

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 24, 2017

AGENCY: MAP

FH #: 7575907Q

In the Matter of the Appeal of
[REDACTED]
from a determination by the New York City
Department of Social Services

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:
:
:

**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 15, 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 ("the MLTC Plan")

Jillian Hinkson, Grievance and Appeals Manager

ISSUE

Was the MLTC Plan's determination to reduce Appellant's Personal Care Services authorization from 49 hours weekly, authorized under a task-based plan of care, to 36 hours weekly, authorized under a task-based plan of care, 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. Appellant, aged 80, resides in New York City, and is in receipt of Medicare Parts A, B, and D; Appellant is also authorized to receive Medicaid. Appellant had been enrolled with a different MLTC Plan called Centerlight, which had authorized Appellant to receive Personal

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Care Services in the amount of 49 hours weekly, authorized under a task-based plan of care, provided 7 days weekly.

2. Effective February 1, 2017, Appellant transferred to his current MLTC Plan, Centers Plan for Healthy Living, which continued his existing Personal Care Services authorization in effect for a minimum of ninety days, in compliance with State policy.

3. On May 8, 2017, a nurse obtained a UAS-NY combined nursing and social assessment on behalf of Appellant's new MLTC Plan.

4. On June 5, 2017, the MLTC Plan issued an Initial Adverse Determination Notice stating the MLTC Plan's determination to reduce Appellant's Personal Care Services to the amount of 36 hours weekly, authorized over just 6 days weekly, "because the health care service is not medically necessary."

5. By Action Taken Notice also dated June 5, 2017, the MLTC Plan again advised Appellant of its determination to reduce the Appellant's Personal Care Services hours. This particular notice included a citation of law.

6. The Agency's June 5, 2017 Action Taken Notice did not make use of one of the reasons specified in State policy, such as a change in medical or social circumstances. Rather, the Action Taken Notice summarized the amount of assistance Appellant required with a variety of activities of daily living.

7. On July 24, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive 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. A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

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:

- o for reductions, the previous and new amounts of assistance or benefits provided;
- o the effective date of the action;
- o the specific reasons for the action;

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18 NYCRR 358-2.2

Volume 42 of the Code of Federal Regulations, section 438.404, states, regarding Notices to be issued by Managed Long-Term Care Plan:

Notice of action.

(a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of § [438.10\(c\)](#) and [\(d\)](#) to ensure ease of understanding.

(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.
- (3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
- (4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
- (5) The procedures for exercising the rights specified in this paragraph.
- (6) The circumstances under which expedited resolution is available and how to request it.
- (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.**

(c) *Timing of notice.* **The MCO or PIHP must mail the notice within the following timeframes:**

- (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§ [431.211](#), [431.213](#), and [431.214](#) of this chapter.
- (2) For denial of payment, at the time of any action affecting the claim.
- (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in § [438.210\(d\)\(1\)](#).
- (4) If the MCO or PIHP extends the timeframe in accordance with § [438.210\(d\)\(1\)](#), it must—
 - (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
 - (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

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

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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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--

(i) The enrollee and his or her representative;

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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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.
2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.
3. The Contractor agrees to allow each Enrollee the Choice of Participating Provider of covered service to the extent possible and appropriate.
4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum

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function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal. Note: 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.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

The model contract for partially capitated MLTC plans advises that Social and environmental supports are services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Pursuant to Appendix G, Social and environmental supports may

be provided through care management. Care management is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

Pursuant to the New York State Department of Health Office of Health Insurance Programs MLTC Policy 15.03, for all MLTC partial capitation plan decisions made on or after July 1, 2015 that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately without first requesting an internal appeal of the determination.

Person Centered Service Plan (or plan of care) is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the Enrollee, as well as the person's functional level and support systems. Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person centered service plan or elsewhere in the care management record.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. 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:

- (2) Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.
- (4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and

positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

- (5) 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.

(a) Nutritional and environmental support functions include assistance with the following:

- (1) making and changing beds;
- (2) dusting and vacuuming the rooms which the patient uses;
- (3) light cleaning of the kitchen, bedroom and bathroom;
- (4) dishwashing;
- (5) listing needed supplies;
- (6) shopping for the patient if no other arrangements are possible;
- (7) patient's laundering, including necessary ironing and mending;
- (8) payment of bills and other essential errands; and
- (9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include 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;

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- (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) turning and positioning;
- (8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
- (9) feeding;
- (10) 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;
- (11) providing routine skin care;
- (12) using medical supplies and equipment such as walkers and wheelchairs; and
- (13) changing of simple dressings.

18 NYCRR 505.14(b)(5)(v)(c) requires written notification of any determination to deny, reduce, or discontinue personal care services. Subpart (2) of this provision identifies the following appropriate reasons and notice language to be used when reducing or discontinuing personal care services:

- (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.

As explained by the Office of Health Insurance Programs, Division of Long-Term Care in MLTC Policy 16.06, a managed long-term care plan may not reduce or discontinue an enrollee's Personal Care Services unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi) excerpted immediately above.

NYS DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

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

II. Accessing the benefit

- a. Request for Service: A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request...
- b. Nursing and Social Assessment:
 - i. Initial assessment
Once the request is received the MCO is responsible for arranging an assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.
 - ii. Social Assessment
In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment

performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated, whether the member's home has adequate sleeping accommodations for a personal care aide.

This nursing assessment and the social assessment can be completed at the same time. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139...

- c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period the MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.
- d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN and the personal care services worker to develop the plan of care based on the MCO's authorization.

III. Authorization and Notice Requirements for Personal Care Services

- e. Standards for review. Requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate 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; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or

termination of previously approved services.

- f. Timing of authorization review.
 - i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
 - ii. A “first time” assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).
- g. 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).
- h. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):
 - i. that were previously authorized, if any;
 - ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
 - iii. that are authorized for the new authorization period; and
 - iv. the original authorization period and the new authorization period, as applicable.
- i. 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.
 - i. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).
 - ii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for

aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.

- 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.

The Partial Capitation Managed Long-Term Care Model Contract states, in part:

If an Enrollee is transferring from the Contractor's MLTCP to another MLTCP or Medicaid Managed Care plan, the Contractor must provide the receiving plan with the individual's current person centered service plan in order to ensure a smooth transition.

The New York State Department of Health's MLTC Policy Document 13-13 speaks of a 90 day continuity period for recipients newly transferred into an MLTCP.

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

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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).

DISCUSSION

At the hearing, the MLTC Plan placed into evidence its Initial Adverse Determination Notice and its Action Taken Notice, each of which is dated June 5, 2017. The Initial Adverse Determination Notice mentions that the Personal Care Services (“PCS”) hours already in effect are “not medically necessary,” and lists some of Appellant’s purported abilities with tasks. The Action Taken Notice does not provide one succinct reason of any kind, but includes a lengthy summary of Appellant’s purported abilities regarding activities of daily living. Neither Notice is adequate under explicit State policy set forth in year 2011, and made even more explicit on November 17, 2016 with the release of the New York State Department of Health’s MLTC policy guide number 16.06.

The just named “Policy 16.06” document begins by stating:

“The purpose of this directive is to provide further guidance to MLTC plans concerning appropriate reasons and notice language to be used when proposing to reduce or discontinue PCS or CDPAS. In particular, it addresses notices that propose to reduce or discontinue PCS or CDPAS for either of the following reasons: a change in the enrollee’s medical or mental condition or social circumstances; or a mistake that occurred in the previous authorization or reauthorization.

A MLTC plan may not reduce or discontinue an enrollee’s PCS or CDPAS unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi), for PCS, and 18 NYCRR §§ 505.28(h)(5)(ii)(a) through (f), for CDPAS. Two such examples are discussed in greater detail below. The MLTC plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering the facts of the individual enrollee’s circumstances and thus cannot reduce services as part of an “across-the-board” action that does not consider each individual enrollee’s particular circumstances and need for assistance.

The general purpose of these requirements is to assure that the plan’s notice accurately advises the enrollee, in plain comprehensible language, *what* the plan is proposing to change with regard to the enrollee’s PCS or CDPAS and *why* the plan is proposing to make that change. The more specificity the plan’s notice provides with regard to the specific change in the enrollee’s services, the reason for the change, and why the prior services are no longer needed, the better able the plan will be to defend its proposed reduction or discontinuance at any fair hearing, at which the plan bears the burden of proof to support its proposed action (i.e. the plan must establish that its proposed reduction or discontinuance is correct).”

The just-cited policy memorandum goes into particular detail with regard to two mandated reasons: (A) change in enrollee's medical or mental condition or social circumstances, and (B) a mistake made in the prior assessment. Yet, the full array of reasons found at 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi) (incorporated by reference in the MLTC Policy 16.06 quoted above) are as follows:

- (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.

Previously, a year 2011 New York State Department of Health release entitled "Guidelines for the Provision of Personal Care Services in Medicaid Managed Care", which Guidelines remain in effect, directed Plans (meant to apply both to Mainstream Medicaid Managed Care and to Managed Long-Term Care) to select one of the following reasons:

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

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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.

The MLTC Plan flatly ignored all of the above-mentioned guidelines in drafting its Notices sent to Appellant, advising Appellant of the reductions. As adequate written Notice goes to the heart of due process, the MLTC determination here at issue is not sustained.

It may be noted that, while it is true that the hours previously in place reflected hours authorized by a prior MLTC Plan, and were given, in part, as an extension of at least 90 days for purposes of continuity of care. (See Action Taken Notice, page 2). However, State policy does not give carte blanche for reducing PCS hours once said 90 days have passed. Rather, the above-described law and policy concerning acceptable reasons for reductions, and drafting of adequate Notices, must still be followed.

DECISION AND ORDER

The MLTC Plan's determination to reduce Appellant's Personal Care Services authorization from 49 hours weekly, authorized under a task-based plan of care, to 36 hours weekly, authorized under a task-based plan of care is not correct and is reversed.

1. The MLTC Plan is directed to cancel its Notices dated June 5, 2017, and to restore Appellant's Personal Care Services authorization to the amount of 49 hours weekly, under a task-based plan of care, authorized over 7 days weekly.

2. The MLTC Plan is directed to continue to authorize Appellant to receive Personal Care Services in the amount of 49 hours weekly, under a task-based plan of care, authorized over 7 days weekly.

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

DATED: Albany, New York
09/13/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "DA Traum". The signature is written in a cursive, flowing style with a horizontal line extending from the top of the "A".

Commissioner's Designee