STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 23, 2018
[redacted]
AGENCY: MAP
FH #: 7728886H

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 July 12, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan for Healthy Living (CHL) Managed Long Term Care Plan

Julia Rolffot, Manager for Appeals and Grievances, on May 1, 2018
Appearance by Evidence Packet Only, June 7, 2018

ISSUE

Was the Appellant's Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services authorization from 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week to 8.5 hours per day, 7 days per week, for a total of 59.5 hours per week correct?

FACT FINDING

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 94, is in receipt of Medicaid including Personal Care Services (PCS) provided by Centers Plan for Healthy Living (CHL) the Managed Long Term Care Plan.

2. By Notice of Intent dated March 21, 2018, CHL advised the Appellant of its determination to reduce the Appellant's PCS from 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week to 8.5 hours per day, 7 days per week, for a total of 59.5 hours per week effective April 1, 2018 because "The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool."

3. On March 23, 2018, this fair hearing was requested.

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

d. 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…

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...

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.

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;

(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.

Subsection (b) of 18 NYCRR section 505.14 provides, in part:

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

DISCUSSION

The credible evidence establishes that the Appellant is enrolled in a Medicaid 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 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week. The credible evidence also establishes that by notice dated March 21, 2018, the Managed Long Term Care Plan advised the Appellant of its determination to reduce the Appellant's Personal Care Services authorization because "The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool." The notice further states the MLTC will provide 8.5 hours per day, 7 days per week, for a total of 59.5 hours per week Personal Care Services effective April 1, 2018.

The Managed Long Term Care Plan notice dated March 21, 2018, 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 March 21, 2018, advised the Appellant of its determination to reduce the Appellant's Personal Care Services authorization "based on the UAS-NY comprehensive assessment conducted on 2/12/2018, your Personal Care Aide (PCA) services will be decreased…."

The credible evidence establishes that the Managed Long Term Care Plan's notice dated March 21, 2018, 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 March 21, 2018, 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 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week cannot be sustained.

It is noted that on June 7, 2018, the Appellant's Son advised that Appellant has been hospitalized since May 31, 2018, as the result of a fall.

DECISION AND ORDER

The Appellant's Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services authorization from 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week to 8.5 hours per day, 7 days per week, for a total of 59.5 hours per week is not correct and is reversed.

1. The Managed Long Term Care Plan is directed to restore Appellant's Personal Care Services authorization to the amount of 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week, for a total of 124 hours per week.

2. The Managed Long-Term Care Plan is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 20 hours per day, 5 days per week and 12 hours per day, 2 days per week, for a total of 124 hours per week.

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 Appellant's Representative 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 Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
07/27/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee