STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 28, 2018
[redacted]
AGENCY: Nassau
FH #: 7729009J

In the Matter of the Appeal of

[redacted]

from a determination by the Nassau County 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 11, 2018, in Nassau County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan

On papers only – Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, dated March 21, 2018, to reduce the Appellant's Personal Care Services authorization from 77 hours per week (11 hours per day 7 days per week) to 52.5 hours per week (7.5 hours per day 7 days per week) correct?

FACT FINDINGS

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

1. Since December 1, 2017, the Appellant, age 84, has been enrolled in a Medicaid Managed Long Term Care Plan through Centers Plan for Healthy Living (hereinafter, the "Plan") and, through the Plan, has been in receipt of a Personal Care Services (hereinafter, "PCS") authorization of 77 hours per week (11 hours per day 7 days per week).

2. On February 1, 2018, the Plan's nurse completed a routine assessment of the Appellant.

3. Based on such assessment, by Initial Adverse Determination dated March 21, 2018, the Plan determined to reduce the Appellant's PCS authorization, effective April 1, 2018, from 77 hours per week (11 hours per day 7 days per week) to 52.5 hours per week (7.5 hours per day 7 days per week) reasoning as follows:

"…The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool…You have been enrolled with [the Plan] since 12/1/2017 and have been receiving the following service Level 2 Personal Care Aide (PCA) services eleven (11) hours per day, seven (7) days per week (Totaling seventy-seven (77) hours per week) for 120 days as a Continuity of Care of your pre-existing service plan…A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted by [the Plan] on 2/1/2018 as your 120 days Continuity of Care is ending 3/31/2018. This assessment showed that you have demonstrated the following in your abilities to perform your Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)…The current UAS-NY assessment conducted on 2/1/2018 demonstrated that your needs can be effectively met with seven seven-and-a-half (7.5) hours per day, seven (7) days per week (Totaling fifty-two and a half (52.5) hours per week) of (Personal Care Aide (PCA)) Services to complete the above-mentioned tasks…"

4. On March 28, 2018, 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 pertinent part:

> (a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:
>
> > (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
> >
> > (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

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

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

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

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(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 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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through

subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

GIS 01 MA/044 reminds districts that regulations provide that a determination to reduce, discontinue or deny a client's prior authorization must be stated in the client notice. The regulations set forth several examples of appropriate reasons and notice language to be used when reducing, discontinuing or denying services. [18 NYCRR 505.14(b)(5)(v)(c)(1)-(10)].

For example, the new regulations provide that one reason for reducing or discontinuing personal care services is "the client's medical, mental, 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 than they were previously" [18 NYCRR 505.14 (b)(5)(v)(c)(1)]. Consistent with the Court ruling in Mayer, the State requires that client notices citing this reason for reducing or discontinuing services must identify the specific medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction or discontinuation in services. The client notice must explain why the change in the client's circumstances results in the need for fewer hours of services.

Plans are reminded that State policy, as reflected in the new regulations, requires that when Plans determine to reduce, discontinue or deny personal care services, the client notice must identify the specific reason (whether a prior mistake in the authorization, the client's refusal to cooperate with the required assessment or other specific reason set forth in the regulations) that justifies the action. The client notice must also explain why the cited circumstance or event necessitates the reduction, discontinuance or denial of services.

In addition to clarifying requirements for client notices under Mayer, the Department's new regulations also reflect a Court ruling in Mayer regarding the use of task based assessments [18 NYCRR 505.14(b)(5)(v)(d)]. Specifically, social services districts are prohibited from using task-based assessments when authorizing or reauthorizing personal care services for any recipient whom the district has determined needs 24 hour care, including continuous 24 hour services (split-shift), 24 hour live-in services or the equivalent provided by a combination of formal and informal supports or caregivers. In addition, the district's determination whether the recipient needs such 24 hour personal care must be made without regard to the availability of formal or informal supports or caregivers to assist in the provision of such care. For a further explanation of this requirement, districts should consult GIS message 97 MA/033, issued on November 26, 1997.

Federal Regulations (Title 42) state, in pertinent part:

§ 438.210 Coverage and authorization of services.

(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 § 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…

(c) ***Notice of adverse action***. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

(d) ***Timeframe for decisions.*** Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established

timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.*

(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

§438.404 Notice of action.

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

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

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

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) ***Timing of notice.*** The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

§431.211 Advance notice.
The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

§431.213 Exceptions from advance notice.
The agency may send a notice not later than the date of action if—
(a) The agency has factual information confirming the death of a beneficiary;
(b) The agency receives a clear written statement signed by a beneficiary that—
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;
(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);
(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the beneficiary's physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

§431.214 Notice in cases of probable fraud.
The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and
(b) The facts have been verified, if possible, through secondary sources.

18 NYCRR 360-10.8(e)(2)(i)(f)(11) provides, in part, that:

(e) Notices
…
(2) An MMCO or its management contractor shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing in a manner and form determined by the department whenever a notice of action is issued. For the purposes of this paragraph, *MMCO* means an HMO, PHSP or HIV SNP. A notice of action that sets forth all of the information

required by subparagraph (i) of this paragraph will be considered an adequate notice for the purposes of section 358-2.2 of this Title.

(i) The notice of action shall include:

…

(f) the enrollee's right to a fair hearing and the procedures for exercising this right, including:

…

(11) if an MMCO or its management contractor has determined to reduce, suspend, or terminate a service or benefit currently authorized: the circumstances under which the enrollee's benefits will be continued unchanged; how to request that benefits be continued; explanation that a request for an MMCO appeal is not a request for the enrollee to have benefits continue; and the circumstances under which the enrollee may be required to pay the costs of continued services. Such notice shall be issued within the timeframes required by federal regulations at 42 CFR 438.404(c)(1) and sections 358-2.23, 358-3.3(a)(1), and 358-3.3(d)(1) of this Title.

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for a Public Assistance or Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Public Assistance or Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Public Assistance or Medical Assistance in another district.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;

- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;
- when the agency action or proposed action is a reduction, discontinuance, restriction or suspension of public assistance, medical assistance, SNAP benefits or services, the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued; that a fair hearing must be requested separately from a conference; and a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services; and that participation in an agency conference does not affect the right to request a fair hearing;
- a statement that a fair hearing must be requested separately from a conference;
- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services;
- a statement that participation in an agency conference does not affect the right to request a fair hearing;
- the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;
- an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;
- the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;

- the right to present written and oral evidence at the hearing;

- the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;

- information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and

- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

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). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Policy Guidance document entitled “MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services” issued on November 17, 2016 by the Department of Health Office of Health Insurance Programs states:

On December 30, 2015, the Department notified all managed long term care (“MLTC”) plans of recent changes to the Department’s regulations governing personal care services (“PCS”) and consumer directed personal assistance (“CDPAS”), including revised regulatory provisions governing notices that deny PCS or CDPAS or propose to reduce or discontinue PCS or CDPAS. (See MLTC Policy 15.09 at http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm.).

The purpose of this directive is to provide further guidance to MLTC plans concerning appropriate reasons and notice language to be used when proposing to reduce or discontinue PCS or CDPAS. In particular, it addresses notices that propose to reduce or discontinue PCS or

CDPAS for either of the following reasons: a change in the enrollee's medical or mental condition or social circumstances; or a mistake that occurred in the previous authorization or reauthorization.

A MLTC plan may not reduce or discontinue an enrollee's PCS or CDPAS unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi), for PCS, and 18 NYCRR §§ 505.28(h)(5)(ii)(a) through (f), for CDPAS. Two such examples are discussed in greater detail below. The MLTC plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering the facts of the individual enrollee's circumstances and thus cannot reduce services as part of an "across-the-board" action that does not consider each individual enrollee's particular circumstances and need for assistance.

The general purpose of these requirements is to assure that the plan's notice accurately advises the enrollee, in plain comprehensible language, *what* the plan is proposing to change with regard to the enrollee's PCS or CDPAS and *why* the plan is proposing to make that change. The more specificity the plan's notice provides with regard to the specific change in the enrollee's services, the reason for the change, and why the prior services are no longer needed, the better able the plan will be to defend its proposed reduction or discontinuance at any fair hearing, at which the plan bears the burden of proof to support its proposed action (i.e. the plan must establish that its proposed reduction or discontinuance is correct).

A. Change in Enrollee's Medical or Mental Condition or Social Circumstances

In such a case, the Plan's notice must indicate:

- The enrollee's medical or mental condition or social circumstances have changed and the plan determines that the services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. If the reason for the proposed reduction or discontinuance is a change in one or more such conditions or circumstances, the plan's notice must not simply recite the underlined language in the previous sentence, which would impermissibly make it the enrollee's responsibility to figure out which particular condition or circumstance had changed. Such boilerplate recitations are inadequate. Instead, the plan's notice must:

  1) state the enrollee's particular condition or circumstance - whether medical condition, mental condition, or social circumstance – that has changed since the last assessment or authorization;
  2) identify the specific change that has occurred in that particular medical or mental condition or social circumstance since the last assessment or authorization; and
  3) state why the services should be reduced or discontinued as a result of that change in the enrollee's medical or mental condition or social circumstances.

  Example of a change in medical condition: The plan authorized an enrollee for personal care services. At the time of the assessment, the enrollee was recuperating from hip

replacement surgery. As the enrollee recovered from her surgery, her medical condition improved. Specifically, the enrollee's hip has now healed sufficiently that she is now able to walk 30 feet alone. The physician's order documented this improvement in her medical condition. Due to the improvement in her medical condition, she no longer needs the previously authorized level and amount of assistance with personal care services. Accordingly, the enrollee no longer needs help ambulating inside her apartment.

Example of a change in social circumstances: The plan had authorized an enrollee for Level II personal care services, support with dressing. At the time of the initial authorization, the enrollee lived in her longtime residence with no family or friends who could help dress and undress. Her sister then moved next door and agreed to help with this task. Due to the change in the enrollee's social supports, she no longer needs the previously authorized amount of assistance for dressing and undressing.

B. Mistake

In such a case, the Plan's notice must indicate:

- A mistake occurred in the previous PCS or CDPAS authorization or reauthorization. The plan's notice must identify the specific mistake that occurred in the previous assessment or reauthorization and explain why the prior services are not needed as a result of the mistake.

  Plans must adhere to the following guidelines when proposing to reduce or discontinue services based on a mistake that occurred in the previous assessment or reassessment:

  1) A mistake in a prior authorization or reauthorization is a material error that occurred when the prior authorization was made. An error is a material error when it affected the PCS or CDPAS that were authorized at that time.

  Example of a mistake: The plan authorized, among other services, assistance with the Level I task of doing the enrollee's laundry. This authorization, however, was based on an erroneous understanding that the enrollee's apartment building did not have laundry facilities and that the aide would need to go off-site to do the enrollee's laundry. During a subsequent assessment, it was determined that the aide did, in fact, have access to a washer and dryer in the basement of the enrollee's apartment building. The plan thus proposed to reduce the time needed for the aide to perform the enrollee's laundry to correct the prior mistake and reflect that less time is needed to complete this task than was previously thought.

  2) This particular reason for reducing or discontinuing services is intended to allow an MLTC to rectify a material error made in a previous authorization for a particular enrollee. It must not be expanded beyond that narrow application or otherwise used as a

reason to reduce services across-the-board or reduce services for a particular enrollee without a legitimate reason as described in this policy directive. For example:

-A MLTC plan must not implement a new task-based assessment tool that contains time or frequency guidelines for tasks that are lower than the time or frequency guidelines that were contained in the plan's previous task-based assessment tool, and then reduce services to an individual or across-the-board on the basis that a "mistake" occurred in the previous authorization.

-A MLTC plan must not reduce services when implementing a new task-based assessment tool, if those services were properly contained in the former task-based assessment tool, on the basis that a "mistake" occurred in the previous authorization.

3) A prior authorization for PCS or CDPAS is *not* a mistake if it was based on the UAS-NY assessment that was conducted at that time but, based on the subsequent UAS-NY assessment, the enrollee is determined to need fewer hours of PCS or CDPAS than were previously authorized. In such a case, a subsequent assessment might support the plan's determination to reduce or discontinue services for one of the reasons enumerated in NYCRR §§ 505.14(b)(5)(v)(c)(2)(i)-(vi) for PCS and 18 NYCRR §§ 505.28(h)(5)(ii)(a)-(f) for CDPAS.

For example:

-There has been an improvement in the enrollee's medical condition since the prior authorization. In such a case, the MLTC plan's notice must identify the specific improvement in the enrollee's medical condition and explain why the prior services should be reduced as a result of that change, as set forth above.

Plans are reminded that enrollees are entitled to timely (i.e. 10 day prior notice) and adequate notice whenever plans propose to reduce or discontinue PCS or CDPAS or other services. All partially capitated plans must also use the State-mandated fair hearing notices. In additions, plans must comply promptly with all aid-continuing directives issued by the NYS Office of Temporary and Disability Assistance.

MLTC Policy 16.06 (November 17, 2016).

Policy Guidance document entitled "MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services" issued on November 17, 2016 by the Department of Health Office of Health Insurance Programs states, in pertinent part:

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.

If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance. [Emphasis added]

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring, supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates. [Emphasis added].

  NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

  Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such

cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.

- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link …

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTC Policy 16.07 (November 17, 2016).

Policy Guidance document entitled "Managed Long Term Care Policy 17.02: MLTC Plan Transition Process – MLTC Market Alteration" states, in pertinent part:

Effective immediately, the Department is establishing a process applicable to Managed Long Term Care (MLTC) enrollees in Partially Capitated, Programs of the All-Inclusive Care for the

Elderly (PACE), and Medicaid Advantage Plus (MAP) plans who are required to involuntarily transition from one MLTC plan to another MLTC plan, as the result of (a) plan closure, (b) a plan's service area reduction or withdrawal, or (c) merger, acquisition or other arrangement approved by the Department.

…

A. Plan Closures

…

3. Transition of Enrollees. Enrollees may not be transitioned until the request for plan closure and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process the transfer to the new plan of choice via a 'warm transfer' process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will subsequently process the enrollment transaction to the receiving plan. The plan that is closing must provide the new plan of choice with detailed information on the enrollee's plan of care and network provider relationships within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select or are auto-assigned to the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion…

MLTC Policy 17.02 (September 22, 2017).

DISCUSSION

At issue is the Plan's determination to reduce the Appellant's PCS authorization, effective April 1, 2018, from 77 hours per week (11 hours per day 7 days per week) to 52.5 hours per week (7.5 hours per day 7 days per week).

In a fair hearing concerning a reduction of services, the Plan bears the burden of establishing that its action was correct. The Plan failed to so establish in this case, as fully set forth below.

Pursuant to the relevant Regulations and policy, a specific reason for the determination to reduce, discontinue or deny a client's PCS authorization must be stated in the notice (whether a prior mistake in the authorization, improvement in the condition, change in the circumstances or other specific reason). The notice must also explain why the cited circumstance or event necessitates the Plan's action. The Regulations and policy set forth several examples of appropriate reasons and notice language to be used when reducing, discontinuing or denying

PCS services. 18 NYCRR 505.14(b)(5); General Information System message GIS 01 MA/044 and MLTC Policy 16.06. For example, the Regulations provide that one reason for reducing or discontinuing PCS hours is "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. ... 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…" 18 NYCRR 505.14 (b)(5); see also MLTC Policy 16.06.

The Plan's notice of March 21, 2018 was carefully reviewed at the hearing as to the specific stated reason to justify the Plan's action to reduce the Appellant's PCS hours. The notice states as follows:

"…The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool…You have been enrolled with [the Plan] since 12/1/2017 and have been receiving the following service Level 2 Personal Care Aide (PCA) services eleven (11) hours per day, seven (7) days per week (Totaling seventy-seven (77) hours per week) for 120 days as a Continuity of Care of your pre-existing service plan…A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted by [the Plan] on 2/1/2018 as your 120 days Continuity of Care is ending 3/31/2018. This assessment showed that you have demonstrated the following in your abilities to perform your Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)…The current UAS-NY assessment conducted on 2/1/2018 demonstrated that your needs can be effectively met with seven seven-and-a-half (7.5) hours per day, seven (7) days per week (Totaling fifty-two and a half (52.5) hours per week) of (Personal Care Aide (PCA)) Services to complete the above-mentioned tasks…"

Pursuant to the applicable Regulations and policy set forth above, the Plan failed to set forth an adequate reason for its determination to reduce Appellant's PCS authorization. Merely stating that the most recent nurse assessment justifies the reduction in hours is insufficient; nor is stating that the Appellant's prior PCS authorization was continued from Appellant's prior Managed Long Term Care Plan by virtue of the Continuity of Care policy.

Moreover, 18 NYCRR 358-2.2 states that notices of adverse action must contain the specific laws and/or regulations upon which the action is based. The Plan's notice at issue only cites MLTC Policy 17.02 for the proposition that Appellant's 77-hour per week PCS authorization had been continued by virtue of the Continuity of Care policy set forth in said policy guidance document. This does not justify the Plan's determination to reduce Appellant's PCS authorization. No other law or regulation was cited in the Plan's notice to justify the Plan's subject determination, in violation of 18 NYCRR 358-2.2.

Finally, the Plan failed to otherwise establish that the Appellant's PCS authorization of 77 hours per week granted by Appellant's prior Managed Long Term Care Plan was somehow inappropriate or that new circumstances that did not exist at the time necessitate the reduction.

Indeed, the record fails to show that the Plan had reviewed any prior nurse assessment reports for the Appellant to determine if the prior Managed Long Term Care Plan had made a mistake in the assessment or if the Appellant's circumstances have changed or condition has improved or that any other reasons exist to justify a reduction in Appellant's PCS authorization, other than the fact that the Appellant "tasked" at 52.5 hours per week on the latest nurse assessment, which basis is, in any event, insufficient in and of itself, to justify a reduction in PCS hours, as a matter of the Regulations and policy.

For all of these reasons, the Plan's determination at issue is reversed.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, dated March 21, 2018, to reduce the Appellant's Personal Care Services authorization from 77 hours per week (11 hours per day 7 days per week) to 52.5 hours per week (7.5 hours per day 7 days per week) was not correct and is reversed.

1. The Plan is directed to cancel its Initial Adverse Determination of March 21, 2018.

2. The Plan is directed to restore the Appellant's Personal Care Services authorization to 77 hours per week (11 hours per day 7 days per week) and continue to provide the Appellant with such Personal Care Services authorization.

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

DATED: Albany, New York
06/13/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee