STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 2, 2017
[redacted]
AGENCY: MAP
FH #: 7545308Z

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 27, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Alisha Jacobs, Centers Plan for Healthy Living, Fair Hearing Representative

ISSUE

Was the Managed Long Term Care Plan's determination dated May 19, 2017 to reduce the Appellant's Personal Care Services authorization from 168 hours (24 hours per day, 7 days a week) to 56 hours (8 hours a day, 7 days a 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 91, had been in receipt of Medicaid benefits provided through a Managed Long Term Care Plan, CenterLight, Health System and was in receipt of Personal Care Services for 168 hours (24 hours per day, 7 days a week.)

2. The Appellants Managed Long Term Care provider was changed from CenterLight to Centers Plan for Healthy Living.

3. By Initial Adverse Determination notice dated May 19, 2017, Centers Plan for Healthy Living determined to reduce the Appellant's Personal Care Services authorization from 168 hours (24 hours per day, 7 days a week) to 56 hours (8 hours a day, 7 days a week.

4. By Amended Initial Adverse Determination notice dated June 15, 2017, Centers Plan for Healthy Living determined to reduce the Appellant's Personal Care Services authorization from 168 hours (24 hours per day, 7 days a week) to 56 hours (8 hours a day, 7 days a week).

5. On June 2, 2017 this fair hearing was requested.

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.

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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> III. e. Terminations and Reductions…
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> 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.

18 NYCRR 505.14(b)(5)(v)(c)(2) provides, in part, that:

(c) The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice.

(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…

By Dear Health Plan Administrator letter dated March 2, 2015, the Department advised of the implementation of model notices as of May 15, 2015, for use by MLTC Partial Cap and Medicaid Advantage Plus (MAP) plans, as follows:

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Managed Long Term Care Action Taken – Denial, Reduction or Termination of Benefits…

This model notice is designed to ensure enrollees are made aware of their due process rights and must be included with the Model MLTC Initial Adverse Determination Notice and all other Action notices, including those for restrictions to benefits. Considerable input from the advocate community was solicited to help clarify the language, e.g. regarding aid continuing rights for services that are stopped, reduced, or restricted. Plans must develop mechanisms to ensure the form is appropriately completed for the Action being taken.

Below is a list of certain new and noteworthy aspects of this model notice:

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- "detailed explanation of change in medical condition or social circumstances" This information MUST be included in the reason for denial if the Action determines to reduce or stop CBLTCS the enrollee has been receiving.

DISCUSSION

The evidence establishes that the Appellant has been in receipt of Medicaid benefits provided through a Managed Long Term Care Plan, Centers Plan for Healthy Living. The evidence also establishes that by Initial Adverse Determination notice dated May 19, 2017, the Managed Long Term Care Plan determined to reduce the Appellant's Personal Care Services authorization from 168 hours (24 hours per day, 7 days a week) to 56 hours (8 hours a day, 7 days a week.)

On June 15, 2017, Centers Plan for Healthy Living issued an amended Notice to reduce the Appellants personal care services. The Appellant seeks review of the Agency determination.

The Managed Long Term Care Plan's notices of reduction dated May 19, 2017 and June 15, 2017 were carefully reviewed as to the specific stated reason to justify its action to reduce the Appellant's Personal Care Services authorization.

Pursuant to the Regulations, the Notice must contain a detailed explanation of the change in the Appellants medical condition, mental condition, economic condition or social circumstances. The district must also determine that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours.

The Managed Long Term Care Plan's notice dated May 19, 2017 provided, in part, as follows: "The plan is taking this action because the health care service is not medically necessary. The UAS-NY comprehensive assessment completed 4/19/17 and the plans' client tasking tool showed that you need 8 hours a day/seven days a week of Level II Personal Care services. Dr. [redacted] on 5/2/2017 spoke with Office manager to confirm that you had no clinical changes and your status remains stable." "Based upon the results of the recent UASNY performed on April 19, 2017 your needs can be successfully met with Personal Care Aide service 56 hours a day/seven days a week…which is enough time to complete the above tasks and adequately meet your needs."

The Managed Long Term Care Plan's notice dated June 15, 2017 provided, in part, as follows: "The plan is taking this action based on the NYS Department of Health Uniformed Assessment System (UAS-NY) assessment and tasking tool." The Notice essentially restates the same information as was contained in the April 19, 2017 notice.

The credible evidence establishes that the Managed Long Term Care Plan's notices dated April 19, 2017 and June 15, 2017 do not adequately identify an appropriate reason to justify its action to reduce the Appellant's Personal Care Services authorization. The Managed Long Term Care Plan's stated reason that "the health care service is not medically necessary," and "the plan is taking this action based on the NYS Department of Health Uniformed Assessment System (UAS-NY) assessment and tasking tool," is not proper.

Notices citing this reason for reducing services must identify the specific (emphasis added) medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction in services. The Managed Long Term Care Plan has failed to identify the specific medical, mental, social or economic change in the client's circumstances, in its notices, that justified the proposed reduction in services.

The Notices fail to establish that there was "any" change in the Appellants medical, mental, social or economic condition from the prior authorization of 168 hours.

For the foregoing reasons, the Managed Long Term Care Plan's determination dated May 19, 2017 and June 15, 2017 to reduce the Appellant's Personal Care Services authorization from 168 hours to 56 hours per week cannot be sustained.

DECISION AND ORDER

The Managed Long Term Care Plan's determination dated May 19, 2017 and June 15, 2017 to reduce the Appellant's Personal Care Services authorization is not correct and is reversed.

1. The Managed Long Term Care Plan, Centers Plan for Healthy Living is directed to restore the Appellant's Personal Care Services authorization to the amount of 168 hours (24 hour/ 7 days a week, live in.).

As required by Section 358-6.4 of the Regulations, the Managed Long Term Care Plan must comply immediately with the directives set forth above.

DATED: Albany, New York
07/03/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By H. Cooper Gregory

Commissioner's Designee