STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 27, 2017
[redacted]
AGENCY: MAP
FH #: 7523685L

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 7, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan (Managed Long Term Care Plan)

Jillian Hinkson, Fair Hearing Representative

ISSUES

Was the determination of Centers Plan For Healthy Living to reduce the Appellant's Personal Care Services correct?

Was Centers Plan For Healthy Living's determination to deny the Appellant's request for an increase of Personal Care Services from 70 hours per week to 24 hours live in 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, who is 93 years old, receives Medical Assistance from Centers Plan For Healthy Living.

2. Appellant has been in receipt of an authorization for Personal Care Services in the amount of 24-hour live in.

3. On April 19, 2017, Centers Plan For Healthy Living notified the Appellant that it would reduce the Appellant's Personal Care Services from 49 hours per week to 38.5 hours per week because the health care service is not medically necessary.

4. On April 19, 2017, Centers Plan For Healthy Living notified the Appellant that it would reduce the Appellant's Personal Care Services from 24 hour live in to 45.5 hours per week because the health care service is not medically necessary.

5. Appellant's Representative requested a standard appeal.

6. By notice dated May 11, 2017, Centers Plan For Healthy Living notified the Appellant that the appeal had been reviewed and the determination to reduce the service was being partially reversed. The Appellant's Personal Care Services will be 10 hours per day, 7 days per week.

7. Appellant's Representative requested an increase to 24 hours per week live in.

8. On April 27, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

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).

MLTC Policy 16.06, entitled Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services (Date of Issuance: November 17, 2016) provides as follows:

> "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: 2

• 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."

NYS DEPARTMENT OF HEALTH

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

I. Scope of the Personal Care Benefit

(a) vii. Personal care services include some or total assistance with:

1. Level I functions as follows:
   a. Making and changing beds;
   b. Dusting and vacuuming the rooms which the member uses;
   c. Light cleaning of the kitchen, bedroom and bathroom;

d. Dishwashing;
e. Listing needed supplies;
f. Shopping for the member if no other arrangements are possible;
g. Member's laundering, including necessary ironing and mending;
h. Payment of bills and other essential errands; and
i. Preparing meals, including simple modified diets.

2. Level II personal care services include Level I functions listed above and the following personal care functions:
   a. Bathing of the member in the bed, the tub or the shower;
   b. Dressing;
   c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
   d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
   e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
   f. Transferring from bed to chair or wheelchair;
   g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
   h. Feeding
   i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
   j. Providing routine skin care;
   k. Using medical supplies and equipment such as walkers and wheelchairs; and
   l. Changing of simple dressings….

III. Authorization and Notice Requirements for Personal Care Services

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

ii. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).

iii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.

iv. 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.

In Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y. 1996), Plaintiffs challenged New York City's efforts to reduce their personal care services. The Court found that prior to issuing any reduction notice, the Agency must first identify some development that justifies altering a recipient's level of services. Specifically, the Agency was enjoined from reducing recipient's home care services unless the Agency's notice states that a reduction is justified because of a series of reasons as listed immediately above.

GIS 96/MA 019 states, in part,

"In general, Mayer et al. v. Wing, (S.D.N.Y.) 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 Mayer court, however, illustrated this general principle by setting forth six specific circumstances in which social services districts may reduce or discontinue recipients' personal care services. Effective immediately, a social services district may reduce or discontinue a recipient's personal care services only when the district has first identified that the proposed reduction or discontinuance is justified by one or more of the following reasons:

(1) the recipient's medical, mental, economic or social circumstances have changed;
(2) a mistake occurred in the previous authorization of services;
(3) the recipient refused to comply with the required reassessment of services;
(4) a technological development renders certain services unnecessary or less time consuming;
(5) the recipient can be more appropriately and cost-effectively served through other MA programs or services, such as assisted living programs, personal emergency response services, shared aide or other programs or services set forth in State statute or Department regulations. (This circumstance would permit districts to discontinue services based upon the results of the fiscal assessment); or,
(6) based upon a task-based assessment that the district conducted of the recipient, the district believes that the personal care services provided under the last authorization or reauthorization can be provided in fewer hours than they were previously.

When a social services district has determined to reduce or discontinue a recipient's personal care services because one or more of these circumstances exist, the district must include the specific reason for the reduction or discontinuance in the timely and adequate notice that the district sends to the recipient. This is consistent with long-standing Department policy and regulations."

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).]"

DISCUSSION

The record establishes that the Appellant, age 93, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan operated by Centers Plan For Healthy Living ("CP").

The record further establishes that by an "Initial Adverse Determination" dated April 19, 2017, Centers Plan determined to reduce the Appellant's personal care services from 24 hour live in to 45.5 hours a week.

At the hearing, the Plan submitted a copy of the "Initial Adverse Determination" that stated that CP was reducing the Appellant's authorization from 24 hour live in to 45.5 hours per week because "the health care service is not medically necessary." In summary the Initial Adverse Determination states that the Uniform Assessment System (UAS) and Plan Client Tasking Tool both completed on 3/31/2017, demonstrate the following abilities of the Appellant to perform activities of Daily Living and Instrumental Activities of Daily Living: totally dependent with meal preparation; extensive assistance with personal hygiene, dressing upper body, bed mobility; maximal assistance with walking, locomotion, transfer toilet, bathing, toilet use, set-up for eating; limited assistance with managing medication; independent with ordinary housework; no reported falls in 90 days and no reported hospitalizations in 90 days.

On May 8, 2017, the Appellant's Representative requested a standard appeal. By notice dated May 11, 2017, Centers Plan For Healthy Living notified the Appellant that the appeal had been reviewed and the determination to reduce the service was being partially reversed based on medical necessity. The Appellant's Personal Care Services will be 10 hours per day, 7 days per week. In addition to the above, the notice indicates that the March 31, 2017 UAS demonstrates that the Appellant requires setup for phone use and eating; the Appellant is frequently incontinent of bladder; the Appellant has an ataxic gait and needs a walker to ambulate indoors with assistance and a wheelchair outdoors; the Appellant cannot stand for extended periods of time due to hip pain from her fracture in 2009.

NYS Department of Health Guidelines lists nine appropriate reasons for reducing Personal Care Services authorized under Mainstream Managed Care or Managed Long-Term Care. CP's April 19, 2017 determination failed to adequately identify an appropriate reason to justify its decision to reduce the Appellant's PCS authorization, making the notice inadequate. Specifically, the notice failed to 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. The MLTC

Plan is reducing the Appellant's existing hours by more than half, from 24 hour live in to 70 hours per week. Also, the notice fails to establish that the Appellant's medical, mental, economic or social circumstances have changed and 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 provided.

All the evidence has been considered. The Plan's notice is defective and the Plan has failed to establish any basis under the applicable law that would justify reducing the level of the Appellant's Personal Care Services. While the Plan's Representative nonetheless attempted to prove at the hearing that the Appellant prior health care service was not medically necessary, thereby justifying the reduction in her hours, the reason the prior health care service was not medically necessary was not provided in the notice of reduction. Accordingly, Centers Plan For Healthy Living has not met its burden of showing that its determination to reduce the Appellant's Personal Care Services authorization was correct.

DECISION AND ORDER

Centers Plan For Healthy Living's determination to reduce the Appellant's authorization for Personal Care Services from 24 hour live in to 70 hours a week is not correct and is reversed.

1. Centers Plan For Healthy Living is directed to continue to authorize Personal Care Services to the Appellant in the amount of 24 hour live in and to notify Appellant upon compliance with this fair hearing decision.

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

DATED: Albany, New York
06/30/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee