STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 27, 2018
[redacted]
AGENCY: MAP
FH #: 7728717Y

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 April 23, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan for Healthy Living (CHL) Managed Long Term Care Plan

Alisha Jacobs, Grievance and Appeals Supervisor

ISSUE

Was the Managed Long Term Care Plan's determination of March 26, 2018 to reduce the Appellant's Personal Care Services, correct?

FACT FINDING

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 85, is in receipt of Medicaid including Personal Care Services (PCS) provided by Centers Plan for Healthy Living (CHL) the Managed Long Term Care Plan.

2. By Notice of Intent dated March 26, 2018, CHL advised the Appellant of its determination to reduce the Appellant's PCS from 24 hours daily, 7 days weekly continuous care ("split shift"), provided by more than one Personal Care Services aide, to 24 hours per day live-

in, 7 days per week, effective March 31, 2018.

3. On March 27, 2018, this fair hearing was requested.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case. 18 NYCRR 358-4.3(b).

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

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

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;

- the circumstances under which public assistance, medical assistance, Supplemental Nutrition Assistance Program (SNAP) benefits or services will be continued or reinstated until the fair hearing decision is issued;

- a statement that a fair hearing must be requested separately from a conference;

- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services;

- a statement that participation in an agency conference does not affect the right to request a fair hearing;

- the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;

- an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;

- the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;

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

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

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

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

Volume 42 of the Code of Federal Regulations, section 438.404, states, regarding Notices to be issued by Managed Long-Term Care Plan:

> Notice of action.
>
> **(a)** ***Language and format requirements.*** The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.
>
> **(b)** ***Content of notice.*** The notice must explain the following:
>
> (1) The action the MCO or PIHP or its contractor has taken or intends to take.
> (2) The reasons for the action.
> (3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
> (4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
> (5) The procedures for exercising the rights specified in this paragraph.
> (6) The circumstances under which expedited resolution is available and how to request it.
> **(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to** request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
>
> **(c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:**
>
> (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§ 431.211, 431.213, and 431.214 of this chapter.
> (2) For denial of payment, at the time of any action affecting the claim.
> (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1).
> (4) If the MCO or PIHP extends the timeframe in accordance with § 438.210(d)(1), it must—
>
> > (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
> > (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

The above-referenced § 431.211 requires a notice be issued at least 10 days in advance of its effective date.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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I. Accessing the benefit

a. Request for Service: A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request…

b. Nursing and Social Assessment:
   i. Initial assessment
   Once the request is received the MCO is responsible for arranging an assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.
   ii. Social Assessment
   In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated , whether the member's home has adequate sleeping accommodations for a personal care aide.

   This nursing assessment and the social assessment can be completed at the same time. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139…

c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period the

MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.

d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN and the personal care services worker to develop the plan of care based on the MCO's authorization.

II. Authorization and Notice Requirements for Personal Care Services

a. Standards for review. 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.

b. Timing of authorization review.
    i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
    ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

c. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a

Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).

d. Level and Hours of Service. 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.

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.
    i. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).
    ii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.
    iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:
        1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
        2. a mistake occurred in the previous personal care services authorization;
        3. the member refused to cooperate with the required assessment of services;
        4. a technological development renders certain services unnecessary or less time consuming;

5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice.

DISCUSSION

The evidence establishes that by Notice of Intent dated March 26, 2018, the Managed Long Term Care Plan CHL advised the Appellant of its determination to reduce the amount of Appellant's PCS, effective March 31, 2018.

At the hearing, the CHL's representative presented CHL's Notice of Intent dated March 26, 2018. However, the record in this case establishes that CHL's Reduction Notice of March 26, 2018 has an effective date of March 31, 2018, that is less than 10 days before the date upon which the proposed action is to become effective. Pursuant to 18 NYCRR Section 358-2.23, a "timely" notice is a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. See also 42 C.F.R. section 432.211, the basis for the State rule; 42 C.F.R. section 434.404, specifically making section 432.211 applicable to Managed Long-Term Care Plan determinations.

In addition, CHL did not make use of an appropriate reason. Boiled down, CHL's stated reason was "due to recent observations of your level of need." Since the fact that a reduction is occurring makes clear that the Agency or Plan involved previously found more hours to be medically necessary and appropriate for the individual under consideration, a rule has developed that the Plan or Agency must explain that some improvement has occurred in the patient, or that a mistake took place in an earlier assessment. See the New York State Department of Health's **Guidelines for the Provision of Personal Care Services in Medicaid Managed Care.**

Moreover, it should be taken into account that the same Department's Office of Health Insurance Programs, Division of Long-Term Care issued MLTC Policy 16.06 in year 2016, explaining that use of the "improvement" or "previous mistake" reasons must not be pro forma. For example, an improvement should be in an underlying condition, such as healing of a broken limb, rather than merely a sense that less assistance is required with certain tasks now than previously.

For the above-stated reasons, the Managed Long Term Care Plan's determination of March 26, 2018 to reduce the Appellant's PCS cannot be sustained.

DECISION AND ORDER

CHL's determination of March 26, 2018 to reduce the Appellant's PCS is not correct and is reversed:

1. The Managed Long Term Care Plan is directed to restore the Appellant's PCS benefits by authorizing Appellant's PCS in the amount of 24 hours daily, 7 days weekly continuous care ("split shift"), provided by more than one Personal Care Services aide.

2. The Managed Long Term Care Plan is directed to continue to authorize the Appellant to receive PCS in the amount of 24 hours daily, 7 days weekly continuous care ("split shift"), provided by more than one Personal Care Services aide.

3. In the event that the Managed Long Term Care Plan determines to implement its previously contemplated action, the Managed Long Term Care Plan is directed to provide the Appellant with a notice that meets the requirements set forth in State and federal Regulations; in the Guidelines for the Provision of Personal Care Services in Medicaid Managed Care; and in Policy Memorandum MLTC 16.06.

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 Appellant's Representative promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
06/08/2018

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee