STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 8, 2019
[redacted]
AGENCY: MAP
FH #: 7958281Z

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 11, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the MLTC Plan (Centers Plan for Healthy Living)

Debora Ferguson, Centers Plan for Healthy Living, Fair Hearing Representative

ISSUE

Was the Managed Long Term Care Plan's determination to reduce the Appellant's Consumer Directed Personal Assistance Program (CDPAP) 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 86, has been in receipt of Medicaid benefits provided through a Managed Long Term Care Plan, Centers Plan for Healthy Living (the Plan).

2. The Appellant currently has a CDPAP authorization in the amount of 6 hours per day/7 days per week (42 hours total).

2. By Initial Adverse Determination dated March 26, 2019, the Plan determined to reduce the Appellant's CDPAP from 6 hours per day/7 days per week (42 hours total) to 3.5 hours per day/7 days per week (24.5 hours total) because the health care service "is not medically necessary."

3. On March 25, 2019, the Appellant asked for a Plan appeal.

4. By Final Adverse Determination dated April 25, 2019, the Plan stated that it had affirmed its previous determination to reduce the Appellant's CDPAP from 6 hours per day/7 days per week (42 hours total) to 3.5 hours per day/7 days per week (24.5 hours total) because the health care service "is not medically necessary."

5. On May 8, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

In general, a recipient of Medical Assistance or 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. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Medical Assistance or Services; or has determined to change the amount of one of the items used in the calculation of a Medical Assistance spenddown. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Medical Assistance in another district.

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:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

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...

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, 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. 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. 18 NYCRR 358-5.9(a).

DISCUSSION

The evidence establishes that the Appellant, age 86, has been in receipt of Medicaid benefits provided through a Managed Long Term Care Plan, Centers Plan for Healthy Living (the Plan). The Appellant currently has a CDPAP authorization in the amount of 6 hours per day/7 days per week (42 hours total). By Initial Adverse Determination dated March 26, 2019, the Plan determined to reduce the Appellant's CDPAP from 6 hours per day/7 days per week (42 hours total) to 3.5 hours per day/7 days per week (24.5 hours total) because the health care service "is not medically necessary." On March 25, 2019, the Appellant asked for a Plan appeal. By Final Adverse Determination dated April 25, 2019, the Plan stated that it had affirmed its previous determination to reduce the Appellant's CDPAP from 6 hours per day/7 days per week (42 hours total) to 3.5 hours per day/7 days per week (24.5 hours total) because the health care service "is not medically necessary."

The Final Adverse Determination stated that the Plan nurse evaluated the Appellant on March 22, 2019 and contended that the Appellant had improved compared to the previous assessment on September 6, 2018. The notice broadly stated that most of the Appellant's abilities to perform physical functioning improved, noting dressing upper and lower body, personal hygiene, bed mobility, walking, bathing, toilet transfer and use, eating, meal preparation, medication management and ordinary housework.

At the hearing, the Appellant's representative, her son, explained that his mother's mobility "is gone," "her age is working against her," "she needs help with everything," and "she is getting worse, not better." The Appellant cannot take her medications on her own, and cannot even open a bottle, he stated. Further, her son testified that the Appellant does not comprehend anything, and she will "just answer 'yes, yes' to everything you ask her, no matter what you ask her." Her son also explained that the Appellant has gotten noticeably worse over the past year, both physically and mentally deteriorating. "Her memory is gone, and she asks the same question after just being answered," he stated.

In support of his position, the Appellant's son submitted documentation from a doctor dated April 9, 2019. It stated that the Appellant has senile dementia, high blood pressure, osteoarthritis, hypothyroidism, cannot leave the house by herself, and should avoid using the stove. It further stated that due to her medical condition, the doctor recommended services to assist the Appellant with skilled tasks, personal care and light housekeeping.

At the hearing, it was observed that the Appellant walked extremely slowly with a walker into the hearing room, had a vacant look on her face throughout the hearing, and did not participate at all on her behalf.

At the hearing, the Plan representative reiterated that the reduction in hours was due to the Appellant having "improved," without, however, specifying the reason for that conclusion. The Plan's appears to solely rely on its own March 22, 2019 inexplicably improved assessment which noticeably conflicts with the Appellant's representative's testimony, medical documentation and with direct observation of the Appellant at the hearing. For example, the March 22, 2019 assessment states that the Appellant's memory is ok and she has no dementia, contrary to her doctor's documentation. The March 22, 2019 assessment does state however that the Appellant suffers from and is receiving treatment for numerous conditions, including: [redacted].

The Final Adverse Determination and evidence provided by both sides was carefully reviewed. At the hearing, when directly asked why the Appellant has improved, the Plan failed to offer an answer. Furthermore, the written determination was not adequate. The evidence establishes that the notice does not adequately identify an appropriate reason to justify its reduction of the Appellant's PCS, such as a credible, verifiable change in the Appellant's medical, mental, or social circumstances, or that a mistake occurred in the previous PCS authorization. There was no evidence that the Appellant's former need was only due to a temporary condition or accident and that now that she has healed or no longer has the condition that necessitated her hours. At the Appellant's age, 86, and with her conditions, it is hard to fathom how the Appellant has improved and now requires so much less CDPAP than she was receiving, going from 42 total hours to 24.5 total hours weekly.

The conclusory statements in the Final Adverse Determination do not constitute a legally sufficient reason or basis for the reduction of the Appellant's PCS authorization. The notice did not clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition.

As stated in the law above, "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. 18 NYCRR 358-5.9(a)." The Plan has not established that its actions were correct in reducing the Appellant's CDPAP hours and therefore it has not met its burden concerning the reduction of Medical Assistance benefits.

For the foregoing reasons, the determination by the Plan to reduce the Appellant's CDPAP cannot be sustained.

DECISION AND ORDER

The Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services is not correct and is reversed.

1. The Managed Long Term Care Plan is directed to restore the Appellant's CDPAP to the amount of 6 hours per day/7 days per week (42 hours total) and to notify Appellant in writing upon compliance with this decision after fair hearing.

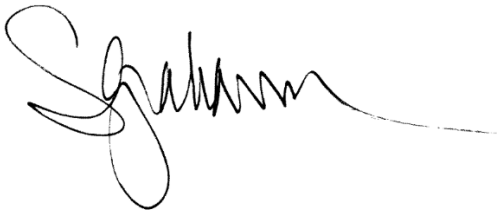
Should the Managed Long Term Care Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to the Managed Long Term Care Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
06/19/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee