

## **Mis-Managed Care**

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Fair Hearing Decisions on Medicaid Home Care Reductions  
by Managed Long Term Care Plans  
June – Dec. 2015

July 2016

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## EXECUTIVE SUMMARY

In 2015, elder lawyers and other advocates who represent consumers enrolled in Medicaid Managed Long Term Care (MLTC) plans in New York observed a sharp increase in the number of clients reporting that their MLTC plans had sought to reduce their home care services. This increase in cases raised concerns about whether these reductions violated the rights of plan members. Advocates undertook this study to examine the prevalence and extent of reductions by MLTC plans, and to assess plan compliance with procedural requirements for reducing hours of care.

This study was conducted by advocates who searched for all fair hearing decisions in the New York State Office of Temporary and Disability Assistance online Fair Hearing archive for which the issue was an MLTC plan's proposed reduction in hours of Medicaid home care services. For purposes of this report, "home care services" include both personal care services and Consumer Directed Personal Assistance (CDPA) services. Personal care services are performed by personal care aides employed by home care agencies that contract with MLTC plans. These services include housekeeping, meal preparation for special diets, and shopping, as well as assistance with activities of daily living such as bathing, dressing, grooming, toileting, walking, feeding, providing routine skin care, and assistance with administering medications.<sup>1</sup> CDPA services are performed by personal care assistants hired directly by the consumer and paid by MLTC plans through a fiscal intermediary. CDPA services include all personal care services plus the performance of skilled tasks that normally would only be provided by a nurse.<sup>2</sup>

### Findings

The study found 1,042 decisions involving home care reductions by MLTC plans during the seven-month period, June 1, 2015 – December 31, 2015. The number of decisions issued each month increased six-

fold from June to December 2015, with 98% of decisions involving MLTC members living in New York City.

Of the 1,042 hearing decisions, 87 percent involved proposed reductions by three MLTC plans. In order of prevalence, these plans are Senior Health Partners, VNSNY Choice, and CenterLight.

Had the proposed reductions taken effect in all 1,042 cases, the aggregate number of hours authorized in those cases would have decreased by 43 percent. Thirty-one percent of all hearings involved proposed reductions in hours between 40-49 percent.

MLTC plans prevailed in only 1.2% (13 out of 1,027) of hearings. See Figure 4, *infra*. MLTC members were able to thwart the plan's attempt to cut their services in 90% of all hearings, either by winning a favorable decision (26% of all hearings) or because the MLTC plan failed to appear at the hearing or withdrew its proposed reduction at the hearing (64% of all hearings). In another 8.7% of the decisions, the matter was settled by a "stipulation" in which the member -- often in the absence of counsel -- agreed to accept the MLTC plan's offer of a reduction in hours that was less than the plan originally proposed.

### **Concerns Raised by Data**

A review of all of the hearings in which decisions were issued overturning the threatened reduction reveals a systemic pattern of reductions unjustified under *Mayer v Wing*, a federal court decision implemented by New York State regulations. This case, based on fundamental Constitutional principles of due process, prohibits a reduction in Medicaid home care services unless the agency establishes a change in medical condition or other circumstances that make the hours previously authorized unnecessary. In decision after decision, Administrative law judges found that the MLTC plans failed to sustain their burden of proof to establish any such justification. One-fourth of the written decisions overturning the plan's determination to reduce services were based solely upon a finding that the plan failed to provide the required written notice of its proposed reduction to the

member. Such notice of action is the most basic due process requirement that explains the reasons for the reduction and the member's appeal rights including, in some instances, the right to continue services until a hearing decision is rendered.

Fair hearings are not an adequate remedy for this illegal pattern of reductions. MLTC members are, by definition, dependent on assistance with daily activities. For every member who had the wherewithal to request, travel to, and present their case at a hearing, undoubtedly there were many who could not. Worse yet, based on the decisions found in this study, many members never even received a notice of reduction from the plan informing them of the proposed action and their right to appeal. Instead, they were simply notified by telephone – or not at all – that the plan will be reducing their services as of a certain date. Many were likely not aware of their right to challenge the decision.

In 8.7% of all of the hearing decisions, the member accepted a partial reduction as a settlement. In one of those cases involving an unrepresented member, the final hearing decision rejected the settlement because the plan had so clearly failed to meet its burden of proof that the reduction was justified. One cannot help but wonder how many members accepted their plans' offer of only a partial reduction, fearful of losing more hours, when they could have fully prevailed on the grounds that the plan never provided notice, provided defective notice, or could not satisfy its burden of proof.

## **Recommendations**

1. Monitoring and Public Accountability – The New York State Department of Health {DOH} should increase monitoring of plans by collecting and publishing detailed data:

- a) For the period of this report, DOH should identify how many more MLTC members than are tracked in this report faced reductions, assess whether the plans complied with legal

requirements for the reductions, and continue to assess compliance going forward.

- b) DOH should analyze and publish data on the number of members authorized to receive various ranges of hours of home care, reported by all plans in the Quarterly Managed Medicaid Cost and Operating Reports (“MMCOR”),<sup>3</sup> with changes over time. This data is important to monitor whether plans are authorizing a continuum of services across a bell curve, meeting the needs of high-need consumers.
- c) DOH should annually publish plan-specific data on appeals and grievances with specific issues and outcomes.

2. DOH should take protective action to restore home care that was unlawfully reduced, including for members who agreed to accept a reduction, and ensure member rights are protected in the future. DOH should reopen cases settled by stipulation less than fully favorable to the member and review the legality of the original proposed reduction. Given the extremely high rate of instances where plans failed to provide members with basic due process rights, DOH should also audit MLTC plans to ensure that notices were provided each time a member’s services were reduced or terminated, restoring benefits in any instance where such notice was not provided or was defective.

3. Hearings posted in the online Fair Hearing Archive should be redacted less so as to promote State oversight and public accountability. Key information, such as the name of the plan, the extent of the proposed reduction, and whether or not the member has legal representation should not be redacted. Decisions should also include clear information on aid continuing status and the type of plan involved (MLTC, mainstream managed care, etc.)

## INTRODUCTION

In 2015, elder lawyers and other advocates who represent consumers enrolled in Medicaid Managed Long Term Care (MLTC) plans in New York observed a sharp increase in the number of clients reporting that their MLTC plan had initiated actions to reduce their home care services. The increase in cases raised concerns about whether these reductions violated the rights of plan members. Advocates undertook this study to examine the prevalence and extent of reductions by MLTC plans, and to assess plan compliance with procedural requirements for reducing hours of care.

This report uses the publicly available data in the Office of Temporary and Disability Assistance (OTDA) Fair Hearing Decision Archive, in which all fair hearing decisions issued by this state agency are posted in a searchable database. The OTDA archive was searched for all hearing decisions in which the issue was a reduction in home care services by an MLTC plan during the seven-month period June 2015 through December 2015. For purposes of this report, “home care services” include both personal care services and Consumer Directed Personal Assistance (CDPA) services. Personal care services are performed by personal care aides employed by home care agencies that contract with the MLTC plans. These services include housekeeping, shopping, preparing meals for special diets, as well as providing assistance with activities of daily living such as bathing, dressing, grooming, toileting, walking, feeding, and providing routine skin care, and assisting with administering medications.<sup>4</sup> CDPA services are performed by personal assistants hired directly by the consumer and paid by MLTC plans through a fiscal intermediary. CDPA services include all personal care services plus the performance of skilled tasks that normally would only be provided by a nurse.<sup>5</sup>

The OTDA archive search revealed a pattern of procedural and substantive law violations by MLTC plans. Primarily, this consisted of arbitrary reductions in home care hours without a legal justification, and failure to provide written notice to the consumer explaining the

reasons for the proposed reduction and how to appeal it. Violations included lack of any written notice at all, and failure to provide a legally adequate notice.

According to the data in this report, consumers who challenged reductions through the fair hearing process won approximately 90 percent of the time. While one might be tempted to view this statistic as a reflection of how favorably the system works for those who access it, we are concerned about those consumers who never make it through the fair hearing process. By definition, MLTC members are people who require significant assistance with the most basic daily activities, such as walking around their homes, getting up from and transferring between a chair and bed, getting to and using the bathroom, bathing, dressing and eating. Because most MLTC members are of advanced age,<sup>6</sup> often with compromised visual acuity and problems with comprehension,<sup>7</sup> it stands to reason that many lacked the wherewithal to appeal a proposed reduction, or to travel to a hearing that they requested. Still others may have felt pressure to accept a partial reduction in hours without appealing it for fear that they would lose their appeal and forfeit even more hours.

Moreover, of the 90% of hearings that were favorable to members, 71% (971) were won because the MLTC plans did not defend the reduction. In these cases, the plan either agreed at the hearing not to reduce the hours or failed to appear at the hearing at all. This suggests that the plans were well aware that there was no legal justification for their action in the majority of their proposed reductions, and took the chance that they could institute a reduction in services without being challenged.

It is beyond the capacity of this report to ascertain the extent and impact of reductions in hours beyond those reflected in the fair hearing decisions made public online. Moreover, there is no substantive written decision for the majority of homecare reduction cases that go to hearing – those that resulted from plan default or stipulation – and therefore no publicly available information on the basis for most

proposed reductions. Hence, as further discussed in the Recommendations section below, the New York State Department of Health (DOH) should investigate the issue of home care reductions with better data collection and make the data available to the public.

This report will first review the background of MLTC in New York, and the legal standards and procedures MLTC plans must follow when proposing home care reductions for members. It will then present an analysis of fair hearing decision data on home care reductions by partially capitated MLTC plans (MLTC plans that only provide certain Medicaid services) for the seven-month period from June 1, 2015 through December 31, 2015. The report concludes with a series of conclusions, concerns, and recommendations to DOH with the goal of gaining a better understanding of this trend and stemming the tide of such egregious consumer violations.

## MANAGED LONG TERM CARE IN NYS

### Brief History of Managed Long Term Care

Before 2012, most New Yorkers who received both Medicare and Medicaid benefits (“dual-eligibles”) accessed Medicaid home care services under a “fee-for-service” model through their local county Medicaid office or the New York City Human Resources Administration (NYC HRA). Only a small number of Medicaid recipients opted for alternate home care models such as Managed Long Term Care, which had been a voluntary option since 1997, and other programs.<sup>8</sup> Statewide, MLTC enrollment in December 2008 was 22,528,<sup>9</sup> compared to 73,118 average monthly beneficiaries receiving Medicaid personal care on a fee-for-service basis in 2008.<sup>10</sup>

In the fee-for-service model, home care services were authorized by the local county Medicaid offices or NYC HRA after an extensive assessment process specified in state regulation.<sup>11</sup> These local government offices provided for services by contracting with home

care agencies and fiscal intermediaries that billed Medicaid on a fee-for-service basis for providing the authorized hours of care.

In 2011, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT) with a stated goal of controlling Medicaid costs, creating efficiencies in Medicaid administration and improving health outcomes.<sup>12</sup> One of the major changes to New York's Medicaid program initiated by the MRT and approved by the state legislature was the mandatory transition of most Medicaid long term care services from the counties to managed care plans, including MLTC plans.<sup>13</sup> Under mandatory MLTC enrollment, all dual eligible adults who had been receiving home care or other community-based long term care through NYC HRA or the counties were required to transition to MLTC. Dual eligible adults newly needing such services were required to enroll in MLTC from the outset.

Mandatory enrollment in MLTC plans started in August 2012 in New York City and rolled out gradually to include all counties in the state. Mandatory MLTC has been in effect statewide since fall 2015.<sup>14</sup> As of December 2015, statewide enrollment in partial capitation MLTC plans totaled 137,705 members – a six-fold increase since 2008. Of these, 112,549 were in New York City.<sup>15</sup>

The transition to mandatory MLTC shifted the authorization of Medicaid home care services from the counties and NYC HRA to MLTC plans, and changed the payment system for these services. MLTC plans are now responsible for assessing the need for and authorizing home care and other community-based long term care services. MLTC plans also contract with home care agencies and fiscal intermediaries to provide these services to plan members. The MLTC plan receives a flat monthly “per member per month” (“capitation” or “PMPM”) payment from the State Medicaid program. The rate is the same for every member within a plan, regardless of whether the member needs very little care or round-the-clock care. Plans receive varying rates based upon the overall health of their members (the “risk score”). As in any insurance model, the risk is spread across all the plan's members

whose needs range along a bell curve from low to high. The plan is expected to save money on the low-need members and spend more on those who need extensive hours of care, up to 24 hours/day, either by a live-in aide or in two 12-hour shifts.<sup>16</sup>

## **Legal Standards and Procedures Required to Reduce Home Care Services**

When a Medicaid beneficiary is receiving home care services, the entity authorizing the services – whether the county/NYC HRA or an MLTC plan – is permitted to change the service plan, but only to the extent permitted by and consistent with substantive and procedural safeguards established by law, regulation, policy, and contract. These safeguards include strict requirements for notice to Medicaid beneficiaries founded in the Due Process Clause of the Fourteenth Amendment of the United States Constitution, as interpreted in case law, statute, regulation and policy, and which are binding on MLTC plans. In addition, individuals transitioning to MLTC from receiving community-based long term care through various fee-for-service programs receive time-limited additional “transition protections” against reductions in hours.

### ***Case Law - Mayer v. Wing Federal Court Decision Prohibiting Reduction of Personal Care Services Without Justification***

In the seminal 1996 decision *Mayer v. Wing*, a New York federal court held that Medicaid personal care services may not be reduced or terminated without proof that the individual's medical condition or social circumstances had changed since the services were originally authorized and that the change justifies the reduction, proof that a mistake was made in the original authorization, or proof that certain other limited justifications apply.<sup>17</sup> *Mayer* was certified as a class action because of a pattern of arbitrary reductions in personal care services made by NYC HRA at the time. The Court stated in part:

At a minimum, "due process requires that government officials refrain from acting in an irrational, arbitrary or capricious manner." [cite omitted]. This is precisely the manner in which the City

Defendant appears to have acted. The testimony ... indicates that the City Defendant has, without any adequate justification, repeatedly determined to reduce services initially authorized to home care recipients. The capricious nature of these decisions is evidenced by the fact that Plaintiffs received notices of reduction while in the same or worse physical condition they were in when home care was initially authorized, and were given no explanation for why they were assessed differently the second time around.<sup>18</sup>

### ***New York State Regulations on Personal Care***

The *Mayer* requirements have long been codified in New York State regulation, which lists the permissible reasons for reductions such as medical improvement, as described above.<sup>19</sup> The regulation further specifies requirements for the content of notices to consumers regarding service reductions. In December 2015, DOH strengthened these notice requirements in state regulation,<sup>20</sup> and specifically instructed MLTC plans that the regulation applies to MLTC.<sup>21</sup> Strict notice standards and their application to MLTC, however, long pre-date the 2015 amendments.

### ***Plans Bound by Same Standards and Procedures that Apply to Home Care Outside of Managed Care***

MLTC plans are legally and contractually bound by the due process procedures and notice requirements articulated in *Mayer*. The *Mayer* regulation explicitly applies to managed care products.<sup>22</sup> The federal Medicaid statute requires that all managed care plans make services available to the same extent they are available to recipients of fee-for-service Medicaid.<sup>23</sup> MLTC plans are bound by the Managed Long Term Care Partial Capitation Contract, which provides that “Managed care organizations may not define covered services more restrictively than the Medicaid Program.”<sup>24</sup> Moreover, in requiring MLTC plans to implement mandatory model notice templates, DOH specifically directed MLTC plans to include in their notices specific facts and reasons justifying proposed reductions.<sup>25</sup>

## ***Proper Procedure for Reducing Home Care Services***

The procedures MLTC plans must follow if they propose to reduce home care services, under *Mayer v. Wing*, and related law and regulations, include:

1. **Reasons for reduction** – the *Mayer* decision outlined limited acceptable reasons for reductions, such as a change in medical condition or social circumstances, or a mistake in the prior authorization.<sup>26</sup>
  
2. **Advance written notice** – Advance written notice of a proposed reduction is a basic due process right. Requirements include:
  - a. **Timely notice** – written notice must be mailed at least 10 days before the effective date of the reduction;
  - b. **Adequate notice** – Medicaid notices must include certain information, including but not limited to:<sup>27</sup>
    - i. The right to request a hearing, how to do so, and how to obtain the documents relied on by the agency or plan;<sup>28</sup>
    - ii. The law and regulations upon which the determination was based;
    - iii. The right to receive “aid continuing,” which is the continuation of the previously authorized services unchanged until the hearing is decided, if the hearing is requested before the effective date of the notice;
    - iv. The specific reason for the reduction. It is not sufficient for the notice to simply allege that a “mistake” was made or that the member’s medical condition “changed.” The notice must identify the specific mistake that occurred in the previous authorization and state why the prior services are not needed as a result of the mistake or identify the change in condition and explain how the

member's needs can be met with the reduced hours.<sup>29</sup>

### ***Transition Rights***

When a member transitions to MLTC, the MLTC plan must continue to authorize the same type and amount of home care services that were previously authorized by the county, NYC HRA or other fee-for-service Medicaid program for a 90-day “transition period.”<sup>30</sup> After the transition period, the MLTC plans are allowed to change the service plan, but only to the extent permitted by, and consistent with, the substantive and procedural safeguards described above.

## **NOTES ABOUT DATA**

The data in this report covers a seven-month period from June 1, 2015 through and including Dec. 31, 2015.

- 1. The data includes decisions involving partially capitated Managed Long Term Care (MLTC) plans only.** The report does not include cases involving proposed home care reductions by other types of managed and managed long term care plans, such as Medicaid Advantage Plus (MAP), Programs for All Inclusive Care for the Elderly (PACE), Fully Integrated Dual Advantage (FIDA) plans, or “mainstream” Medicaid managed care plans which serve people without Medicare. Because hearing decisions often redact plan names, in some instances an inference was drawn from the decision that the case involved a partially capitated MLTC.
- 2. The data may not have captured all decisions involving reductions by partially capitated MLTCs.** Due to redaction, stylistic differences among authors of hearing decisions, and the search function, it was not possible to find every decision, or to discern whether a particular decision involved an MLTC plan thereby necessitating its exclusion from the study.
- 3. Assumptions.** Findings in this report include measuring the extent of the reduction in hours proposed. For cases involving split shift or

continuous care, 168 hours per week are assumed (7 days x 12 hours x 2 shifts/day). For sleep-in care, 112 hours per week (16 hours x 7 days) are assumed, based on the home care aide being entitled to eight hours of sleep per night.

4. **Redactions.** Plan names were almost always redacted, but could often be discerned from the name of the plan’s representative. However, in 74 cases all information was redacted so the plan could not be identified. In some cases, the dates of the notice, and the number of hours authorized previously and proposed, were also redacted.
5. **These findings only analyze decisions issued after fair hearing regarding a proposed reduction.** The database used for this study does not include the number of hearings requested but later withdrawn with no decision ever issued. Nor does the study identify the number of members who never challenged reductions in hours, or who resolved reductions informally or through the internal appeals process within the MLTC plan.

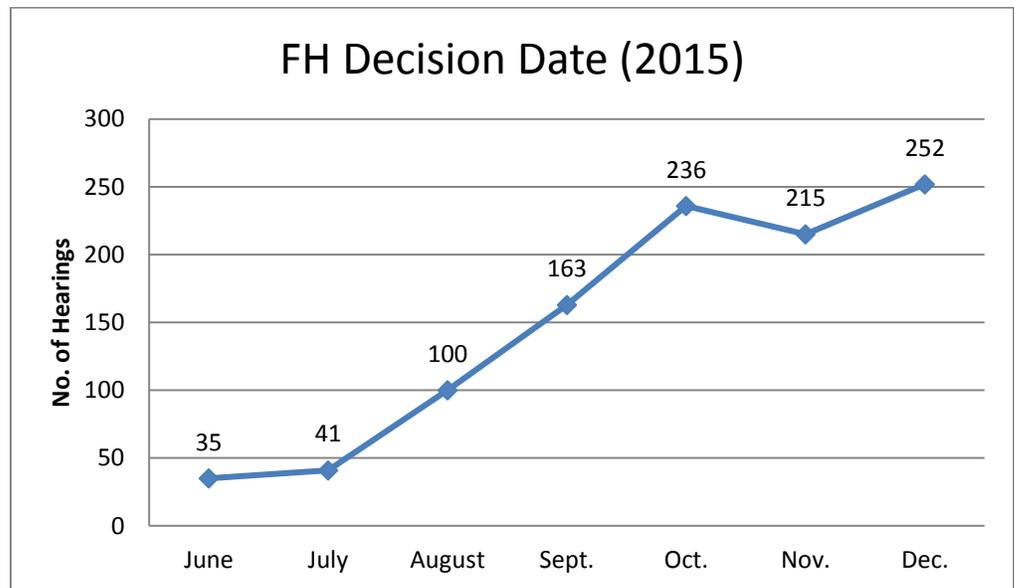
## FINDINGS

### **FINDING 1: The Number of Hearings per Month on MLTC Reductions Increased Six-Fold from June to December 2015**

In the seven-month period during which the study was conducted (June 1 through December 31, 2015), there were a total of 1,042 fair hearing decisions rendered statewide that involved a proposed reduction in home care hours by an MLTC plan. The number of hearing decisions issued per month regarding proposed reductions in hours by MLTC plans grew significantly from only 35 decisions in June 2015 to 252 decisions in December 2015. See Figure 1. This increase in hearings did not go unnoticed by DOH. Indeed, that agency reported in its 2015 Partnership Plan Report to CMS a “significant increase in Fair Hearings [involving MLTC] during the July to September 2015 period,” noting there were 428 MLTC fair hearings in the third calendar quarter of 2015 alone.<sup>31</sup> During that same period, this study identified 304

hearing decisions involving reductions in hours. The reasons for the higher number identified by DOH may be due to the inclusion of hearings by members of “full capitation” managed long term care plans (MAP and PACE), hearings regarding issues other than homecare, and hearings challenging denials of requests for increased hours, as opposed to reductions in hours.<sup>32</sup> Also, the higher figure may include fair hearings requested but that did not reach a decision that was posted on the public website.

**Figure 1: Number of Home Care Reduction Hearing Decisions by Month – Statewide**



**FINDING 2: Ninety-Eight Percent of Decisions Involved New York City MLTC Members**

All but 2% of MLTC home care reduction hearings in the state involved NYC members. Figure 2 shows the number of hearings in each county during the seven-month period, in relation to the total MLTC enrollment in those counties as of June 2015.

**Figure 2: Geographic Distribution of Home Care Reduction Hearings (6/1/15 – 12/31/15)**

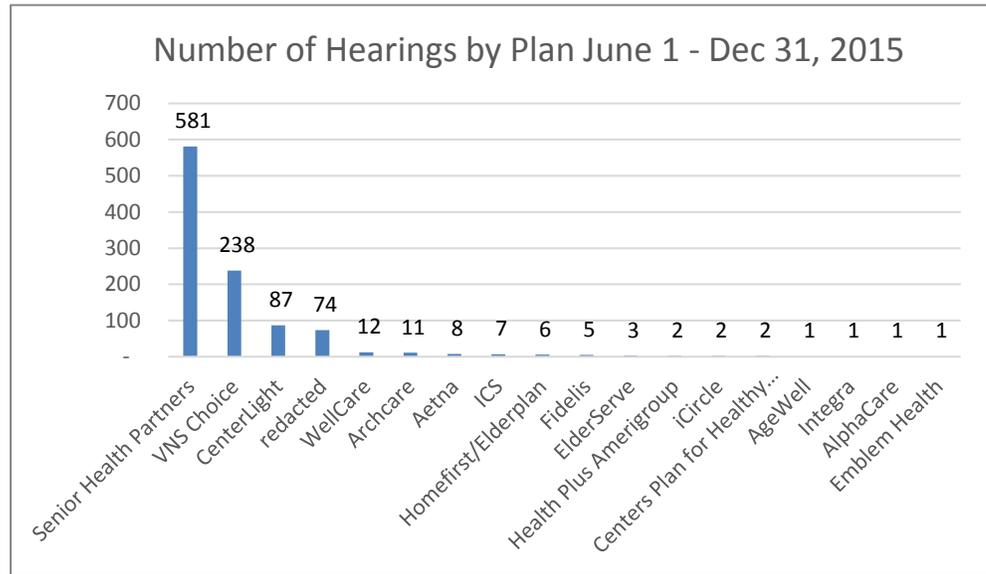
County	Number of Fair Hearings	Total County Enrollment June 2015 <sup>33</sup>
New York City	1,020	108,286
Westchester	10	3,125
Albany	1	496
Monroe	2	1,014
Nassau	6	6,640
Ontario	1	44
Suffolk	2	3,367
Rest of state	0	5,425
<b>TOTAL</b>	<b>1,042</b>	<b>128,397</b>

The high proportion of hearings from NYC may be attributed to two factors. First, NYC has a much higher enrollment in MLTC. In part, this is because mandatory enrollment began in NYC in early 2012, only becoming mandatory statewide in mid-2015. In addition, historically, proportionally fewer dual eligibles outside of NYC have received home care services; they are more likely to have received care in a nursing home.<sup>34</sup> Second, NYC dual eligibles have been more likely to receive higher hours of care, including 24-hour care, than dual eligibles outside NYC.<sup>35</sup> Therefore, NYC members are more likely to be impacted.

**FINDING 3. Eighty-seven Percent of Hearing Decisions Involved Three MLTC plans, led by Senior Health Partners.**

Eighty-seven percent (87%) of the hearing decisions identified involved proposed reductions by three MLTC plans. See Figure 3.1. Over half of the decisions – 56% – involved a single plan, Senior Health Partners, the MLTC plan owned by Healthfirst, Inc. Two other plans also had a significant number of hearing decisions regarding proposed reductions – VNSNY Choice (23% of hearings) and CenterLight (8.3% of hearings). All other plans together accounted for fewer than 13% of all hearing decisions.

**Figure 3.1: Distribution of Home Care Reduction Hearing Decisions by MLTC Plan Statewide**



Senior Health Partners also had the highest percentage of members with a hearing decision on a proposed reduction during this period (4.2%). VNSNY Choice and CenterLight followed with 1.6% and 1.4% respectively. See Figure 3.2. These figures include all written decisions regardless of the outcome.

**Figure 3.2: Percent of Members with Home Care Reduction Hearing Decisions by Plan**

MLTC Plan	MLTC Enrollment June 2015		No. Hearing Decisions	% Members with Hearings
	Statewide	NYC		
Senior Health Partners	13,997	13,494	581	4.2%
VNSNY Choice	14,701	13,396	238	1.6%
CenterLight	6,202	5,646	87	1.4%
Wellcare	7,194	6,306	12	.2%
Archcare	1,898	1,425	11	.6%
Aetna	3,137	2,533	8	.3%
ICS	5,335	5,335	7	.1%
Plan name redacted	93,497	75,750	74	NA

<b>All other plans</b>			24	.03%
<b>Total</b>	<b>128,397</b>	<b>108,286</b>	<b>1,042</b>	<b>.8%</b>

**FINDING 4. MLTC Plans Won Only 1.2% of all Hearings, While MLTC Members Fully Prevailed in 90% of all Hearings, and Secured Partial Relief by Settlements in 8.8% of Hearings.**

MLTC plans won only 1.2% (13) of all hearings that reached a decision. MLTC members fully prevailed in 90% (940) of all hearings that reached a decision; this included decisions that were settled fully favorably to the member by stipulation on the record. The actual number of members who defeated proposed reductions is likely to be higher, because this data does not include hearing requests that were withdrawn prior to the hearing based on reaching a settlement, or cases resolved through an internal appeal that never proceeded to a hearing. The recent 2015 Partnership Plan Section 1115 Quarterly Report and Annual Report (“DOH 2015 Partnership Plan Report”) cites 1,531 MLTC internal appeals during the third quarter of 2015, of which 1,157 (75%) involved the same three plans with the highest number of hearings identified in this report.<sup>36</sup>

In 671 (71%) of the 940 hearings decided fully in the members’ favor, the MLTC plan did not defend its proposed reduction at the hearing. The plan either withdrew its notice of reduction at the hearing (582 cases) or defaulted by failing to send a representative to make its case without formally waiving its appearance, resulting in a favorable decision for the member (89 cases).

In the remaining 268 cases decided fully in the members’ favor, a written decision was rendered rejecting the proposed reduction in hours based on procedural defects with the notice, on the merits, or both. In at least 32% (87) of these decisions, which constitutes 8.3% of all 1042 decisions in the study, the sole basis of the decision was the plan’s failure to send the member legally adequate notice, or any

notice at all. In these cases, the member automatically won. Many of the 181 other decisions that reversed a plan’s reduction on the merits also found the plan’s notice to be legally inadequate. See Figure 4.

**Figure 4: Hearing Outcomes by Resolution Type**

<b>OUTCOMES WHOLLY IN FAVOR OF MEMBER</b>	<b>No. of Decisions</b>	<b>% of Decisions</b>
<b>Substantive Decision Reversing Plan’s Proposed Action - Fully Favorable to Member</b>	<b>268</b>	<b>25.7%</b>
○ <b>No Written Notice of the Reduction</b>	16	1.5%
○ <b>Notice of Reduction Inadequate (If sole ground of decision)</b>	71	6.8%
○ <b>Decision on Merits of Reduction – Plan failed to meet burden of proof that member’s condition improved, that a mistake was made, or that another change occurred. Many decisions also find the plan’s notice was inadequate.</b>	181	17.4%
<b>Plan Defaulted at Hearing (did not send a representative and did not request waiver of its appearance)</b>	<b>89</b>	<b>8.5%</b>
<b>Plan Withdrew Proposed Reduction on the Record</b>	<b>582</b>	<b>55.9%</b>
<b>Subtotal: Outcomes in Members’ Favor</b>	<b>940</b>	<b>90.1%</b>
<b>OUTCOMES IN FAVOR OF PLAN</b>		
<b>Decisions Upholding Plan’s Reduction on the merits</b>	<b>7</b>	<b>0.7%</b>
<b>Decisions dismissing appeal because failed to exhaust internal appeal (notices prior to July 1, 2015 only) or past statute of limitations to request hearing</b>	<b>6</b>	<b>0.6%</b>
<b>Subtotal: Outcomes Allowing Reduction</b>	<b>13</b>	<b>1.2%</b>
<b>STIPULATION PARTLY FAVORABLE TO MEMBER</b>		
<b>Stipulation – Plan &amp; Member Agreed on Compromise Reduction Allowed but Less than Plan Proposed</b>	<b>92</b>	<b>8.8%</b>
<b>Subtotal: Outcomes Allowing Partial Reduction</b>	<b>92</b>	<b>8.8%</b>

<b>Grand Total</b>	<b>1042</b>	<b>100%</b>
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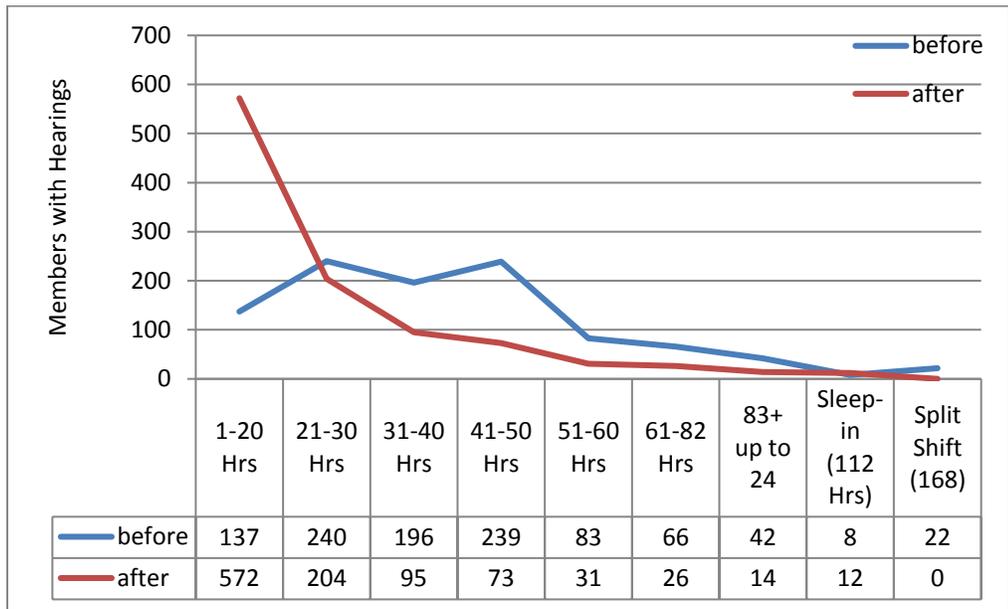
## **FINDING 5. Proposed Reductions Would Markedly Reduce Hours of Service.**

A comparison of the number hours proposed by the MLTC plans to the number of hours previously authorized reflects an attempt by the MLTC plans to significantly reduce home care services.<sup>37</sup> The data also shows that, had the proposed reductions been implemented, the result would have been the virtual elimination of higher hours of care for the cohort faced with reductions during this period. Indeed, the majority of members would have had their hours reduced to the lowest range of weekly hours – under 20 hours per week.

***Finding 5.1. If implemented, the percentage of the study cohort receiving more than 41 hours per week would have decreased from 45% to 15%, and the percentage receiving 20 hours or less would have increased from 13% to 56%.***

In Figure 5.1, the horizontal axis represents 9 different ranges of weekly hours, from under 20 hours per week on the far left to 24-hour continuous care (“split shift”) on the far right. The vertical axis reflects the number of members receiving the different ranges of hours of care. The blue line reflects the baseline – the number of members whose authorized hours before the proposed reduction fell within the different ranges of weekly hours. The red line shows the number of members whose services would fall within the different ranges of weekly hours *if* the plans’ proposed reductions had been implemented. The row of numbers at the bottom of the graph shows the actual number of cases within each range of hours before and after the proposed reductions. This data is based on the proposed reductions, not on the actual outcomes of the hearings.

**Figure 5.1: Comparison of Number of Cases by Hours Authorized Before and After Proposed Reduction**



**NOTE:** The number of cases is fewer than 1042 because the number of hours was redacted or omitted in 15 decisions.

As Figure 5.1 shows, the number of cases with mid- to high-hour authorizations would have sharply decreased with the proposed reductions. Before the proposed reductions, the blue line shows a modified bell curve, weighted toward the lower end with most people receiving 50 or fewer hours per week. A significant number – 289 (23% of the study pool) – were receiving between 41-50 hours per week of home care services, at the middle range of the bell curve. However, the red line shows a complete eradication of the bell curve had the proposed reductions taken effect. The number of cases poised to receive the fewest number of hours per week, 20 or fewer, would have increased from 137 (13%) to 572 (56%). The number receiving 41 or more hours per week would have decreased from 460 (45%) to 156 (15%). Before the proposed reductions, 138 members (13%) were authorized to receive more than 60 hours per week, of whom 30 received split-shift or continuous 24-hour care. Had all of the proposed reductions been upheld, only 5% of all members in the study (52 of 1,027) would be authorized to receive more than 60 hours per week.

***Focus on 24-Hour Care Cases***

Thirty fair hearing decisions involved members previously authorized to receive 24-hour care, either through live-in or split-shift services. Figure 5.2 shows that, had the plans’ reductions in these cases been upheld, 22 members previously authorized to receive 24-hour continuous split-shift care would have had their services reduced to either sleep-in (12 cases) or fewer hours (eight cases). Of the eight cases originally authorized for sleep-in care, two would have received 12 hours per day of care, and five would have received 7 - 10 hours per day of care. In all but one of the 30 proposed reductions of 24-hour care, the reduction was withdrawn by the plan or reversed by hearing decision. In one Monroe County hearing, a reduction from split-shift to sleep-in care was upheld.

**Figure 5.2 Focus on 24-hour cases**

	BEFORE	AFTER: Proposed Numbers of Weekly Hours									
	Original No. of Cases	49	56	70	77	82	84	91	140	NA	Sleep-in
<b>Sleep-in</b>	8	2	1	2			2			1	
<b>Split Shift</b>	22		1		1	1	4	1	2		12
<b>Total</b>	<b>30</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>6</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>12</b>

***Finding 5.2. Aggregate Number of Hours Authorized For Members with Hearings in Study Period Would Decrease by 43 Percent if Proposed Reductions were Implemented.***

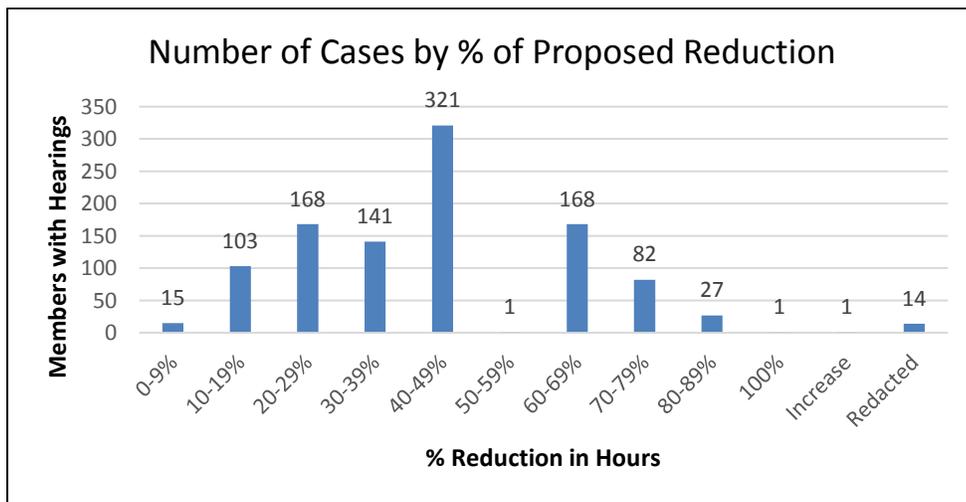
The aggregate number of hours authorized for all members facing reductions in the study period would have decreased by 43% if all proposed reductions had been upheld. The combined total number of hours authorized for all members in the study would have decreased from 44,402 to 25,385 total hours. (Live-in cases are calculated for this report at 16 hours/day.) This is a massive reduction in hours. These members were previously found to need the original higher hours because of chronic conditions that do not generally improve. If

implemented, the cuts would likely be detrimental to members who, by definition, have disabilities that make them dependent to various degrees on an aide for daily assistance.

***Finding 5.3. 31% of all Hearings Involved Proposed Reductions of between 40-49 percent of hours.***

The largest number of cases – 321 (31%) of 1,042 members – faced reductions between 40-49 percent of their previous weekly authorized hours. In 27% of cases – 280 of the 1,042 members – the proposed reduction was over 50% of their previously weekly authorized hours. In Figure 5.3, the horizontal axis is the percentage by which the MLTC plans proposed to reduce the weekly total number of hours. The vertical axis is the number of members with hearing decisions.

**Figure 5.3: Number of Members with Different Percentages of the Proposed Reduction in Weekly Hours**



**CONCERNS RAISED BY DATA**

**Systemic Pattern of Unjustified Reductions**

As evidenced by decisions reviewed for this study, some MLTC plans are reducing home care hours without legal justification. Examples of decisions reversing a plan’s reduction for lack of justification are Hearing No. 7120263Y, dated Dec. 2, 2015, and No. 7101569J, dated

Oct. 6, 2015.<sup>38</sup> Moreover, the large number of cases in which decisions were not rendered because the MLTC did not defend or withdrew its proposed reduction suggests that some plans are aware that most of their proposed reductions are not legally defensible. While withdrawals of proposed reductions and defaults result in favorable outcomes for the member, the burden of requesting and traveling to these hearings has a real cost for people who, by definition, need help with their basic daily living activities because of their disabilities. Moreover, it raises the question of how many legally insufficient reductions in hours have members simply acquiesced to by not challenging the reductions.

At least one, if not more, of the three plans with the highest number of hearings appears to be engaging in a pattern of arbitrary reductions in home care hours, and of failing to comply with *Mayer v. Wing* and its implementing regulations. As shown in Figures 3.1 and 3.2, three MLTC plans had the majority of hearing decisions: Senior Health Partners had 581 (56%), VNSNY Choice had 238 (23%), and CenterLight had 87 (8%). Unfortunately, another 74 decisions (7%) have the plan and plan representative names redacted, but presumably some of these are also from these three plans. The remaining 62 decisions (6%) are distributed among 15 other plans.

Of the 581 Senior Health Partners hearings, the plan won only three hearings, two on the merits and one because the member failed to exhaust the internal plan appeal process, a requirement that DOH subsequently eliminated in July 2015. Senior Health Partners members fully prevailed in 491 cases (84.5%). A settlement was reached with a partial reduction in hours in 87 cases (15%).

It is troubling that the DOH 2015 Partnership Plan Report on the status of the shift to mandatory enrollment in MLTC fails to analyze the pattern of reductions by MLTCs.<sup>39</sup> The report specifically acknowledges a “significant increase” in fair hearings regarding MLTC in the third quarter of 2015 (428 hearing decisions, of which 375 were in favor of the member).<sup>40</sup> The report attributed this increase to the elimination

of the internal plan appeal exhaustion requirement and also indicates that the increase may relate to a spike in hearings in the prior quarter “relating to plan implementation of quality initiatives that resulted in a proposed reduction of hours.” Report at p. 16.<sup>41</sup> However, in not one of the 189 decisions on the merits in this seven-month period did the MLTC plan claim that the proposed reduction of hours was based on a so-called “quality initiative.” More importantly, without a showing of actual improvement or other change in any member’s circumstances, no “quality initiative” would be sufficient grounds to reduce hours of home care under *Mayer v. Wing* and its implementing regulation.

### **Fair Hearings are not an Adequate Solution to Prevent Harm to MLTC Members**

While MLTC members who manage to request a hearing and appear before an administrative law judge have a high rate of success, this does not mean the system is working for all MLTC members. Many MLTC members never get before a judge. The data in this report only examines those cases that reached a fair hearing decision. Given the aggressive attempts by some MLTC plans to slash home care hours, we must assume that many more MLTC members experienced reductions in their hours, or were threatened with reductions. These cases do not appear in the online fair hearing archive for various reasons. Many never appeal because, unlike 88 members in this study who managed to proceed to a hearing despite lack of written notice, the plan failed to give *any* written notice of the reduction, or gave only defective notice. In other cases, hearings were requested by MLTC members, but were abandoned by those who lacked the wherewithal to attend the hearing or even to seek assistance.

As was the case with NYC HRA in *Mayer v. Wing*, advocates are concerned that large numbers of home care reductions by MLTC never make it to a hearing:

The fair hearing process is a particularly poor remedial device here. As noted, the vast majority of those who receive notices of reduction do not even request a fair hearing. The fact that home

care recipients are in such poor health undoubtedly contributes to this phenomenon.<sup>42</sup>

Still other cases are settled with the plan prior to the hearing date, whether through an internal appeal or informally. While many of these may have been favorably settled for the member, there is no public record of these settlements, reducing plan accountability. In the experience of advocates who contributed to this report, unrepresented members may settle with the plan, but not with a result that is fully favorable for the member.

It is quite likely that the breadth and extent of the reductions cited in this report would increase dramatically if data on reductions and threatened reductions that did not reach a hearing were added to the data in this report.

Additionally, a high success rate for members indicates that MLTC plans are not applying clear, consistent, and rational standards to their proposed reductions. As the court said in *Mayer, supra*, when NYC HRA was found to have engaged in a pattern of arbitrarily reducing hours of personal care services much like some MLTC plans are engaging in now:

Due process demands that decisions regarding entitlements to government benefits be made according to "ascertainable standards" that are applied in a rational and consistent manner ... Perhaps the best evidence of the erratic nature of [NYC HRA's] decision-making is how infrequently its decisions to reduce care are upheld at fair hearings. Ninety-two percent of fair hearings requested involving personal care services result in the agency withdrawing its notice of reduction or being reversed.<sup>43</sup>

While fair hearings are essential to ensure due process before entitlements are reduced, a fair hearing is not enough. The fact that so many members who manage to get to a fair hearing succeed means that the system that led them there is fundamentally flawed in its protection of due process.

Even for those who win their hearing, the threat of reductions inflicts stress and anxiety on extremely vulnerable seniors, people with disabilities, and their families. The constant threat of reductions in hours has a chilling effect on MLTC members' willingness to complain about the quality of care and to request necessary increases in hours. Advocates contributing to this report are aware of clients who are frightened to request increases in hours that they acknowledge they need, for fear that the plan will try to reduce hours they already have.

Also, many who did manage to request a hearing may not have done so in the short 10-day time limit to secure aid continuing and therefore may have suffered a reduction in vital services while awaiting a hearing decision. It was not evident on the face of the decisions whether the members were entitled to and receiving aid continuing. One of our recommendations is to ensure that information regarding aid continuing is contained in hearing decisions going forward. Given the high reversal rate, the risk of depriving any member of aid continuing, requiring that they endure an actual reduction in hours, even if later remedied by the hearing decision, is clearly unwarranted.

Even apart from the harm of an actual reduction in hours from a deprivation of aid continuing, the hearing process also takes its toll. It is extremely burdensome to require these individuals and families to navigate the process of requesting a hearing, obtaining the documents the plan used to make its determination, finding representation, and traveling to the hearing site, which may be far from home. Given this burden, it is particularly disturbing that the MLTC plans simply did not show up for the hearing in 89 of the reported cases. Again, while those members automatically "won," there was nevertheless a high price paid for that win in terms of stress, and, if they did not receive aid continuing, in enduring a wrongful reduction in services while the hearing was pending.

## **Members May Have Entered Unfavorable Settlements, Accepting a Partial Reduction, Without Knowing Their Rights**

In 8.7 percent (92) of all cases that reached a hearing decision, the case was settled by a stipulation in which the plan and the member agreed on a reduced schedule of hours, with the reduction less severe than the plan had originally proposed. See Figure 4. Because the decisions are overly redacted, it is impossible to tell the number of these cases in which the member was *pro se*, or represented by a lay person such as a family member or friend, rather than a lawyer or other professional. Our assumption is that in most of these stipulated cases the member was *pro se*.<sup>44</sup>

Given that 268 (95%) of the 281 decisions issued on the merits reversed proposed reductions based on either procedural defects in the plan's notice, or lack of substantive grounds for the reduction, it is fair to assume that at least 95% of the same notice or substantive defects existed in the 92 cases that were settled. Had these members proceeded to a hearing, even *pro se*, they would have had a substantial likelihood of fully prevailing. Moreover, had the members been represented by a knowledgeable advocate, many would not have settled by agreeing to an unwarranted reduction.

In at least one hearing decision, the DOH Commissioner's designee who issued the final decision *rejected* the settlement that the member and the plan had agreed upon. The plan proposed to reduce the authorized hours from 20 hours per week to six hours per week. The member agreed on a compromise of 18 hours per week at the hearing. While the administrative law judge who presided at that hearing drafted a proposed decision memorializing that settlement agreement, the Commissioner's designee, who is in effect the supervisor of the administrative law judge, examined the transcript and the record and rejected the settlement. The final decision states:

Appellant may well have accepted the offered deal based upon the belief that the Plan's counsel was correct in stating that the Plan was not legally permitted to allot time to "additional findings."

Even if it cannot be known to a certainty that Appellant based her acceptance of the resolution upon such statement of law, the transcript nonetheless demonstrates that there is a danger that this occurred, which offends the notions of due process underlying the Fair Hearing process. Since Counsel's legal contention was incorrect, and was not in [sic] way questioned or even discussed by the Administrative Law Judge, and, furthermore, because the Plan made use of an inadequate Notice and did not appear with evidence sufficient to establish that its determination was correct, the present decision is being issued in place of the draft initially prepared by the Administrative Law Judge.<sup>45</sup>

We agree with the reasoning and holding in this hearing decision, and make recommendations below to correct such due process violations and to prevent them in the future.

### **Accountability for Medicaid Dollars Spent for Diminishing, Inadequate Services and Administrative Burden of Hearings**

Apart from the human cost of the reductions in hours, the cost savings generated by these reductions inures to the benefit of the MLTC plans, which are paid a flat per capita monthly rate under their state contracts. Finding No. 3 shows that the reductions in just seven months of decisions would have reduced total hours provided to the affected members by over 43%. While members prevailed in most hearings, it is likely that the practice of large scale reductions in hours results in significant additional revenue for the plans in the long run to the extent other members do not appeal reductions. As taxpayers, this substantial reduction in services by state contractors raises a concern as to how the State is preventing what amounts to fraud, waste, and abuse of the Medicaid system by plans and ensuring that the plans provide the services for which they are contracted and paid.

The substantial number of hearings in favor of members also raises concerns about the unnecessary financial and administrative burden that is being placed on the fair hearing system by indefensible and undefended home care reductions. For each hearing, the State pays the cost of members' travel to and from the hearing site, and the Office

of Temporary and Disability Assistance has to schedule the hearing. Administrative law judges must take the time to conduct the hearing, and even when there is a default or withdrawal of notice, evaluate the case and then draft and issue a decision.

## RECOMMENDATIONS

As the agency tasked with ensuring that the Medicaid program operates in compliance with the law, DOH is responsible for ensuring that MLTC plans are not illegally reducing home care hours. DOH should exercise its oversight authority to actively monitor MLTC plans and make them accountable for violations of the law.

### **1. DOH should increase its monitoring of plans by collecting and publishing data on the amount of home care services authorized, the extent that plans are reducing home care hours, and the number of appeals and grievances.**

One concern raised in this report is the extent to which certain plans may be eliminating all of their 24-hour or other high-hour cases by reducing hours for their members. DOH has the resources to examine whether the patterns observed in this report are representative of the larger population of MLTC members. For example, are plans that attempted to reduce 24-hour care or other high hours of care during the period of this study now providing services in amounts that meet the needs of all members, including those with high needs?

Monitoring that DOH should be doing includes the following:

#### ***a. Identify How Many More MLTC Members Faced Reductions Than Are Tracked in This Report and Assess Whether the Plans Did Comply and Now Comply with Legal Requirements for the Reductions***

We recommend that DOH examine how many more MLTC members not tracked in this report faced reductions in home care services because they did not appeal, or because their appeals were withdrawn, settled or abandoned and therefore did not result in a hearing

decision. This information can be obtained from the plans as well as from the State Office of Temporary and Disability Assistance (OTDA), which administers the hearings. OTDA can identify how many hearings were requested on MLTC reductions and later withdrawn or abandoned. For each case in the report period, and for reductions going forward, the plans should provide copies of the notices, describe the extent of these reductions (the number of hours before and after the proposed reduction), and state the outcomes of any internal appeals or informal negotiation.

Plans are already required to provide much of this data for people transitioning to MLTC from the counties under the terms of the federal waiver that governs the MLTC program: “For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions.”<sup>46</sup> The data in this report show that the risk of significant reductions in hours impacts not only members newly transitioning to MLTC but all MLTC members. Plans should be required to report these actions.

For the cases identified, DOH should evaluate plans’ compliance with requisite legal and contractual requirements for reducing hours of home care services. Particular attention should be paid to the three plans with the highest number of hearings in this report.

Going forward, DOH should require MLTC plans to regularly report any home care hour reductions, including the previously authorized amount, the reduced amount and the reason for reduction, so that DOH can have the opportunity to identify and address patterns of reductions. This information should be made public.

***b. DOH Should Analyze and Make Public Data on the Number of Members Authorized to Receive Various Ranges of Hours of Home Care, with Changes Over Time, to Ascertain Whether Plans are Meeting the Needs of All Members***

DOH should regularly analyze and publicly report plan-specific home care hour data it receives through the Medicaid Managed Care Operating Reports (MMCOR).<sup>47</sup> Among other data, plans report the number of members for whom they provided personal care services in seven ranges of hours per month, from a low of under 80 hours per month (20 hours/week) to a high of 700 or more hours per month (continuous 24-hour split shift care). Comparing this data for 2014, 2015 and 2016 and ongoing would reveal changes in the ranges of services authorized for the population as a whole, beyond those who appealed reductions at hearings. DOH should analyze these changes on aggregate and plan-specific levels. Under managed care, based on the capitated payments plans receive, the distribution of member hours should produce a bell curve, with most members receiving mid-level amounts of care and fewer members receiving very low or very high amounts of care. This Report shows that had the proposed reductions been implemented, most of the affected members would have received low amounts of care, eradicating the bell curve. Examining the entire MLTC population through the MMCOR data would ascertain whether the same pattern identified in this report, of removing high-hour cases, was evident across the entire population. This data and the analysis of it should be made public.

***c. DOH Should Annually Publish Plan-Specific Data on Appeals and Grievances with Outcomes***

DOH should annually publish plan specific data on plan grievances, internal appeals, external appeals, complaints to DOH, and fair hearings. This information should be broken down by the subject of the appeal, specifying the type of service at issue (e.g., personal care, dental care) as well as the plan action being appealed (e.g., whether the plan denied an increase or proposed to reduce hours of home care). This specificity of issues is not, but should be, included in the

DOH Partnership Reports. Outcomes of the appeals should also be included. Reporting this data would be consistent with what the Department of Financial Services does with commercial insurance plans (see, for example, [http://www.dfs.ny.gov/consumer/health/cg\\_health\\_2014.pdf](http://www.dfs.ny.gov/consumer/health/cg_health_2014.pdf)).

## **2. DOH Should Take Protective Action to Restore Home Care Services That Were Unlawfully Reduced, Including for Members who Agreed to Accept a Reduction, and Ensure Member Rights are Protected in the Future**

Given that 90 percent of decisions rejected the proposed home care reductions as unlawful, or resulted in the plan withdrawing the proposed reduction, there are many people now harmed who either did not appeal, or who accepted reductions not knowing their rights. DOH should take protective action to restore unlawfully reduced services to the prior level for members who failed to appeal, or who accepted a reduction without knowing their rights. Sanctions should be imposed on plans with a pattern of unlawful reductions, whether or not they result in hearing decisions. It is critical that a moratorium on further reductions be imposed for the three plans with a clear pattern of unlawful reductions, and for any other plans which evidence such a pattern. Given the extremely high rate of instances where plans failed to provide members with basic due process rights, DOH should also audit MLTC plans to ensure that notices were provided each time services were reduced or terminated, restoring benefits in any instance where such notice was not provided or was defective.

As discussed above, members may unknowingly enter settlements agreeing to reduce hours without knowing their rights. To correct such errors, we urge DOH to reopen all cases that were decided by stipulation where the number of hours agreed upon was fewer than the number previously authorized by the plan. This includes the 92 cases identified in this Report. The Commissioner should review the notice and record of those cases, and, where the notice fails to meet

the requisite standards, reopen and reverse those decisions and restore services to the amount previously authorized.

To prevent members from entering such stipulations in the future, DOH should instruct administrative law judges to review the validity of plan notices and substantive grounds for reduction in all cases where a stipulation would result in a member receiving fewer hours than initially authorized. Where the plan's proposed reduction is unwarranted or done without proper notice and procedures, the settlement should be rejected and the plan's action reversed, as was done in Hearing No. 7074557N discussed above.

### **3. Hearings Posted to the Online Fair Hearing Archive Should have Less Redaction to Promote State Oversight and Public Accountability**

Currently, fair hearing decisions posted to the hearing archive contain redactions that obscure plan names and other important information that is important for the State and public to ascertain plan compliance.

*Plan names should not be redacted.* Plans are state contractors that are responsible for the provision of medically necessary services to Medicaid recipients in accordance with the Medicaid State Plan. The plans must be accountable for compliance with their contracts, laws and regulations. Findings that plans failed to provide notice at all, or provided only defective notice, or failed to justify a threatened reduction should all be available to the public, and are certainly vital for the State in its monitoring of plans. Unlike members who are entitled to privacy, the plan as a state contractor has no such entitlement. Also, the decision should clearly indicate the type of managed care plan, whether MLTC, mainstream managed care, Medicaid Advantage Plus, etc.

*The number of home care hours previously authorized and as proposed with reduction should not be redacted.* The number of hours in the plan of care does not reveal any confidential information about the

member. These are crucial facts for analysis of the decisions for purposes of plan accountability.

*Decisions should indicate whether a member was represented by counsel or other professional advocate or whether the member appeared pro se.* OTDA and DOH should use this information to monitor how many members are proceeding *pro se*. While the name of the representative may need to be redacted, the fact of whether the member had legal representation should be indicated. This information is critical in order to assess and monitor how MLTC members are able to navigate the appeal process, and to determine whether MLTC plans are taking advantage of *pro se* members by making different settlement offers than they would if members had a legal representative.

*Aid Continuing* -- Decisions should make clear findings on whether a member is entitled to aid continuing, whether aid continuing was ordered by OTDA, and whether aid continuing is actually in place – i.e., whether the plan has continued providing the previously authorized services. This information is important to assessing both plan compliance with aid continuing orders and in evaluating how many members who ultimately prevail at a hearing might have suffered harm due to loss of services pending a hearing decision.

## CONCLUSION

This study of fair hearing outcomes over a seven month period reveals a disturbing pattern on the part of several MLTC plans to arbitrarily reduce the home care services that allow vulnerable individuals to remain safely in the community. It is clear from the data that the plans' efforts to decrease the number of home care hours has been shown to be in all but a few cases not only unjustified, but conducted in a manner that violates federal and state law and regulations. It is equally disturbing that this pattern has been allowed to continue despite DOH's role in overseeing and monitoring the plans' activities.

This pattern of conduct places individuals with chronic illness and disability at great risk for worsening medical conditions. In addition, the loss of services forces individuals to rely on family and friends who go to extraordinary lengths to care for them, often at the expense of their own health, well-being, work obligations, and financial stability. Finally, unwarranted reductions in service threaten members with costly trips to the emergency room and inpatient stays, both of which undercut the State's efforts to reduce avoidable hospitalizations.

MMNY and NY NAELA call on DOH to conduct an analysis of and oversee the activities of the managed care plans, specifically including the plans' reductions in home care hours that take place beyond protected transition periods, and to make this data available to the public.

## APPENDIX: Study Methodology

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Since 2010, NYS OTDA has maintained a public Fair Hearing archive, in which all Fair Hearing decisions are posted, with confidential information redacted. The archive is available at <http://otda.ny.gov/hearings/search/>. This archive is searchable by word or phrase and time period of the decision. The coalitions joining in this report identified this archive as a useful source of public information to examine the actions by MLTC plans statewide in reducing members' home care hours during a specific time period and as a concrete source of data beyond the anecdotal observations of any individual elder law attorney or advocate.

In this project, volunteers searched for all fair hearing decisions which could be identified as involving "managed long term care" plans reducing hours of home care. The time period used was a seven-month period from June 1, 2015 through and including Dec. 31, 2015. Volunteers from the coalitions signed up to search for all decisions from a particular week, and to extract certain information from the decisions, which included:

1. Date of decision
2. Name of plan
3. Details about the reduction:
  - a. Number of hours originally authorized
  - b. Number of hours proposed to be reduced.
  - c. Reason given by the MLTC plan for the reduction, if any indicated in decision
4. The outcome of the hearing – whether:
  - a. Member won -- The authorization remained the same, without any reduction; or
  - b. Plan won - The proposed reduction became effective; or
  - c. A settlement was reached with a compromise on the amount of hours.
5. Where the member won, the type of resolution – whether:

- a. Plan withdrew its own proposed reduction at the hearing, keeping the *status quo*, or
  - b. Written decision was issued by the administrative law judge as designee for the Commissioner of the NYS Department of Health, or
  - c. Parties reached a “stipulation” with a compromise on hours.
6. Where a written decision was rendered in the member’s favor, whether the basis for that decision was:
- a. Defective notice – Notice was untimely (not given 10 days in advance) or inadequate, omitting required elements described above.
  - b. No written notice was provided.
  - c. The plan defaulted – the MLTC did not appear at the hearing at all so did not meet its burden of proof to justify the reduction.
  - d. The plan’s reduction was reversed on the merits, based on a review of the facts and law. Many of these decisions were based both on the merits and on findings that the plan’s notice was defective.
7. Where a written decision was rendered in the plan’s favor, whether the basis of the decision was:
- a. No jurisdiction to hear the appeal, so the plan’s reduction was upheld (e.g., the hearing request was made past the statute of limitations, or, for notices of reduction issued by the MLTC plan prior to July 1, 2015, the member failed to exhaust the internal appeal).
  - b. Plan won on the merits – it met its burden of proof that the proposed reduction was justified.
8. Aid Continuing Status – The study aimed to ascertain how many MLTC members were entitled to and actually received aid continuing, meaning that the proposed reduction in services did not go into effect while the hearing was pending. However, this status could not be ascertained from the face of most fair hearing decisions. Therefore the number of cases where the

reduction actually went into effect while the hearing was pending is not known.

There are four kinds of MLTC plans in New York State: 1) partially capitated plans, in which only certain Medicaid services, including home care, are included in the benefit package; 2) Medicaid Advantage Plus (MAP) plans; 3) Program of All-Inclusive Care for the Elderly (PACE) plans; and Fully Integrated Dual Advantage (FIDA) plans. Members of MAP, PACE and FIDA plans have all of their Medicare and Medicaid services coordinated by the plan. Only partially capitated plans were included in this study, and all references to MLTC herein refer only to partially capitated plans.



## Endnotes

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<sup>1</sup> 18 NYCRR 505.14.

<sup>2</sup> 18 NYCRR 505.28.

<sup>3</sup> Plans must file Quarterly Managed Medicaid Cost and Operating Reports (MMCOR) data with the State Department of Health. See 10 NYCRR § 98-1.16(a)(1)-(3); (b); (c).

<sup>4</sup> 18 NYCRR 505.14.

<sup>5</sup> 18 NYCRR 505.28.

<sup>6</sup> NYS DOH, *2013 Managed Long Term Care Report to the Governor and Legislature* (March 2014) (“NYS DOH 2013 MLTC Report”), p. 13, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/2013-02\\_mltc\\_legislative\\_report.htm](http://www.health.ny.gov/health_care/medicaid/redesign/2013-02_mltc_legislative_report.htm) (last accessed June 13, 2016) (Finding 62.8% of the MLTC population was age 75+ and another 22.3% was between ages 65-75, for a total of 85.1% of the MLTC population age 65+). These demographics are consistent with those found in the New York City personal care population, which later was required to transition to MLTC. Sarah Samis, et. al., United Hospital Fund, *Medicaid Personal Care in New York City: Service Use and Spending Patterns*, Dec. 2010, p. 7, available at <http://www.uhfnyc.org/assets/1365> (last accessed June 13, 2016) (finding 74% of personal care population age 75+ and 26% between ages 65-75).

<sup>7</sup> NYS DOH 2013 MLTC Report, *supra*, at pp. 23-25 (Finding 58% percent of MLTC enrollees had impaired cognitive functioning and 63% were confused in new situations or at various times of day).

<sup>8</sup> Managed Long Term Care plans were first established by the Long-term Care Integration and Finance Act (Chapter 659 of the Laws of 1997), enacting New York Public Health Law § 4403-f. The early history is reviewed in the *DOH New York State Managed Long-Term Care Interim Report to the Governor and Legislature* (May 2003), available at [http://www.health.ny.gov/health\\_care/managed\\_care/mltc/pdf/mltc\\_inter\\_rep.pdf](http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_inter_rep.pdf) (last accessed Apr. 24, 2015), and *DOH NYS Managed Long-Term Care Final Report to the Governor and Legislature* (Mar. 2006), available at [http://www.health.ny.gov/health\\_care/managed\\_care/mltc/pdf/mltc\\_final\\_rep.pdf](http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_final_rep.pdf) (last accessed Apr. 24, 2015). Other voluntary options included the Long Term Home Health Care Program (LTHHCP), also known as the Lombardi program, one of the home-and-community-based waiver programs that are alternatives to fee-for-service personal care services. N.Y. Social Services Law §§ 367-c, 367-e, N.Y. Public Health Law § 3616, 18 N.Y.C.R.R. § 505.21.

<sup>9</sup> NYS DOH Monthly Medicaid Managed Care Enrollment, Jan. 2008, available at [https://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/archives.htm](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/archives.htm) (last accessed Apr. 24, 2016).

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<sup>10</sup> NYS DOH Medicaid Quarterly Reports of Beneficiaries, Expenditures, and Units of Service by Category of Service by Aid Category by Region, CY 2008, available at [http://www.health.ny.gov/statistics/health\\_care/medicaid/quarterly/aid/](http://www.health.ny.gov/statistics/health_care/medicaid/quarterly/aid/) and direct link [http://www.health.ny.gov/statistics/health\\_care/medicaid/quarterly/aid/2008/cy/docs/2008\\_cy\\_aid.xls](http://www.health.ny.gov/statistics/health_care/medicaid/quarterly/aid/2008/cy/docs/2008_cy_aid.xls) (last accessed June 13, 2016).

<sup>11</sup> See 18 N.Y.C.R.R. § 505.14(b).

<sup>12</sup> Establishing the Medicaid Redesign Team, N.Y. Exec. Order No. 5, NY Reg, Feb. 9, 2011 at 82-83.

<sup>13</sup> In 2011, New York Public Health Law section 4403-f was amended to authorize NYS DOH to seek a waiver from the federal Centers for Medicare & Medicaid Services (CMS) to make MLTC enrollment mandatory. CMS granted the waiver in August 2012. See Letter of CMS Administrator to Nirav, Shah, M.D., DOH Commissioner, dated Aug. 31, 2012, posted at [http://www.health.ny.gov/health\\_care/managed\\_care/appextension/docs/cms\\_ward\\_letter.pdf](http://www.health.ny.gov/health_care/managed_care/appextension/docs/cms_ward_letter.pdf), along with CMS “Special Terms & Conditions,” dated August 2012, which govern the waiver, available at [http://www.health.ny.gov/health\\_care/managed\\_care/appextension/docs/special\\_terms\\_and\\_conditions.pdf](http://www.health.ny.gov/health_care/managed_care/appextension/docs/special_terms_and_conditions.pdf). The Special Terms & Conditions have been amended since then, posted at [http://www.health.ny.gov/health\\_care/managed\\_care/appextension/](http://www.health.ny.gov/health_care/managed_care/appextension/).

<sup>14</sup> The original timeline for phasing in MLTC implementation is available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/2012-02-26/mltc\\_enrollment\\_plan.htm](http://www.health.ny.gov/health_care/medicaid/redesign/2012-02-26/mltc_enrollment_plan.htm). Phases IV and V, to expand to upstate counties, were delayed about a year, with all counties mandatory by July 2015.

<sup>15</sup> NYS DOH Monthly Medicaid Managed Care Enrollment Report, Dec. 2015, at [https://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/index.htm](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm), direct link [https://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/2015/docs/en12\\_15.xls](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2015/docs/en12_15.xls) (last accessed Apr 24, 2016).

<sup>16</sup> See definitions of 24-hour live-in care and “continuous” 24-hour (split shift) services at 18 N.Y.C.R.R. § 505.14(a).

<sup>17</sup> *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), modified in part, unpublished Orders (May 20 and 21, 1996); Stipulation & Order of Discontinuance (Nov. 1, 1997) (requirement to prove a reason for changing a previously authorized service stems from the notion that Medicaid services, once authorized as medically necessary, are an entitlement, which cannot be reduced or terminated without due process of law. See *Goldberg v. Kelly*, 397 U.S. 254 (1970). Thus the agency proposing to reduce or terminate a Medicaid service has the burden of proof to show that the recipient is no longer entitled to the service previously authorized.). 18 NYCRR § 358-5.9(a).

<sup>18</sup> *Mayer v. Wing*, 922 F. Supp. at 911.

<sup>19</sup> See 18 N.Y.C.R.R. § 505.14(b)(5)(c)(1)-(10) (“*Mayer* regulation”).

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<sup>20</sup> 18 NYCRR § 505.14(b)(5)(v)(c)(2).

<sup>21</sup> MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), available along with attachments that specify the regulatory changes in 18 N.Y.C.R.R. Part 505.14 and 505.28, effective Dec. 23, 2015, available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/mltc\\_policies.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm) (Last accessed Apr. 24, 2016).

<sup>22</sup> See 18 N.Y.C.R.R. § 360-10.8(a), declaring “Part 358 of this Title is incorporated by reference as if set forth fully herein and is applicable to . . . Medicaid managed care organizations.” Managed long term care plans are a form of health management organization subject to state and federal law and regulations applicable to Medicaid managed care plans. See NY Pub. Health Law § 4403-f, sub. 4 and 5; 42 CFR Part 438. Part 358 also includes Medicaid managed care organizations in its definition of Social Service Agency, stating “Social services agency means the State, county, city, town official or town agency, social services district, HEAP certifying agency or other entity responsible for making the determination or for the failure to act, which is the subject of review at the fair hearing.” 18 NYCRR § 358-2.21.

<sup>23</sup> 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a)(4)(i).

<sup>24</sup> New York State Department of Health, Managed Long Term Care Partial Capitation Contract, App. J, available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrt90\\_partial\\_capitation\\_model.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_model.pdf).

<sup>25</sup> See *Dear Health Plan Administrator* Letter, dated March 2, 2015, from Mark L. Kissinger, Director, NYS DOH Division of Long Term Care, available with notice templates at <http://www.wnylc.com/health/download/579/> and announced in a NYS DOH webinar on April 29, 2015, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/2015-04-29\\_new\\_model\\_initial\\_determination\\_and\\_model\\_action\\_notices.wmv](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-04-29_new_model_initial_determination_and_model_action_notices.wmv) (last accessed March 9, 2016).

<sup>26</sup> See 18 NYCRR § 505.14(b)(5)(v)(c)(2).

<sup>27</sup> See 42 C.F.R. § 431.10 (Medicaid notice requirements generally); 438.404 (Medicaid managed care plans).

<sup>28</sup> Notices from plans prior to July 1, 2015 were required to explain the right to request an internal appeal with the plan, which was required before the member could request a fair hearing. This “exhaustion” requirement was eliminated effective July 1, 2015. See NYS DOH [MLTC Policy 15.03](#): “End of Exhaustion Requirement for MLTC Partial Plan Enrollees,” available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/mltc\\_policies.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm).

<sup>29</sup> See 18 NYCRR 505.14(b)(5)(v)(c)(2)(i)-(ii) (amended Dec. 23, 2015); NYS DOH *Dear Health Plan Administrator* Letter dated Mar. 2, 2015, *supra*, n. 25; and NYS DOH MLTC Policy 15.09, *supra*, n. 21. The amended regulation provides, “The notice must identify the specific change in the client’s medical or mental condition or

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economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change.” 18 NYCRR 505.14(b)(5)(v)(c)(2)(i). The amended regulations require the same detail for mistakes. 18 NYCRR 505.14(b)(5)(v)(c)(2)(ii).

<sup>30</sup> The “transition period” was initially 60 days and was expanded to 90 days. See CMS Special Terms & Conditions August 2012, \p. 17 ¶ 28(d) ; MLTC Policy 13.01 REVISED: *Transition of Care for Fee for Services Participants in Mandatory Counties*, Feb. 6, 2013, available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/mltc\\_policy\\_13-01\\_revised.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-01_revised.htm) (last accessed Apr. 24, 2016) (60-day period); MLTC Policy Guidance 13.10 - *Communication with Recipients Seeking Enrollment and Continuity of Care*, dated May 8, 2013, (90-day transition period), available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/mltc\\_policy\\_13-10.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-10.htm) (last accessed Apr. 24, 2016).

<sup>31</sup>NYS Dept. of Health, *Partnership Plan – Section 1115 Quarterly Report and Annual Report, Demonstration Year 17 (10/1/2014 – 9/30/2015); Federal Fiscal Quarter 4 (7/1/2015 – 9/30/2015)* (“2015 DOH Partnership Plan Report”) (Dec. 21, 2015) at 16, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/2016/partnership\\_plan\\_2015\\_annual\\_rpt.htm](http://www.health.ny.gov/health_care/medicaid/redesign/2016/partnership_plan_2015_annual_rpt.htm) (Last accessed April 21, 2016).

<sup>32</sup> The percent of reduction cases is likely higher as this study only looked at reductions by partially capitated MLTC plans while DOH’s figure of 428 hearings includes MAP and PACE plans as well. *Id.*

<sup>33</sup> Data from NYS DOH Medicaid Managed Care Enrollment Reports, available at [http://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/](http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/).

<sup>34</sup> See, e.g. Michael Birnbaum, et al., *Medicaid Long-Term Care in New York: Variation by Region and County*, United Hospital Fund (2010) available at <http://www.uhfny.org/publications/880719> (last accessed May 6, 2016) (“One-sixth (16 percent) of elderly duals in New York City used nursing home services at some point in the year; in all other regions of the state, twice as many—one-third or more—relied on nursing homes... Eighteen percent of elderly duals in New York City used personal care, compared to a range of 7 percent (Upstate Urban) to 13 percent (Westchester/Rockland) in other regions.”)

<sup>35</sup> M. Birnbaum, *MEDICAID LONG-TERM CARE IN NEW YORK: VARIATION BY REGION AND COUNTY*, United Hospital Fund NY (2010), *supra*, (finding higher rate of use of personal care and other home care services -- and lower rate of nursing home use -- by dual eligibles in New York City compared to many upstate counties; also finding higher average spending per recipient on personal care services in New York City compared to many other counties, explained “principally by differences in the volume of services delivered.” *Id.* at 12.

<sup>36</sup> *2015 DOH Partnership Plan Report, supra*, at 13-14. Presumably some of these internal appeals concerned issues other than home care reductions.

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<sup>37</sup> Of the 1,042 hearing decisions, 20 decisions had key information redacted -- the baseline number of hours previously authorized and/or the number of reduced hours per week proposed by the plan. A before-and-after comparison could not be done in those cases.

<sup>38</sup> Decisions available at [http://otda.ny.gov/fair%20hearing%20images/2015-12/Redacted\\_7120263Y.pdf](http://otda.ny.gov/fair%20hearing%20images/2015-12/Redacted_7120263Y.pdf) and [http://otda.ny.gov/fair%20hearing%20images/2015-10/Redacted\\_7101569J.pdf](http://otda.ny.gov/fair%20hearing%20images/2015-10/Redacted_7101569J.pdf) (last accessed June 13, 2016).

<sup>39</sup> *2015 DOH Partnership Plan Report, supra, at 16*

<sup>40</sup> *Id.*

<sup>41</sup> The *2015 DOH Partnership Plan Report, supra*, also attributes the increase in fair hearings to the to the July 1, 2015 elimination of the requirement that members “exhaust” internal appeals before requesting a hearing. DOH [MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Plan Enrollees](#), dated July 2, 2015, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/mltc\\_policy\\_15-03.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-03.htm), (last accessed May 17, 2016).

<sup>42</sup> *Mayer, supra*, 92 F. Supp. at 912.

<sup>43</sup> *Id.* at 911.

<sup>44</sup> This assumption is backed up by anecdotal information from MLTC members who have reported that they felt pressured to accept a lower number of hours, as well as observations by various advocates who have seen plan attorneys (specifically those representing Senior Health Partners) pressuring members and their family members in the Fair Hearing waiting room, before they have an opportunity to make their case before an administrative law judge.

<sup>45</sup> In Re Hearing No. 7074557N, dated Sept. 22, 2015 (available at [http://otda.ny.gov/fair%20hearing%20images/2015-9/Redacted\\_7074557N.pdf](http://otda.ny.gov/fair%20hearing%20images/2015-9/Redacted_7074557N.pdf)).

<sup>46</sup> CMS Special Terms & Conditions (revised as of Oct. 2015) ¶ 25(d), page 19 available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/2015-10-01\\_1115\\_waiver\\_stcs.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-10-01_1115_waiver_stcs.pdf). This data should be released publicly. However, this data only captures reductions made after the initial transition to MLTC, not on an ongoing basis.

<sup>47</sup> See note 3, 10 NYCRR § 98-1.16(a)(1)-(3); (b); (c).