
In the Matter of the Appeal of
██████████
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 November 24, 2015, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

██

For the Managed Long Term Care Plan (“Aetna Better Health of NY”)

Plan’s personal appearance waived by the Office of Administrative Hearings, appearance on waiver packet only.

ISSUE

Was the October 13, 2015 determination of the Appellant's Managed Long Term Care Plan, Aetna Better Health, to reduce the Appellant’s Personal Care Services authorization from 120 hours per week (12 hours per day x 4 days per week plus 24 hours per day “sleep-in” x 3 days per week) to 104 hours per week (8 hours per day x 4 days per week plus 24 hours per day “sleep-in” x 3 days 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. The Appellant, ██████████, is in receipt of a Medical Assistance authorization and has been enrolled in a Managed Long Term Care plan with Aetna Better Health.

2. The Appellant is diabetic and is in dialysis three days per week.

3. The Appellant has been in receipt of Personal Care Services in the amount 120 hours weekly (12 hours per day x 4 days per week plus 24 hours per day, “sleep-in”, 3 days per week). The three days per week whereby the Appellant receives 24 hour per day care are the days she is in receiving dialysis treatment.

4. On September 20, 2015, a nursing assessor completed a Uniform Assessment System-New York Assessment (Comprehensive) Report of the Appellant’s personal care needs.

5. By notice dated October 13, 2015 and entitled “NOTICE OF ACTION”, the Agency advised the Appellant that it had denied an October 13, 2015 request that Aetna Better Health pay for attendant care services for 120 hours per week (12 hours per day 4 days per week, 24 hours per day 3 days per week) and to provide instead personal care services in the amount of 104 hours per week (8 hours per day x 4 days per week plus 24 hours per day “sleep-in” x 3 days per week) effective October 27, 2015.

6. On October 26, 2015, the Appellant requested this fair hearing to contest the Managed Long Term Care plan’s determination.

APPLICABLE LAW

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 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).

Regulations at 18 NYCRR 358-3.3(a)(1) states that, except as provided in subdivision (d) a recipient has a right to a timely and adequate notice when a social services agency:

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

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:

- the specific laws and/or regulations upon which the action is based;

Section 358-5.9.* Fair hearing procedures.

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements 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 or is exempt from work requirements pursuant to Part 385 of this Title. 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.

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.
 - (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:

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- (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--

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- (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)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support functions. 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:

- (6) 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 shall include some or total assistance with the following:

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- (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.

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

- (a) Personal care functions shall include some or total 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) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
 - (8) feeding;
 - (9) 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;

- (10) providing routine skin care;
- (11) using medical supplies and equipment such as walkers and wheelchairs; and
- (12) changing of simple dressings.

DISCUSSION

The Appellant and her representatives at the fair hearing testified that she needed daily 24 hour assistance with, among other things, eating, toileting, and bathing.

The hearing record establishes that Aetna Better Health issued a Notice of Action advising of the plan's determination to reduce Appellant's Personal Care Services from 120 hours per week (12 hours per day x 4 days per week plus 24 hours per day, "sleep-in", x 3 days per week) to 104 hours per week (8 hours per day x 4 days per week plus 24 hours per day, "sleep-in" x 3 days per week).

A review of the written "reasons for our decision" as contained in the notice states as follows:

"Facts About Your Condition or Situation That Support Our Decision"

You have been getting aide services 12 hours 4 days and 24 hours 3 days a week. We compared the assessment you had on 3/15/15 with the assessment you just had on 9/20/15. The new assessment shows that you do not need as many hours of aide services as you have been receiving. The nurse used two things to understand your needs. One is required by the State of New York and is called a Universal Assessment System-NY. The other is called the Home and Community-based service needs tool. The HCBS helps us list all of the things and aide needs to do for you every day, It also tells us how much time it takes to do each task, These are things like helping you to bathe, dress, get meals, shop and get to your medical appointments. The things we noted:

*You have gotten better since the time you left the hospital.
You only need limited help when you walk around.
You do not need a lot of help with meal set-up or eating.
Although duly notified of the time and place of the hearing.*

You do not need total assistance with toileting or bathing.

You needed a total of 3780 minutes before, now you only need 2975 minutes. The extra time was removed. When we add up the time that you need help from an aide it comes to 8 hours on the

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days that you do not go to dialysis. We are recommending an aide for 8 hours a day 4 days, and a live-in on the days you go to dialysis. Your case manager explained this to you when she spoke to you on 10/6/2015. The new schedule, 8 hours 4 days and 24 hours 3 days a week of aide services, will start in 10 days. We will keep watching your condition. If something changes [then] more hours of home care may be approved. If you have any questions, please contact your nurse care manager.”

The aforesaid notice, while providing some information regarding what amount of hours the plan believes that the Appellant needs for weekly personal care services, does not provide an actual reason for the reduction, such as lack of medical necessity of any of the tasks for which task minutes had previously been provided. Nor does the aforesaid recitation of the Appellant’s deemed personal care service task needs constitute indicate a mistake made.

The basis for the reduction of personal care services as contained in the Aetna Better Health is therefore deficient and inadequately provides a “reason” which the Appellant may readily understand and does not provide a grounds upon which the Appellant may make an informed request for a fair hearing. It is noted that the regulations at 18 NYCRR 358-3.3(a)(1) requires that an adequate notice must contain the **specific laws and/or regulations upon which the action is based** (emphasis added). Aetna Better Health’s notice contains no law or regulations upon which its determination is based. It is also noted that Aetna Better Health’s notice is worded as a denial of a request, not a reduction in services, even though the Appellant’s services were being reduced, and that Aetna Better Health’s notice fails to adequately detail the reasons for its determination.

Based upon the aforesaid October 13, 2015, notice, the determination of the plan to reduce the Appellant’s personal care services cannot be sustained.

DECISION AND ORDER

The October 13, 2015 determination by Aetna Better Health to reduce the Appellant’s Personal Care Services from 120 hours per week (12 hours per day x 4 days per week plus 24 hours per day “sleep-in” x 3 days per week) to 104 hours per week (8 hours per day x 4 days per week plus 24 hours per day “sleep-in” x 3 days per week) cannot be sustained and is reversed.

The Managed Long Term Care plan, Aetna Better Health, is directed to:

1. Take no further action upon the plan’s October 13, 2015, and restore the Appellant’s personal care services to 120 hours per week (12 hours per day x 4 days per week plus 24 hours per day “sleep-in” x 3 days per week) through the current assessment period.

Should Aetna Better Health need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant’s Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant’s Representative must provide it to Aetna Better Health promptly to facilitate such compliance.

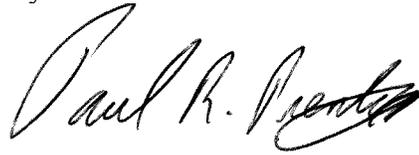
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As required by Section 358-6.4 of the Regulations, Aetna Better Health must comply immediately with the directives set forth above.

DATED: Albany, New York
12/11/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "Paul R. Puro". The signature is written in a cursive style with a large, sweeping initial "P".

Commissioner's Designee