STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST May 20, 2003
CASE # TNXXXXXQ
CENTER # N/A
FH # 3915572Z

In the Matter of the Appeal of :

ED : **DECISION AFTER FAIR HEARING**

from determinations by a Medicaid Managed Long Term Care Provider :

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 September 11, 2003, in New York City, before Peter K. Zaret, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Aysha Ramseur and Kim Morgan, Representatives; JF and NR, Witness

For the Managed Long Term Care Provider (Co-Op Care Plan)

John Bolton, Esq. and Sue Brown, Representatives for Co-Op Care Plan

ISSUES

Was the Appellant's Managed Long Term Care Provider's determination dated May 13, 2003, to reduce the Appellant's home care services from the amount of twenty-four hour continuous care by more than one personal care aide to the amount of 10 hours daily, 7 days weekly correct?

Was the Appellant's Managed Long Term Care Provider's determination dated July 31, 2003, to involuntarily disenroll the Appellant from the Managed Long Care Program in which she has been participating on the grounds that the Appellant was no longer self-directing, unable to direct her personal care worker regarding her medications and activities of daily living, and because the Appellant's family was either unwilling or unable to provide the necessary direction of Appellant's care and has refused to approve the Appellant's transfer to a nursing home, correct?

FACT FINDINGS

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 85, has been enrolled in a Managed Long Term Care Program and has received care and services, including home care services, through a Medicaid Managed Long Term Care Health Plan operated by Co-Op Care

Plan.

2. The Appellant was in receipt of home care services in the amount of twenty-four hour continuous care (split-shift) by more than one personal care aide.

3. The Appellant's home care services have been reduced as of the date of this hearing.

4. By a letter from Co-Op Care Plan dated May 13, 2003, the Appellant's Managed Long Term Care Provider determined to reduce the Appellant's home care services from the amount of twenty-four hour continuous care by more than one personal care aide to the amount of 10 hours daily, 7 days weekly, effective May 19, 2003.

5. By a letter from Co-Op Care Plan dated July 31, 2003, and effective August 18, 2003, the Appellant's Managed Long Term Care Provider's determined to involuntarily disenroll the Appellant from the Managed Long Care Program in which she has been participating on the grounds that the Appellant was no longer self-directing, unable to direct her personal care worker regarding her medications and activities of daily living, and because the Appellant's family was either unwilling or unable to provide the necessary direction of Appellant's care and has refused to approve the Appellant's transfer to a nursing home.

6. On May 20, 2003, the Appellant's Representative requested this hearing to review the correctness of the determination of the Appellant's Managed Long Term Care Provider dated May 13, 2003, to reduce the Appellant's Personal Care Services authorization. Subsequently, the determination of the Appellant's Managed Long Term Care Provider dated July 31, 2003, to involuntarily disenroll the Appellant from the Managed Long Care Program in which she has been participating was added as a second issue for review.

APPLICABLE LAW

Section 358-3.1 of the Regulations provides, in part:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a right to a fair hearing if:

(1) your application has been denied by a social services agency, or you have agreed in writing that your application should be withdrawn but you feel that you were given incorrect or incomplete information about your eligibility for the covered program or service...

(3) your public assistance, medical assistance, food stamps or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP or services are inadequate...

Section 358-2.21 of the Regulations provides:

Social services agency means the State, county, city, town official or town agency, social services district or HEAP certifying agency responsible for making the determination or for the failure to act, which is the subject of review at the fair hearing.

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

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

Section 358-2.23 of the Regulations provides that

Timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective.

Section 358-2.2 of the Regulations defines "adequate notice", and provides in part that an adequate notice means a notice of action, or an adverse action notice or an action taken notice which sets forth:

except in the case of an acceptance of an application for a covered program or service, the specific 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.

The MLTC Version #2 (Commonweath Contract) for Co-Op Care Plan, Article III.D pertains to disenrollment of an Long Term Managed Care Plan participant. Article III.E of that Contract is titled "Enrollee Protections" and states, in part that the Contractor agrees to comply with federal Medicaid law and State Social Services Law as it related to due process, Articles 44 and 49 of Public Health Law and implementing regulations governing coverage determinations, grievances, and appeals. The Contractor agrees to establish a complaint and grievance resolution process and a utilization review plan and utilization review appeal process consistent with Articles 44 and 49 and 42 CFR Part 456.

The MLTC Version #2 (Commonweath Contract) for Co-Op Care Plan, Article III.D.5 provides that an enrollee shall only be involuntarily disenrolled upon the LDSS's (i.e., the New York City, Human Resources Administration's) concurrence with the Contractor's determination which is initiated as described in subsection D.3 and 4.

Federal Medicaid Managed Care Regulations at 42 CFR Section 438.400 provide in part that:

(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:

Action means--

In the case of an MCO or PIHP--

(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...

Federal Medicaid Managed Care Regulations at 42 CFR Section 438.402 provide in part that:

(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...

Federal Medicaid Managed Care Regulations at 42 CFR Section 438.404 provide in part that:

Notice of action.

(a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.

(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...

DISCUSSION

At the hearing, the attorney for the Managed Long Term Care Provider stated that the Managed Long Term Care Provider's two above described determinations were not subject to a Fair Hearing because the Managed Long Term Care Provider was not a social services agency (Section 358-2.21 of the Regulations). This contention has been considered but is not persuasive.

With regard to the correctness of the Appellant's Managed Long Term Care Provider's determination dated May 13, 2003, to reduce the Appellant's home care services from the amount of twenty-four hour continuous care by more than one personal care aide to the amount of 10 hours daily, 7 days weekly, the credible evidence establishes that the notice failed to clearly identify the development that justified altering the Appellant's amount of services, and the reason for the action taken. The Notice specifies that "Based on the

assessment most recently completed, CO-OP Care Plan will be reducing the number of aide hours you are currently receiving. The Assessment performed by the Registered Nurse supports the reduction of services..." When asked at the hearing if the rationale supporting the May 13, 2003, determination to reduce the Appellant's Personal Care Services was because the Appellant's medical, mental or physical condition had improved, the Managed Long Term Care Provider Representatives testified that this was not the reason for the reduction action. The Managed Long Term Care Provider Representatives testified that the reduction action was taken because Co-Op Care Plan determined that the Appellant was a non-self-directing individual; that the Appellant's family was thus expected to be more involved as caregivers in order to keep the Appellant at home with home care; and that if the Appellant's family members were more involved as caregivers, then the authorized home care services could be reduced. This was clearly not the identified reason for the reduction that was set forth on the notice of action dated May 13, 2003. The May 13, 2003 Notice violates the applicable provisions of the State Law and Regulations, and Federal Regulations, and is not sustained. It must be noted that at the hearing that the Appellant's daughter, JF, and grand-daughter, KM, testified that they would be willing to take responsibility for any needed supervision or direction for the Appellant.

It is also noted that the May 13, 2003 Notice states, in part, that the Managed Long Term Care Provider periodically reassess all members, and that the reassessment "includes but is not limited to the following:

> a conversation with the members physician, case conferences with the Co-op Care Plan medical director and a complete assessment performed by a Registered Nurse. . . . Based on the nurses' assessment there is a tool, which is completed which determines the amount of hours an aide is needed to assist the member with their needs."

Two "Follow-Up Assessment 120 Day Report" forms (form OASIS-B1) were submitted at the hearing. These forms are signed by a registered nurse, one on January 16, 2003, the other on May 8, 2003. The record does not show that "a tool, which is completed which determines the amount of hours an aide is needed" was obtained. Furthermore, at the hearing, both parties agreed that the Appellant's physician was Dr. EJW. The Managed Long Term Care Provider failed to establish that there had been a "conversation" with Dr. EJW regarding this matter. At the hearing, the Managed Long Term Care Provider presented a note listing or history sheet that indicated that "RN VENDOR/HS LEFT SEVERAL MESSAGES FOR CURRENT PCP EW@ XXX-XXX-XXXX to return call for clarification and submission of amends for current medication profile. As of 5/23/03 no response received from PCP." No other contact with Dr. EJW was established by the Managed Long Term Care Provider at the hearing. At the hearing, the Appellant's Representative presented two letters from Dr. EJW dated April 8 and 23, 2003, that indicated that he was opposed to a reduction in the Appellant's home care services. The Managed Long Term Care Provider's note listing also referred to a Dr. N in one part, a Dr. N in another part, and a Dr. N in a third part, all on the same page. This physician was not clearly identified either in the spelling of his name or in his relationship with the Appellant, by the Managed Long Term Care Provider at the hearing.

With regard to the correctness of the Appellant's Managed Long Term Care Provider's determination dated July 31, 2003, to involuntarily disenroll the Appellant from the Managed Long Care Program in which she has been

participating on the grounds that the Appellant was no longer self-directing, unable to direct her personal care worker regarding her medications and activities of daily living, and because the Appellant's family was either unwilling or unable to provide the necessary direction of Appellant's care and has refused to approve the Appellant's transfer to a nursing home, the credible evidence establishes that this action was not proper.

The credible evidence establishes that that Managed Long Term Care Provider properly referred this involuntary disenrollment matter to the New York City, Human Resources Administration ("HRA"). However, the credible evidence fails to establish that the New York City, Human Resources Administration agreed with the decision to involuntarily disenroll Appellant. A document titled "HRA Response to Managed Long Term Care Provider Denials of Enrollments or Involuntary Disenrollments" dated June 10, 2003, and pertaining to Appellant, was submitted at the hearing. On this document, is a place for HRA to check whether it agrees with the Provider. This box is not checked; only a handwritten entry is made: "Deferred Refer to APS". The record does not show that HRA agreed with the disenrollment determination. As the substantial weight of the credible evidence does not establish that the New York City, Human Resources Administration agreed with the Managed Long Term Care Provider's plan for involuntary disenrollment, the Managed Long Term Care Provider's determination dated July 31, 2003, to involuntarily disenroll the Appellant from the Managed Long Care Program in which she had been participating is not sustained.

DECISION AND ORDER

The Appellant's Managed Long Term Care Provider's determination dated May 13, 2003, to reduce the Appellant's home care services from the amount of twenty-four hour continuous care by more than one personal care aide to the amount of 10 hours daily, 7 days weekly was not correct and is reversed.

1. The Appellant's Managed Long Term Care Provider is directed to take no further action on its May 13, 2003, notice, and to restore home care services to the Appellant in the amount of twenty-four hour continuous care by more than one personal care aide.

The Appellant's Managed Long Term Care Provider's determination dated July 31, 2003, to involuntarily disenroll the Appellant from the Managed Long Care Program in which she has been participating on the grounds that the Appellant was no longer self-directing, unable to direct her personal care worker regarding her medications and activities of daily living, and because the Appellant's family was either unwilling or unable to provide the necessary direction of Appellant's care and has refused to approve the Appellant's transfer to a nursing home, was not correct and is reversed.

2. The Appellant's Managed Long Term Care Provider is directed to take no further action on its July 31, 2003, notice, and to continue Appellant's enrollment in its Managed Long Term Care Program.

Should the Managed Long Term Care Provider 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 Representatives promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's Representatives must provide it to the Managed Long Term Care Provider promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Managed Long Term Care Provider must comply immediately with the directives set forth above.

DATED: Albany, New York
September 25, 2003

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee