STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 16, 2018
[redacted]
AGENCY: MAP
FH #: 7684792M

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 13, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Healthfirst, Senior Health Partners)

Donia Sawwan, Esq., Outside Counsel, Fair Hearing Representative

ISSUE

Was Healthfirst's January 11, 2018 determination to reduce the Appellant's Consumer Directed Personal Care Services authorization from 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse), to 28 hours per week of shared Consumer Directed Personal Care Service (14 shared hours plus 14 hours shared by the Appellant's spouse,) 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 seventy, resides with his daughter, age forty-five, and has been enrolled in a partially capitated Managed Long Term Care Plan through Healthfirst, Senior Health Partners (Healthfirst), since November 1, 2017.

2. The Appellant had been enrolled previously in a partially capitated Managed Long Term Care Plan through Centers Plan for Healthy Living (Centers Plan), through October 31, 2017.

3. The Appellant has been in receipt of an authorization for Consumer Directed Personal Care Services for 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse).

4. The Appellant is separated from his wife, but receives the shared hours of Consumer Directed Personal Care Service at his wife's apartment, not in his own apartment which he shares with his daughter.

5. On August 25, 2017, a registered nurse performed a home assessment of the Appellant's needs on behalf of Centers Plan and issued a Uniform Assessment System [UAS] – New York Comprehensive Community Assessment Report.

6. On September 25, 2017, a registered nurse performed a home assessment of the Appellant's needs on behalf of Healthfirst and issued a Uniform Assessment System [UAS] – New York Comprehensive Community Assessment Report and an ATSP which recommended 14.92 hours of Personal Care Services.

7. On January 11, 2018 Healthfirst issued to the Appellant a written Initial Adverse Determination together with a written "Managed Long Term Care Action Taken" which advises the Appellant of Healthfirst's determination to reduce the Appellant's Consumer Directed Personal Care Services authorization from 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse) to 28 hours per week of shared Consumer Directed Personal Care Service (14 shared hours plus 14 hours shared by the Appellant's spouse).

8. On January 16, 2018, the Appellant requested this fair hearing.

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 438.402 of 42 CFR Subpart F provides in part:

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

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

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

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

(2) The reasons for the action...

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

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

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home…

Section 505.14(a) of the Regulations provides in part that:

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

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

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions shall include some or total assistance with the following:

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

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

(8) feeding;

(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment

to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(10) providing routine skin care;

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

(12) changing of simple dressings.

In general, a recipient of Medical Assistance or 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. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Medical Assistance or Services; or has determined to change the amount of one of the items used in the calculation of a Medical Assistance spenddown. 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 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 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 Medical Assistance in another district.

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;
- 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

Pursuant to recently revised 18 NYCRR § 505.14(b)(5)(v)(c)(2):

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

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

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

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

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

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

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

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

GIS message GIS 96 MA/019 advises of a federal court decision that applies to social services districts' reductions or discontinuations of personal care services. [Mayer et al. v. Wing, (S.D.N.Y.)] In general, the Mayer decision holds that a social services district must have a

legitimate reason to reduce or discontinue a recipient's personal care services. Before reducing or discontinuing personal care services, the district must individually assess the recipient to determine whether the reduction or discontinuance is justified by State law or Department regulation. A social services district cannot reduce or discontinue a recipient's personal care services arbitrarily, capriciously or as part of a blanket, across-the-board reduction or discontinuance of services that does not consider each individual recipient's particular circumstances. This general principle is entirely consistent with the Department's policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Department's Managed Care Personal Care Services Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

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

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

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

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

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

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;
(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
(iii) the client is not self-directing and has no one to assume those responsibilities;
(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;
(v) the client refused to cooperate in the required assessment;
(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming 18 NYCRR 505.14(b)(5)(v)(c)(1)

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

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

exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

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

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

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

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

(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(c)(2)

MLTC Policy 15.04: Interim Guidance for MLTC Partial Capitation Appeal Notices provides in relevant part:

Within Section 1.B. of Appendix K of the Partial Capitation Model Contract, there are four required notice templates relating to Expedited and Standard Appeals. This document describes how these notices will be affected by the elimination of the exhaustion requirement for internal appeals.

This guidance is effective immediately and will also be reflected in the forthcoming renewal of the partial capitation contracts for the period between January 1, 2015 and December 31, 2016....

Notice Template 4:

To reflect the elimination of the internal appeal exhaustion requirement, and related policy changes, plan appeal final determination notices must comply with the following: Final Determination Notices

The Contractor shall ensure that all notices are in writing and in easily understood language and are accessible to non-English speaking and visually impaired enrollees. Notices shall include that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

All notices must include up-to-date contact information for the Independent Consumer Advocacy Network (ICAN), along with the following statement: "You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:"

A) Notice to the enrollee of Action Appeal Determinations shall be dated and include:

1) Date the action appeal was filed and a summary of the action appeal;

2) Date the action appeal process was completed;

3) The results and the reasons for the determination, including the clinical rationale, if any;

4) If the determination was not wholly in favor of the enrollee, and:

a) The contractor upheld its original action, a statement that reminds the enrollee of their right to request a fair hearing, including:

i) That a request for a fair hearing must have been made to the State within 60 calendar days of the initial action notice;
ii) The date by which such request must have been made; and
iii) If time remains for a fair hearing to be requested, instructions on how to request a fair hearing; or a statement that time to request a fair hearing has expired.
b) The contractor modified its original action in any way, a statement that the action appeal determination constitutes a new action, and the enrollee has a right to request a fair hearing, including:
i) That a request for a fair hearing must be made to the State within 60 calendar days of the date of the action appeal notice; and
ii) A completed NYSDOH standard "Managed Long Term Care Action Taken" notice for denial of benefits or for termination or
reduction in benefits, as applicable, containing the enrollee's fair hearing and aid continuing rights.
5) The right of the enrollee to contact the New York State Department of Health regarding his or her complaint, including the NYSDOH's toll-free number for complaints; and
6) For action appeals involving personal care services, the number of hours per day, number of hours per week, and the personal care services function (Level I/Level II):
a) That were previously authorized, if any;
b) That were requested by the enrollee or their designee, if so specified in the request;
c) That are authorized for the new authorization period, if any; and
d) The original authorization period and the new authorization period, as applicable.
7) For action appeals involving medical necessity or an experimental or investigational treatment, the notice must also include:
a) A clear statement that the notice constitutes the final adverse determination and specifically use the terms "medical necessity" or "experimental/investigational;"
b) The enrollee's coverage type;
c) The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;
d) Statement that the enrollee is eligible to file an external appeal and the timeframe for filing, and if the action appeal was expedited, a statement that the enrollee may choose to file a standard action appeal with the contractor or file an external appeal;
e) A copy of the "Standard Description and Instructions for Health Care Consumers to Request an External Appeal" and the External Appeal application form;
f) The contractor's contact person and telephone number;
g) The contact person, telephone number, company name and full address of the utilization review agent, if the determination was made by the agent; and
h) If the contractor has a second level internal review process, the notice shall contain instructions on how to file a second level action appeal and a statement in bold text that the timeframe for requesting an external appeal begins upon receipt of the final adverse determination of the first level action appeal, regardless of whether or not a second level of action appeal is requested, and that by choosing to request a second level action appeal, the time may expire for the enrollee to request an external appeal.

Care Services or Consumer Directed Personal Assistance Services provides:
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.

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

DISCUSSION

The record in the matter establishes that the Appellant, age seventy who resides with his daughter, has been in a receipt of an authorization from Healthfirst, his Managed Long Term Care Plan, for Consumer Directed Personal Care Services for 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse). The Appellant is separated from his wife, but receives the shared hours of Consumer Directed Personal Care Service at his wife's apartment, not his own.

It is noted that the Appellant was previously enrolled in another Managed Long Term Care Plan, Centers Plan, through October 31, 2017 and that he voluntarily disenrolled from Centers Plan and enrolled in Healthfirst, effective November 1, 2017.

The record also establishes that on August 25, 2017, a registered nurse performed a home assessment of the Appellant's needs on behalf of Centers Plan and issued a Uniform Assessment System [UAS] – New York Comprehensive Community Assessment Report. On September 25, 2017 another registered nurse performed a home assessment of the Appellant's needs on behalf of Healthfirst and issued a UAS Report and an ATSP which recommended 14.92 hours of Personal Care Services.

The record further establishes that on January 11, 2018 Healthfirst issued to the Appellant a written Initial Adverse Determination together with a written "Managed Long Term Care Action Taken" which advise the Appellant of Healthfirst's determination to reduce the Appellant's Personal Care Services authorization from 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse) to 28 hours per week of shared Consumer Directed Personal Care Service (14 shared hours plus 14 hours shared by the Appellant's spouse).

It is noted that at the hearing, Healthfirst's representative contended that the January 24, 2018 Initial Adverse Determination did not constitute a reduction in Personal Care Service hours, but rather an initial determination by a newly enrolled member. This contention is rejected in that the Initial Adverse Determination itself addresses the change as a reduction in shared Consumer Directed Personal Care Service hours. Moreover, Healthfirst continued the previous hours authorized by Center's Plan and did not attempt to change the hours until January 24, 2018, even though it performed an assessment on September 25, 2017.

Healthfirst's notice 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. Healthfirst's notice dated January 11, 2018 does not identify any specific changes in the Appellant's medical, mental, or social circumstances.

The January 24, 2018 notice does set forth what the prior assessment of October 25, 2017 found were the levels of assistance required for several tasks (ADLs and IADLs) compared to the needs for assistance found during the September 25, 2017 assessment. However, the notice states only that "[b]ased upon your new assessment and change in your medical condition you will receive a reduction in hours based upon your current need." It does not specify what the change was in the Appellant's medical condition or why the services should be reduced or discontinued as a result of this undescribed change.

Finally, it is noted that at the hearing, the Appellant's daughter testified that in December 2017, the Appellant developed "shingles" which has made his condition worse and has increased his need for Personal Care Service.

As Healthfirst's notices does not provide a specific valid reason for the reduction in hours, such as a change in circumstances or any specific errors in a prior assessment, and does not state why a reduction in hours is necessary, Healthfirst's determination to reduce the Appellant's shared Consumer Directed Personal Care Services authorization from 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse) to 28 hours per week of shared Consumer Directed Personal Care Service (14 shared hours plus 14 hours shared by the Appellant's spouse).cannot be sustained and is therefore reversed.

DECISION AND ORDER

The January 11, 2018 Initial Adverse Determination by the Appellant's Managed Long Term Care Plan, Healthfirst, to reduce the Appellant's Personal Care Services authorization from 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse) to 28 hours per week of shared Consumer Directed Personal Care Service (14 shared hours plus 14 hours shared by the Appellant's spouse) is not correct and is reversed.

Healthfirst is directed to:

1. Take no further action on the January 11, 2018 Initial Adverse Determination.

2. Continue to provide the Appellant with shared Consumer Directed Personal Care Services hours in the amount of from 53 shared hours per week (4 hours per day [Monday] plus 3.5 hours per day [Tuesday through Sunday] plus 28 shared hours with the Appellant's spouse.)

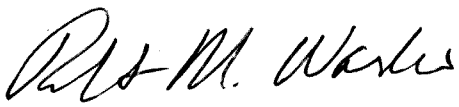
Should Healthfirst need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's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

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

DATED: Albany, New York
02/21/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee