STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 21, 2019
[redacted]
AGENCY: MAP
FH #: 8066432H

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 February 10, 2020, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Agency appearance waived by the Office of Administrative Hearings

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

Debra Ferguson, Centers Plan Representative

ISSUE

Was the Managed Long Term Care Plan's determination dated to reduce the Appellant's Personal Care Services authorization from 42 hours weekly to 35 hours weekly, 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 58, has been in receipt of Medicaid benefits provided through a Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter Centers Plan).

2. By Notice of Initial Adverse Determination dated October 7, 2019, the Managed Long Term Care Plan determined to reduce the Appellant's Personal Care Services authorization from 42 hours weekly to 35 hours weekly.

3. The Appellant requested an internal appeal, and by a Notice of Final Adverse Determination dated November 11, 2019, the Managed Long Term Care plan informed the Appellant of its decision to uphold its previous decision.

4. On April 11, 2019, a nursing assessor completed a Uniform Assessment System evaluation of the Appellant's personal care needs. Among other things, the assessment indicates that the Appellant needs assistance with ambulation, transferring, toileting and positioning.

5. On September 17, 2019, a nursing assessor completed a Uniform Assessment System evaluation of the Appellant's personal care needs.

6. On November 21, 2019, 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.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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III. e. Terminations and Reductions…

iii. 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.

18 NYCRR 505.14(b)(5)(iv)(c)(2) provides, in part, that:

(c) The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice.

(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…

18 NYCRR 505.14(a)(2) provides a new definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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)(4) provides a new definition of "Live-in 24-Hour Personal Care Services" as follows: 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.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides, in part, the intent of 18 NYCRR 505.14 is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping.

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

• The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;

• The specific task or tasks with which the person requires frequent assistance during the night;

• The frequency at which the person requires assistance with these tasks during the night;

• Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;

• The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;

• The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and

• Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

General Information System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

Districts were first advised of the Mayer case in May, 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24 hour care, including continuous 24 hour services ("split-shift"), 24 hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.

This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split shift or live-in services.

When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Remember that the contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing

and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

1.Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24 hour split shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24 hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24 hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The district should authorize services in an amount that is less than 24 hour live-in services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of live-in services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

Important Additional Information on TBA Plans:

Until notified otherwise by the Department, the following also apply to the use of TBA plans:

1. A district cannot use a TBA plan unless the TBA plan was already in use on March 14, 1996, or the district had the Department's approval as of that date to implement a TBA plan. This complies with the temporary restraining order in Dowd v. Bane, which the Department notified districts of in a previous GIS message, 96 MA/013, issued April 4, 1996.

2. Districts are not required to include safety monitoring as an independent task on their TBA forms. The Department recently obtained a stay of the August 21, 1997 federal court order that had required safety monitoring to be included as an independent TBA task. [See GIS 97 MA/26, issued November 6, 1997, informing districts of the stay of the order in Rodriguez v. DeBuono (S.D.N.Y., 1997).]

Regulation 358-5.9 (a) provides:

> At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption 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.

DISCUSSION

The evidence establishes that the Appellant has been in receipt of Medicaid benefits provided through a Managed Long Term Care Plan, Centers Plan. The evidence also establishes that by notice dated November 11, 2019, the Managed Long Term Care Plan determined to reduce the Appellant's Personal Care Services authorization from 42 hours weekly to 35 hours weekly.

18 NYCRR 505.14(b)(5)(v)(c)(2) provides, in part, that for proposed reductions based on a change in the Appellant's medical condition, the notice of reduction must (1) identify the specific change in the client's medical condition from the last authorization or reauthorization and (2) state why the services should be reduced or discontinued as a result of the change.

The Managed Long Term Care Plan's notice of reduction dated November 11, 2019, was carefully reviewed at the hearing as to the specific stated reason to justify its action to reduce the Appellant's Personal Care Services authorization, such as a change in the Appellant's medical, mental, or social circumstances, or if a mistake occurred in the previous personal care services authorization, etc. The Managed Long Term Care Plan's notice dated November 11, 2019, provided, in pertinent part, as follows:

> "There has been an improvement in your functional status and a big improvement in tasking needs."

Similarly, a review of the Plan's Initial Adverse Determination dated October 7, 2019 establishes that the reason described for the Plan's determination consists of a list of task needs as described in two consecutive nursing assessments (dated April 11, 2019 and September 19, 2019). The Notice does not adequately identify the specific change in the client's medical condition from the last authorization or reauthorization that resulted in the finding that the

Appellant now has greater independence in any task. The Managed Long Term Care Plan's failure to provide in its notice of reduction a detailed explanation of the change in the Appellant's medical condition was not proper. The Managed Long Term Care Plan's notices dated October 7, 2019 and November 11, 2019 were not proper.

Further, a review of both of the Uniform Assessments submitted into evidence by Centers Plan at the hearing establishes that the Uniform Assessment dated September 17, 2019, while it does indicate that the Appellant has fewer task needs, also omits the Appellant's primary diagnosis as shown in the April 11, 2019 assessment of Heart Failure. At the hearing, the Appellant states that she suffers from Congestive Heart Failure, is still receiving treatment for that condition, and that her condition has not improved since April 2019. Also, judicial notice is taken of the fact that Congestive Heart Failure is not considered to be a curable condition and is frequently terminal in nature. This omission from the second nursing assessment, which also departs from the previously identified task needs of the Appellant in a dramatic fashion, raises strong questions as to the accuracy of that later assessment.

Lastly, the Appellant's needs as identified in the April 11, 2019 assessment clearly indicated that the Appellant was at that time a Mayer III individual with a need for 24 hour care in the absence of formal or informal supports, based on the presence of unscheduled task needs of ambulation, transferring, toileting and bed positioning. As such, the plan is foreclosed from reducing the Appellant's hours by the use of a task based assessment.

For the foregoing reasons, the Managed Long Term Care Plan's determination dated November 11, 2019, to reduce the Appellant's Personal Care Services authorization from 42 hours weekly to 35 hours weekly cannot be sustained.

DECISION AND ORDER

The Managed Long Term Care Plan's determination dated November 11, 2019, to reduce the Appellant's Personal Care Services authorization from 42 hours weekly to 35 hours weekly is not correct and is reversed.

1. The Managed Long Term Care Plan is directed to restore the Appellant's Personal Care Services authorization to the amount of 42 hours weekly.

2. The Managed Long Term Care Plan is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 42 hours weekly unchanged.

3. The Managed Long Term Care Plan is directed to update its records to designate the Appellant as a "Mayer III" patient whose personal care services cannot be reduced through the use of a task based assessment.

Should the Managed Long Term Care 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 the Managed Long Term Care Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
02/14/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee