STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 15, 2017
[redacted]
AGENCY: MAP
FH #: 7534155J

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on June 14, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the May 11, 2017, determination of the Managed Long Term Care Plan, Centers Plan for Healthy Living to reduce the Appellant's Personal Care Services from 84 hours per week to 59.5 hours per week, correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 44, has been in receipt of Medical Assistance benefits and is enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living ("Centers Plan").

2. The Appellant has been in receipt of personal care services in the amount of 56

hours per week.

3. On April 21, 2017, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report and Plan Client Tasking Tool of the Appellant's personal care needs.

4. By "Initial Adverse Determination" notice dated May 11, 2017, Centers Plan advised the Appellant of its determination to reduce the Appellant's personal care services from 56 hours per week to 42 hours per week on the grounds that "the health care service is not medically necessary."

5. On May 115, 2017, this fair hearing was requested.

APPLICABLE LAW

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides in part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides in part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

MLTC Policy 15.03 advised that for all MLTC partial capitation plan decisions made on or after July 1, 2015, that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately.

This change in policy has the following effects:
1) enrollees are no longer required to exhaust their plan's internal appeals processes before obtaining a State fair hearing;
2) aid-continuing is no longer available if the enrollee asks only for an internal appeal of a plan's proposed reduction or discontinuance of services and does not also timely request a State fair hearing;
3) to obtain aid-continuing, enrollees must request a State fair hearing within 10 days of the date of the Managed Long Term Care Action Taken notice;
4) enrollees do not need to specifically request aid-continuing to obtain it, but they may tell OTDA that they specifically decline it; and
5) the 60 day deadline to request a State fair hearing begins on the date of the Managed Long Term Care Action Taken notice.

Section 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. **The notice must explain** the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) **The reasons for the action**...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.
[18 NYCRR § 505.14(a)(1)

GIS message GIS 96 MA/019 advises of a federal court decision that applies to social services districts' reductions or discontinuations of personal care services. [Mayer et al. v. Wing, (S.D.N.Y.)] In general, the Mayer decision holds that a social services district must have a legitimate reason to reduce or discontinue a recipient's personal care services. Before reducing or discontinuing personal care services, the district must individually assess the recipient to determine whether the reduction or discontinuance is justified by State law or Department regulation. A social services district cannot reduce or discontinue a recipient's personal care services arbitrarily, capriciously or as part of a blanket, across-the-board reduction or discontinuance of services that does not consider each individual recipient's particular circumstances. This general principle is entirely consistent with the Department's policy.

The social services district must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services on forms required by the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements outlined in Part 358 of this Title. 18 NYCRR 505.14(b)(5)(v)(b)

The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice. Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;

(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;

(iii) the client is not self-directing and has no one to assume those responsibilities;

(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

(v) the client refused to cooperate in the required assessment;

(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

(2) Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or 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;

(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

(iii) the client refused to cooperate in the required reassessment;

(iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(b)

The Department's Managed Care Personal Care Services Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service

in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;
ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
iii. that are authorized for the new authorization period; and
iv. the original authorization period and the new authorization period, as applicable.

All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice

Reasons to deny personal care services must be reflected in the notices and include but are not limited to: :

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;
(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
(iii) the client is not self-directing and has no one to assume those responsibilities;
(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's

scope of practice;
(v) the client refused to cooperate in the required assessment;
(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming 18 NYCRR 505.14(b)(5)(v)(c)(1)

Reasons to reduce or discontinue personal care services must be reflected in the notices and include but are not limited to: :

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or 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;
(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;
(iii) the client refused to cooperate in the required reassessment;
(iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(c)(2)

Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively. 18 NYCRR § 505.14(a)(3)(iii)(a)

Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings. 18 NYCRR § 505.14(a)(5)

The purpose of GIS message GIS 03 MA/003 is to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies.

Social services districts, including those using locally developed task based assessment (TBA) instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patient's appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 N.Y.C.R.R.§ 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

When the district, in accordance with 505.14 (a)(4), has determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed**.**

Completion of accurate and comprehensive assessments are essential to safe and adequate care plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

The Department's personal care services managed care guidelines dated May 2013 advise that Managed Care Organizations should authorize some or total assistance with the recognized medically necessary personal care services tasks. Allotment of time separate and apart from the personal care tasks authorized is not required for safety monitoring. However, there is a clear and legitimate distinction between safety monitoring as a non-required stand alone function while no PCS is being provided and the appropriate level of safety monitoring while the enrollee is receiving assistance with PCS tasks such as transferring, toileting, or walking. As an example, if a member requires assistance with getting in and out of the tub and also has a condition that limits the ability to discern temperature the PCS worker would monitor the water temperature for the member as a safety measure. As another example, if a member requires assistance with walking, the PCS worker takes appropriate measures to guard the member's safety while assisting the member with the task of walking. These are but two examples of the appropriate safety monitoring that must be provided to assure that the particular Level I or Level II task is safely completed. Safety monitoring under PCS does not, however, include monitoring an individual with dementia, for example, when no other Level I or Level II personal care services task is being provided, to assure that the individual a does not wander away from home or engage in unsafe behavior. This type of safety monitoring is covered as a discrete service in the Nursing Home Transition and Diversion Waiver.

Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. [18 NYCRR § 505.14(a)(2)]

Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose

need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. [18 NYCRR § 505.14(a)(4)]

The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24 hour personal care, including continuous personal care services, live-in 24 hour personal care services or the equivalent provided by formal services or informal caregivers. 18 NYCRR 505.14(d)

The Department's managed care personal care services guidelines dated May 2013 advise that the MCO may not authorize or reauthorize personal care services based upon a *task-based* assessment when the member has been determined by the MCO to be in need of 24 hour personal care services, including continuous (split-shift or multi-shift) care, 24 hour live-in care or the equivalent provided by a formal or informal caregivers. The determination of the need for 24 hour personal care, including continuous (split-shift or multi-shift) care, shall be made without regard to the availability of formal or informal caregivers to assist in the provision of such care.

MLTC Policy memo 13.09(a): Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York, dated September 24, 2013 reminds Plans of MLTC Policy 13.09: Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York which in turn indicates that effective October 1, 2013, the Uniform Assessment System for New York (UANSY-NY) will replace the Semi-Annual Assessment of Members (SAAM). As per the statewide implementation plan, Plans must use the UANSY-NY for all new members who are scheduled to enroll effective October 1, 2013; the SAAM assessment must not be used for these new enrollees. Additionally, the UANSY-NY must be used for all reassessments beginning October 1, 2013.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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I. **Scope of the Personal Care Benefit**

a. As required by federal regulations, the personal care services benefit afforded to MCO enrollees must be furnished in an amount, duration, and scope that is no less than the services furnished to Medicaid fee-for-service recipients.[42 CFR §438.210]…

i. The assessment process should evaluate and document when and to what degree the member requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may

> occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the member's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b).

DISCUSSION

The credible evidence establishes that the Appellant, age 44, is in receipt of Medical Assistance authorization and enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living ("Centers Plan") and has been in receipt of a Personal Care Services authorization in the amount of 56 hours per week. The credible evidence further establishes that by Initial Adverse Determination dated May 11, 2017, the plan determined to reduce the Appellant's Personal Care Services authorization from 56 hours per week to 42 hours per week on the grounds that that the health care services was not medically necessary.

In this present case, the May 11, 2017, Notice of Initial Adverse Determination stated in relevant part, "The UAS-NY comprehensive assessment outcome produces a Nursing Facility Leve of Care (NFLOC) Score. The UAS-NY assessment performed on 4/21/2017 showed NFLOC score of 21. The current UAS-NY assessment and the plan's client tasking tool showed that you need six (6) hours a day/seven (7) days a week total of forty-to (42) hours a week of Personal Care Aide (PCA) services to complete the above tasks. Pursuant the New York State Department of Health Continuity of Care Policy (Managed Long Term Care Policy 13.13) you have been receiving eight (8) hours a day/seven (7) days a week total fifty-six (56) hours a week

as a continuity of your pre-existing Personal Care Aide (PCA) service plan prior to your enrollment to Centers Plan for Healthy Living on 02/01/2017. These services have been in effect for at least 90 days or until 05/23/2017. Therefore, based on the UAS-NY comprehensive assessment conducted on 04/21/2017, your Level II Personal Care Aide service (PCA) of eight (8) hours a day/ seven (7) days a week, total of fifty-six (56) will be decreased to Level II Personal Care Aide service, six (6) hours a day/ seven (7) days a week, total of forty-two (42) hours a week of PCA service effective 05/28/2017."

The Managed Long Term Care Personal care guidelines have advised in relevant part that a denial, or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

A review of the April 30, 2017 UANSY establishes that it noted that in meal preparation and ordinary housework the Appellant has "Total Dependence" in others in completing these tasks and does not participate in these tasks at all. In managing finance and bed mobility Appellant requires the "Extensive Assistance" of others were the Appellant needs physical help to compete these tasks. In managing medication and eating, Appellant only requires set-up assistance. With stairs, shopping, transportation, bathing, dressing lower body, walking, locomotion, transfer toilet, toilet use Appellant requires "Maximal Assistance" where Appellant needs physical help to complete most of these tasks, however, Appellant can complete some parts of the task herself.

With personal hygiene and dressing upper body Appellant required "Limited Assistance". While the UANSY reported that there had been no falls and hospitalizations, in 90 days it concluded that "No Change" in "ADL status as compared to 90 days ago, or since last assessment if less than 90 days", and "No Change" in "Overall self-sufficiency has changed significantly as compared to status 90 days ago, or since last assessment if less than 90 days."

Section F Comments states: "Member with spinal surgery in 2010. Member needs maximum assistance with lower extremities, limited assistance with upper extremities. Member ambulates always with a rollator indoors and outdoors. Member takes medications independently."

At the hearing, the Appellant stated that she needs the hours she is currently receiving to remain the same because her aide cooks, cleans, washes and picks up her medication. Appellant stated that her aide helps her with ambulation and accompanies her to doctors' appointments for the treatment of her diabetes, hypertension, heart disease and kidney failure. It is noted that the Appellant's aide was not present at this fair hearing.

Review of the documentation and testimony submitted at the hearing, finds that Centers Plan's reduction Appellant's personal service hours on the grounds of not medically necessary of is not correct. The regulations pertaining to personal care services require that all notices must

reflect the reasons for reduction, of a personal care services. Appropriate reasons for reducing personal care services include but are not limited to: the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously. Centers Plan's notice did not include evidence of the Appellant's medical, mental, economic or social circumstances that had changed to warrant a reduction of her hours. Rather, the only fact that had changed was that Appellant had transferred from a pre-existing Personal Care Aide (PCA) service plan to enrollment to Centers Plan for Healthy Living on 02/01/2017.

For the foregoing reasons, the May 11, 2017, determination by the Appellant's Managed Long Term Care plan, Centers Plan, to reduce the Appellant's Personal Care Services authorization from 56 hours per week to 42 hours is not correct and cannot be sustained. However, since review of the Client Task Plan/PCA Level II that was adduced at the hearing established that Appellant is totally dependent in only two areas of her activities of daily living and requires assistance in some, Center Plan is directed to authorize 45 hours a week in personal care services for the Appellant.

DECISION AND ORDER

The May 11, 2017 determination by the Centers Plan, to reduce the Appellant's Personal Care Services authorization from 56 hours per week to 42 hours per week is not correct and is reversed.

1. The Managed Long Term Care Plan, Centers Plan, is directed to immediately authorize the Appellant's Personal Care Services authorization to the amount of 45 hours per week and to take no further action upon the May 11, 2017, Initial Adverse Determination.

2. The Managed Long Term Care Plan, Centers Plan, is directed to provide the Appellant with a Personal Care Services authorization in the amount of 45 hours weekly.

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

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

DATED: Albany, New York
07/28/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee