STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 2, 2015
[redacted]
AGENCY: MAP
FH #: 7069122M

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 August 5, 2015, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan
Jilian Hinkson, Centers Plan for Healthy Living, Fair Hearing Representative

ISSUE

Was the determination of Centers Plan for Healthy Living to reduce Appellant's personal care services from 25 hours per week to 20 hours per 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. Appellant, 61 years of age, had been in receipt of personal care services from Centers Plan for Healthy Living, in the amount of 25 hours per week (5 hours per day, Monday through Friday) from, approximately, May 1, 2015, until June 5, 2015.

2. Effective June 5, 2015, Centers Plan for Healthy Living reduced appellant's personal care services from the aforesaid 25 hours per week to 20 hours per week (5 hours per day, Monday through Thursday), without written notice to the Appellant .

3. On July 2, 2015, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.3(a) provide that a recipient of Public Assistance, Medical Assistance or services has a right to notice when the agency:

(i) proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance authorization or services.

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...

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.

DISCUSSION

It is undisputed that the Appellant, age 61 and disabled, has been in receipt of Personal Care Services via the Managed Long Term Care plan, Centers Plan for Healthy Living, since approximately April 1, 2015. The record indicates that the Appellant was initially in receipt of 15 hours of personal care services a week, and that the amount of her personal care services were increased to 25 hours per week (five hours per day, Monday through Friday) effective on or about May 1, 2015. The record also shows that from on or about June 5, 2015, Centers Plan for Healthy Living reduced appellant's personal care services from the aforesaid 25 hours per week to 20 hours per week (5 hours per day, Monday through Thursday). The reason set forth by the plan regarding the reduction of personal care service hours to 20 per week was that the former amount of 25 weekly hours was "due to [a] misunderstanding".

At the hearing no written notice of reduction was presented by Centers Plan for Healthy Living. The record also shows that no written notice was received by the Appellant with regard to the aforesaid reduction of personal care services from 25 hours to 20 hours on or about June 5, 2015. Although the hearing the representative for Centers Plan for Healthy Living contended that the initial provision of 25 hours of personal care services to the appellant was due to a "misunderstanding", and that the reduction of such hours from 25 to 20 weekly hours was pursuant to the actual authorization of only 20 hours (the verification of which is not at issue for this hearing), such argument does not nullify the requirement that the plan provide a timely written notice to the appellant prior to such reduction, pursuant to applicable Departmental Regulations as cited above. Having provided 25 hours of personal care services purportedly by mistake, the only proper means of reducing personal care service hours down to the level which the plan feels is appropriate is via written notice. Notably, a written notice of reduction must identify the reason for the reduction and must also comport to notice guidelines as set forth above. The absence of such required notice renders the action of Centers Plan for Healthy

Living improper. Accordingly, the determination of Centers Plan for Healthy Living to reduce appellant's personal care services from 25 hours to 20 hours cannot be sustained.

DECISION AND ORDER

The determination of Centers Plan for Healthy Living to reduce Appellant's personal care services from 25 hours per week to 20 hours per week is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to restore the Appellant's personal care services to 25 hours per week and to continue to provide personal care services to the appellant in the amount of 25 hours per week (5 hours per day, Monday through Friday).

Should the Agency 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 requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

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

DATED: Albany, New York
08/13/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee