STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 2, 2017
[redacted]
AGENCY: MAP
FH #: 7526766M

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 27, 2017, 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

Alisha Jacobs, Centers Plan for Healthy Living, Representative

ISSUE

Was the determination of Centers Plan for Healthy Living to reduce the Appellant Husband's Personal Care Services from 24 hours daily, continuous care, 7 days weekly, to 12 hours daily, 7 days weekly, without notice, correct?

Was the determination of Centers Plan for Healthy Living to reduce the Appellant Wife's Personal Care Services from 24 hours daily, continuous care, 7 days weekly, to 12 hours daily, 7 days weekly, without notice, 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 Appellants, [redacted], age 87, "Appellant husband" and [redacted], age 85, "Appellant wife" have been in receipt of Medicaid.

2. The Appellants had been in receipt of Personal Care Services in the amount of 24 hours daily, continuous care, provided through the Managed Long Term Care Plan Centerlight Health Systems.

3. Effective February 1, 2017, both Appellants were disenrolled from Centerlight and reenrolled in Centers Plan for Health Living, a partially capitated Medicaid managed long term care plan.

4. On February 22, 2017, and again on April 2, 2017, a Nurse completed a Uniform Assessment System (UAS) for Appellant husband, [redacted].

5. On April 2, 2017 and again May 7, 2017, a Nurse completed a Uniform Assessment System(UAS) for Appellant wife, [redacted].

6. By Initial Adverse Determination notice dated May 5, 2017, the Managed Long Term Care Plan (Centers Plan) denied the Appellant Husband [redacted]'s request for live-in, 7 days a week, and stated that the Appellant's services would stay at 12 hours/day Personal Care Aide Level 2, 7 days per week, 84 hours weekly.

7. By Authorization notice dated May 5, 2017, the Managed Long Term Care Plan (Centers Plan) approved Home Care, Personal Care Aide Level 2 – Mutual, for the Appellant Wife [redacted] at 84 hours per week for the period May 4, 2017 to October 31, 2017.

8. On May 2, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

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).

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.

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

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.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), dated December 30, 2015, effective December 23, 2015, provided:

The purpose of this policy directive is to inform Managed Long Term Care Plans (MLTCPs) of revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR § 505.14 and 18 NYCRR § 505.28, respectively. These revised regulations are effective on December 23, 2015.

These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous ("split-shift") PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, MLTCPs must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the New York State Register on December 23, 2015.

Regulatory changes for PCS and CDPA applicable to MLTCP's include:

1. The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

2. "Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.

3. The definitions and eligibility requirements for “continuous personal care services,”” live-in 24-hour personal care services,” “continuous consumer directed personal assistance” and “live-in 24-hour consumer directed personal assistance” are revised as follows:

a. *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. 18NYCRR 505.14(a)(2).

b. *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. 18NYCRR 505.14(a)(4)

c. *Continuous consumer directed personal assistance* means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the consumer’s medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.

d. *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer’s medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.

4. Services shall not be authorized to the extent that the individual’s need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

5. The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of “some assistance” and “total assistance” are repealed.

6. The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

7. The social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

8. The regulations also revise the Department's regulations governing the content of notices for denials, reductions or discontinuances of PCS and CDPA. In subparagraph 505.14(b)(5)(v), the provisions governing social services districts' notices to recipients for whom districts have determined to deny, reduce or discontinue PCS are revised and reorganized. Paragraph 505.28(h)(5) is amended to provide additional detail regarding the content of social services district notices when the district denies, reduces or discontinues CDPA. All MLTCPs must ensure that their notices denying, reducing or discontinuing PCS or CDPA are consistent with these regulations and, in particular, include the specific reason for the action and, if applicable, the clinical rationale. All MLTCPs should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements.

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in sub clauses (a)(1) through (a)(3) of this subparagraph. 18 NYCRR 505.14 (a)(3)(iii)(b)

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services, issued November 17, 2016, provides in relevant part that:

Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might

occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night**.** A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link: http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf

GIS message GIS 12 MA/ 026, dated October 3, 2012, provides that the Department has been directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicted and for Medicaid recipients whose only nighttime need is turning and positioning.

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.

18 NYCRR 505.28 Consumer directed personal assistance program.

(a) Purpose. The consumer directed personal assistance program is intended to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.

(b) Definitions. The following definitions apply to this section:

(1) "consumer" means a medical assistance recipient who a social services district has determined eligible to participate in the consumer directed personal assistance program.

(2) "consumer directed personal assistance" means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

(3) "consumer directed personal assistant" means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative. A consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary.

(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14(a)(5) of this Part except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week

(e) Authorization process (6) Nothing in this subdivision precludes the provision of the consumer directed personal assistance program in combination with other services when a combination of services can appropriately and adequately meet the consumer's needs; provided, however, that no duplication of Medicaid-funded services would result.

Department policy regarding personal care services for managed care enrollees states in part that a mutual case is one where two or more members of the household receive care from the same personal care aide. Each case will be assessed individually and an authorization based on the number of hours the member requires to remain safely in the home will be determined. The assessment for the number of hours needed and the level of services may take into account what other services are provided in the home.

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.

MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal 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.

DISCUSSION

The Appellant Husband, [redacted] has been in receipt of Medicaid benefits. He has been enrolled in Centers Plan for Healthy Living since February 1, 2017. The Appellant has been in receipt of Personal Care Services as authorized by Centers Plan. Prior to February 1, 2017, Appellant Husband had been enrolled in Centerlight Health Systems and in receipt of personal care services.

The Appellant Wife [redacted] has been in receipt of Medicaid benefits. She has been enrolled in Centers Plan for Healthy Living since February 1, 2017. The Appellant has been in receipt of Personal Care Services as authorized by Centers Plan. Prior to February 1, 2017, Appellant Wife had been enrolled in Centerlight Health Systems and in receipt of personal care services.

The Appellants' Representative states that the Appellants had been in receipt of Personal Care Services, as a "mutual case", 24 hours per day, continuous care, "split shift" as authorized by Centerlight for approximately 4 to 5 years.

The Appellants' Representative states that Centers Plan for Healthy Living reduced their personal care services hours without notice. When one of the Appellants entered the hospital, Centers Plan would only provide 12 hours of care for the Appellant who was not hospitalized. This left the homebound client without Personal Care Services for 12 hours.

The Appellant's son indicates that when he reached out to Centers Plan, he was told that he would need to request an increase in services. The Appellants seek review of the Plan's determination to reduce the Personal Care Hours from a mutual case, 24 hours, continuous care, "split shift," to only 12 hours shared as a mutual authorization, without sending notice.

The Centers Plan for Health Living Representative states that the Appellant Husband [redacted] was in receipt of 12 hours of Personal Care Services, and that the Appellant Wife [redacted] was in receipt of 12 hours of Personal Care Services. The Plan representative states that the information received from MAXIMUS was that each had 12 hours, Therefore, they only provided 12 hours to the Appellant who remained in the home, while the other was hospitalized. At the hearing no documentation or evaluations were provided from Centerlight Health Systems or from Maximus to support this claim that each Appellant had been authorized for only 12 hours daily of personal care services.

The Centers Plan representative states that there was not a change in the Personal Care Authorization for the Appellants as they had not been authorized for 24 hours continuous care. Therefore, the Plan action did not amount to a reduction of services, but rather a continuation of previously authorized services. Centers Plan however did issue a Notice of denial in response to the request by the Appellant Husband [redacted] for additional hours.

By Initial Determination notice dated May 5, 2017, the Managed Long Term Care Plan denied the Appellant Husband [redacted]'s request for 24 hour live-in, 7 days a week.

The Appellants' son stated that his father requires 2 persons to lift him. He doesn't go to bed. He stays up and needs someone to assist him. His mother is confined to a wheelchair. She also requires additional people to assist her with mobility and other activities of daily living.

On February 22, 2017 and again on April 2, 2017, a Uniform Assessment System (UAS) evaluation of the personal care needs of Appellant Husband was conducted. A review of his two assessments documents the Appellant's conditions as follows:

	February 22, 2017	April 2, 2017

Needs?	can be scheduled	can be scheduled
Left alone?	cannot be left alone	cannot be left alone
Locomotion	Total Dependence	Total Dependence
Toilet Transfer	Maximal Assistance (2+)	Maximal Assistance (2+)
Toilet Use	Total Dependence	Total Dependence
Bed Mobility	Maximal Assistance (2+)	Maximal Assistance (2+)
Bladder	Incontinent occasionally	Has Foley Catheter
Bowel	Continent occasionally incontinent	
Eating	Extensive Assistance	Extensive Assistance
Ordinary Housework	Total Dependence	Total Dependence
Dressing Lower Body	Total Dependence	Total Dependence
Dressing Upper Body	Maximal Assistance	Maximal Assistance (2)
Meal Preparation	Total Dependence	Total Dependence
Ordinary Housework	Total Dependence	Total Dependence
Shopping	Total Dependence	Total Dependence
Bathing/Supervision	Maximal Assistance	Maximal Assistance
Medications	Maximal Assistance	Total Dependence (reminders needed)
Walking	Maximal Assistance	Maximal Assistance
Overall self-sufficiency	No change	No change
Change in ADL Status in last 90 days	No change	No change

The UAS reports indicate that the Appellant Husband [redacted] uses a walker for transfer and ambulation indoors. He uses a wheelchair outdoors. He is unable to bend the lower part of his body: requires total performance by others during dressing lower body and after toilet use. He can participate with bathing with maximum assistance. The Appellant was also hospitalized on January 20, 2017 for edema and acute kidney failure. He was hospitalized again on March 23, 2017 for bilateral lower extremity lymphoma and cellulitis and UTL. (The Appellant and the son were encouraged to raise and move his legs to promote circulation and decrease swelling.)

By "Authorization notice" dated May 5, 2017, the Managed Long Term Care Plan approved Home Care, Personal Care Aide Level 2 – Mutual, at 84 hours per week for the period May 4, 2017 to October 31, 2017 for the Appellant Wife [redacted].

On April 2, 2017 and again on May 7, 2017 the Agency conducted a Uniform Assessment System (UAS) evaluation of Appellant Wife [redacted]. A review of the two assessments document the following changes in the Appellants conditions:

	April 2, 2017	May 7, 2017
Needs	can be scheduled	can be scheduled
Left alone?	cannot be left alone	cannot be left alone
Locomotion	Total Dependence (2)	Total Dependence
Transportation	Maximal Assistance	Maximal Assistance
Toilet Transfer	Maximal Assistance (2)	Maximal Assistance
Toilet Use	Maximal Assistance (2)	Maximal Assistance
	(Total Dependence also listed)	
Bed Mobility	Maximal Assistance	--------
Bladder	Frequently Incontinent	control with catheter
Bowel	Frequently Incontinent	frequently incontinent
Eating	Extensive Assistance	Extensive Assistance
Shopping	Maximal Assistance	--------
Dressing upper Body	Maximal Assistance	Maximal Assistance
Dressing Lower Body	Total Dependence	Maximal Assistance
Meal Preparation	Total Dependence	Total Dependence
Ordinary Housework	Total Dependence	Total Dependence
Shopping	Total Dependence	Total Assistance
Bathing	Maximal Assistance (2)	
	Maximal Assistance	
Overall self-sufficiency	--------	Deteriorated
Medications	Maximal Assistance	Maximal Assistance
Walking	Maximal Assistance (2)	
	Maximal Assistance	

Change in ADL Status in last 90 days No change Declined

The reports indicate that the Appellant Wife [redacted] requires assistance with ADL's and IADL's due to weakness and SOB due to dx of COPD, CHF. She ambulates indoors with a walker with assistance, and is wheeled when going outdoors. The Appellant has b/l [bilateral] lower extremities edema and erythema. The Appellant Wife wears pads or briefs and currently uses a wheelchair. The Appellant Wife also now uses a Foley catheter.

Department policy regarding personal care services for managed care enrollees states in part that *a mutual case is one where two or more members of the household receive care from the same personal care aide (emphasis added)*. Each case will be assessed individually and an authorization based on the number of hours the member requires to remain safely in the home will be determined. The assessment for the number of hours needed and the level of services may take into account what other services are provided in the home.

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

Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. 18 NYCRR 505.14(a)(4)

The Appellant's representative argues that the Plan reduced the personal care services for Appellant husband [redacted] and Appellant [redacted] without notice. The Plan argues that the Appellants were not in receipt of 24 hour continuous care, but rather were receiving 12 hours daily.

Neither party to this proceeding provided written supportive documentation as to the level of each Appellant's prior personal care services authorization. Therefore, the determination in this hearing will be made upon a review of the medical/social status of each Appellant at the time of the transfer to Centers Plan for Healthy Living, or upon the first available UAS and the credible testimony of the parties.

The testimony of the Appellants' son is that his father first received the authorization of 24 hours when he was injured while getting up from the bed. He fell, hit his head and had bruises on his side and knee. At that time, he requested and received 24 hour continuous care, "split

shift" care for the Appellant. The record established that Appellant requires two persons to lift him up. The Appellant also does not go to bed. He likes to stay out of the bed 24/7.

A review of the medical condition of the Appellant Husband [redacted] as of February 22, 2017 demonstrates that the Appellant cannot move his lower body. He requires 2+ people to help him to move, and requires total assistance with movement of his lower body, and with toilet use. He needs maximal assistance with bed mobility. The Appellant was occasionally incontinent of urine but was continent of bowel. Although he was continent of bowel, and occasionally incontinent of urine, he required assistance to complete those activities, which would have occurred during the nighttime hours.

The Appellant's hospitalization in January was due to edema and acute kidney failure. As previously noted, he requires consistent movement of his legs to reduce swelling and to promote circulation. The Appellant was again hospitalized in March 2017 for extremity lymphoma and cellulitis.

Based upon the medical condition of the Appellant Husband [redacted] as of February 22, 2017, which did not change from the previous 90 days, the Appellant required 2 persons to help him to move. He could not move his lower body. He is totally dependent for toilet use and to transfer in and out of the bed. The Plan did not present documentation to show how these needs were being met if the Appellant was only authorized to receive 12 hours of care daily as part of a mutual case.

Based upon the record of the hearing, the Appellant Husband [redacted] would have been eligible for 24 hour continuous care personal care services, split shift. His nighttime needs are so frequent that an 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.

State regulations provide that 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. 18 NYCRR 358-3.3(a).

As the Appellant Husband [redacted]'s medical condition warranted the provision of 24 hour care, his representative's and his witness' claim of prior authorization by Centerlight of 24 hour continuous care, is credible. The Appellant was entitled to notice of the Agency determination to reduce the amount of his Personal Care Services, and no notice was presented.

A review of the medical condition of the Appellant [redacted] as of April 2, 2017, demonstrates that she was totally dependent for locomotion (2 persons) and dressing her lower body. She required maximal assistance (2 persons) for toilet use. It is noted that the UAS indicated maximal assistance on one page and total dependence on a separate page. She was frequently incontinent of both bladder and bowel. There was reportedly "no change" in her ADL status in the last 90 days.

The testimony of the Appellants' son is that his mother is in a wheelchair. On at least one occasion, she fell and was found on the floor. He cannot lift her up by himself.

Based upon the medical condition of the Appellant Wife as of April 2, 2017, which allegedly did not change from the previous 90 days, the Appellant was frequently incontinent and required 2 persons to help her to move, and for toilet transfer and use. The aide would have been unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep. It is further noted that the UAS dated May 7, 2017 indicated a "decline" in the Appellants ADL Status when compared to the April 2, 2017 report. Therefore, the claim of the Appellants' representative and of the Appellants' son, their witness, of a prior authorization by Centerlight of 24 hour continuous care, was credible.

Appellant Wife [redacted] medical condition warranted the provision of 24 hours continuous care, and the Appellant was entitled to notice of the Plan's determination to reduce the amount of her Personal Care Services.

State regulations provide that 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. 18 NYCRR 358-3.3(a).

The record did not support the Plan's determination to reduce the Appellants' mutual personal care services authorization without notice.

DECISION AND ORDER

The Managed Long Term Care Plan's (Center Care's) determination to reduce the Appellant Husband's Personal Care Services from 24 hours daily, continuous care, to 12 hours daily, without notice, is not correct and is reversed.

1. The Managed Long Term Care Plan is directed to restore the authorization of 24 hours continuous care, 7 days weekly for the Appellant husband [redacted], as part of a Mutual Case.

The Managed Long Term Care Plan's determination to reduce the Appellant Wife's Personal Care Services from 24 hours daily, continuous care, 7 days weekly, to 12 hours daily, 7 days weekly, without notice, is not correct and is reversed.

1. The Managed Long Term Plan Centers Plan for Health Living is directed to restore the authorization of 24 hours daily, continuous care, 7 days weekly, for the Appellant Wife [redacted], as part of a Mutual Case.

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
09/11/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By
H Cooper Gregory

Commissioner's Designee