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STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
09 DHR 6765

Association for Home and Hospice Care of North Carolina Inc. Petitioner vs. Division of Medical Assistance North Carolina Department of Health and Human Services Respondent	**ORDER ON PRELIMINARY INJUNCTION**

THIS MATTER comes before the Honorable Donald W. Overby, Administrative Law judge presiding, for consideration of the Petitioner's Motion to Enjoin Contested Action pursuant to North Carolina Rules of Civil Procedure, Rule 65, and N. C. Gen. stat §150B-33(b) and filed in the Office of Administrative Hearings on December 22, 2009; and the Court having considered Petitioner's motion and accompanying documents, Respondent's responses thereto, and the evidence presented in hearing this motion conducted on January 20, 22, and 28, 2010, finds as follows:

Petitioner seeks to enjoin Respondent from: 1) conducting or having its contractor conduct PACT Form Reviews of all current recipients of personal care services (PCS) to determine eligibility; 2) making new determinations concerning the number of hours of PCS; 3) applying the "new" PACT Form Review methodology to making decisions concerning eligibility for PCS; and 4) applying the "new" PACT Form Review methodology to making decisions concerning the number of hours of PCS a recipient may receive.

Session Law 2009-451, more commonly referred to as the "Budget Bill," is the genesis of the issues in this contested case. In Section 10.68A.(a) of the budget bill, the Respondent is given a number of "actions" from which to choose in order to "achieve the budget reductions

enacted . . . for the Medicaid program." Section 10.68A.(a)(3) specifically addresses delivery of the personal care services (PCS) hours at issue.

The underlying question is exactly what is the Respondent being asked to do; what, if any, does the General Assembly mandate of the Respondent? The answer to those questions, broadly speaking, is to achieve the cuts in the budget as directed by the General Assembly. The question then becomes the method by which those budget cuts are to be achieved.

The *de facto* force driving this contested case is money. In responding to the General Assembly's mandate to reduce the budget, Respondent focuses on how much money can be saved in administering the Medicaid program, specifically in the area of delivery of personal care services. Respondent does not favor the current method, especially the time guidance system for allocation of PCS hours, in that it gives too much latitude and/or authority to providers, with little or no accountability or oversight. It, therefore, is seeking an effective method to change the current way of conducting business while achieving the desired costs reduction. Thus is born the PACT Form Review process.

In trying to develop an appropriate remedy, the Respondent has been focused on money. Even in attempting to spur this Court to making a decision on the injunctive relief sought by Petitioner, the Respondent's request was couched in terms implying how much money the State spends while this action is pending. Dr. Craigan Gray, Director of Division of Medical Assistance, even stated that he is bound to follow the law only so long as his agency has the money. While recognizing that money is a finite resource for the State through the budgetary process, this pronouncement is troubling in that the State surely cannot and would not tolerate such a position by its corporate and individual citizenry. Additionally, we must recognize and give credence to the fact that the General Assembly enacts laws with knowledge and

understanding of the ramifications of each such enactment. As such, the agency is mandated to follow the law as written, with a like mandate to find the money to make the law work. No agency in the State has legislative power or the ability to ignore the law although each agency has some discretion in how to accomplish the enacted laws, including the budget. To hold otherwise is to give the State's agencies unbridled authority, beyond the rule of law, which usurps our constitutional form of government with its three independent branches.

One method by which the Respondent may be able to accomplish its goal is to find ways to stop the perceived abuses and misuse of the funds dedicated to delivery of these services, a worthwhile objective which should be the standard across the entirety of State government. Utilization review is a legitimate tool for identifying, at least in part, some of the abuses and misuse of funds. At this juncture, it cannot be determined if stopping the abuses and misuse of funds will accomplish the overall objective of the desired budget cuts.

Assuming that plugging the holes of abuse and misuse of PCS funds does not achieve the General Assembly's mandated reduction in funds, how then does the Respondent achieve the desired results? Is it by an "automatic" reduction in hours? Is it "target" specific; i.e. by achieving an average "target" number of hours to be allocated, or a "target" amount of money to be spent? If so, does the new process account for "medical necessity" and at what costs to the individual recipient? These are the rhetorical questions the Respondent is called upon to answer.

Section 10.68A.(a)(3) of the budget bill clearly establishes a two step process for Respondent to follow in attempting to achieve budget reductions: 1) attempt to achieve budget reductions by the changes set out in this section, and 2) further modify policy in the event that the revised policy as stated within that section has not attained "sufficient reduction in cost". The language of the section is clear. The policy and procedure as set forth in the section must be

attempted and the desired results not achieved before DMA has any discretion to attempt any further changes in policy. Nothing within the language of the budget bill obviates the necessity to follow the established practice for modifying policy. To the contrary, Section 10.68A.(c) establishes what steps must be followed in order to adopt new or amend existing medical coverage policies.

As evidenced by the eloquent presentations of both parties, the language of Section 10.68A.(a)(3)(b) is ambiguous. Petitioner contends that the language provides that only a physician from Community Care of North Carolina (CCNC) is to conduct an independent assessment or review. Respondent contends that an unnamed agency may conduct an independent assessment, or, in the alternative, CCNC may conduct a review. Respondent contends that CCNC withdrew from seeking to contract with DMA for providing the independent assessment; however, that position is not supported by the documentary evidence. The language of the statute is not inconsistent with Respondent contracting with Carolinas Center for Medical Excellence (CCME), or anyone else, to perform the independent assessments. To the degree that Respondent's contract with CCME affects the issues sought to be enjoined, such is not improper.

To accomplish the established goals and mandates of the budget bill, the *de jure* force driving the delivery of PCS services cannot be ignored—medical necessity. Medical necessity must be the bedrock upon which delivery of PCS services is built, and any system of over-sight of those services must have medical necessity as its foundation. In this case, Respondent has acknowledged that PACT Form Review is indeed driven by budgetary concerns, but that the process is based upon individual determination of medial necessity. However, at the same time, Dr. Larry Nason, Section Chief of Facility and Community Care with DMA, states that medical

necessity is a "billing" issue for DMA, not a "medical" issue. Such rationalization focuses on the money aspect of Medicaid and ignores the faces, and plights, of individual recipients and their medical needs.

PACT Form Review was developed by Respondent as a process, a methodology, in part to stop the abuses of PCS services and thereby to save the State money. But for the mandate to achieve the budget reductions and the accompanying change of the oversight of the delivery of PCS services, the PACT Form Review at issue herein would not have been developed, at least not at this time.

Respondent contends that PACT Form Review is "utilization review." The budget bill did not change the basic qualifying criteria. To the degree that PACT Form Review has identified recipients of PCS hours who do not meet minimum requirements for qualification, such review is a valid "utilization review." This includes those recipients who have been identified as not having two qualifying activities of daily living (ADL's), or no certifying Doctor's signature ordering the service, or no certifying nurse's signature, and the like. As of January 2010, PACT Form Review has identified in excess of 3,000 recipients who do not meet the minimum requirements for PCS. In this case, Petitioner is not likely to prevail in a hearing on the merits as limited to this particular aspect of PACT Form Review as being utilization review.

PACT Form Review also has as a portion of the process a "scoring algorithm" or a scoring methodology which determines the number of hours of PCS services a recipient will receive. In this case, there is a likelihood that Petitioner will succeed on the issues of (1) whether the scoring algorithm and process by which a recipient's PCS hours will be established

constitutes a significant change in agency policy, and (2) whether those procedures for changing policy have not been followed.

This Court finds and concludes as a matter of law that Petitioner has standing to bring this action.

This Court finds and concludes as a matter of law that Petitioner's members will suffer irreparable harm if the actions set forth below are not enjoined.

NOW, therefore it is hereby **ORDERED** as follows:

1. The PACT Form Reviews which have determined that as of January 2010, 3030 individual recipients have not met minimum eligibility for PCS hours is pursuant to valid utilization review and the restraints applying only to those recipients are hereby rescinded. Recipients who have been properly identified since January 2010 as not meeting minimum requirements to receive PCS hours are likewise not enjoined. Respondent may send the proper notices to those recipients and/or their care-givers and pursue appropriate remedies, including but not limited to plans for correction and terminations. It is recommended that Respondent adopt the mediation model established in Session Law 2008-118 for handling other Medicaid cases, especially community support hours, which has proven to be a cost effective method of handling such cases and will save the State additional funds.

2. Pending full adjudication on the merits, Respondent, its agent or contractor, is hereby enjoined from using the "scoring algorithm" and/or any other methodology to assign particular PCS hours to the individual recipients.

3. Pending full adjudication on the merits, Respondent, its agent or contractor, is hereby enjoined from using the requirement for prior authorization of services as a condition for

payment for PCS hours as established in the North Carolina Medicaid Bulletin dated January 2010.

4. All other issues set forth in the petition for contested case are reserved for adjudication on the merits.

5. Petitioner is hereby required to submit a surety bond in the amount of $100,000.00 (one hundred thousand dollars), payable within thirty (30) days of the date of this order. The Court reserves the right to modify this bond on motion of either party, and after both parties have opportunity to be heard.

This the 19th day of February, 2010.

Donald W. Overby
Administrative Law Judge

A copy of the foregoing was mailed to:

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This the 19th day of February, 2010.

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