determined to uphold its determination to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 days weekly.

The Managed Long Term Care Plan's notice of reduction dated February 27, 2015, 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, etc. The Managed Long Term Care Plan's notice dated February 27, 2015, provided as follows:

> "… the most recent New York State Uniform Assessment performed on December 22, 2014, reflects you are independent in bed mobility and require setup for meals. Limited assistance is required for bathing, grooming, and toileting, consisting of guided manipulation of limbs without taking weight, which you require when pain is severe. You are cognitively intact and continent of bowel and bladder.
>
> The assessment did not identify any reasons why your needs could not safely be met by a reduction of PCA services to 56 hours a week, the request to continue PCA services at 112 hours a week is, therefore, not considered medically necessary at this time and must be denied.
>
> Therefore, effective February 8, 2015, PCA services will be provided 56 hours a week."

The credible evidence establishes that the Managed Long Term Care Plan's notice dated February 27, 2015, does not adequately identify an appropriate 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. The Managed Long Term Care Plan's notice dated February 27, 2015, was not proper.

For the foregoing reasons, the Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 days weekly cannot be sustained.

DECISION AND ORDER

The Appellant's Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services authorization from 16 hours daily, 7 days weekly to 8 hours daily, 7 days weekly is not correct and is reversed.

1. The Managed Long Term Care Plan is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 16 hours daily, 7 days weekly.

Should the Managed Long Term Care 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 Managed Long Term Care Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
04/10/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee