STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 2, 2018
[redacted]
AGENCY: MAP
FH #: 7675947L

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 January 29, 2018, 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

Alicia Jacobs, Fair Hearing Representative

ISSUE

Was the determination by the Appellant's Managed Centers Plan for Healthy Living, to partially deny the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from 42 hours per week (6 hours per day, 7 days per week) to 56 hours per week (8 hours per day, 7 days per week) 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 94, has been in receipt of Medical Assistance benefits, including Personal Care Services ("PCS") through a Managed Long-Term Care ("MLTC") Health Care Plan ("the Plan") operated by Centers Plan for Healthy Living.

2. The Appellant had been in receipt of Personal Care Services in the amount of 42 hours per week.

3. On December 6, 2017, the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on December 6, 2017. A comparison of UAS-NY assessments completed on August 4, 2017 and December 6, 2017 showed some changes in your Activities of Daily Living in that your NFLOC scores showed decline from 20 on August 4, 2017 and 24 on December 6, 2017, bathing, dressing lower body, walking, locomotion toilet transfer, toilet use and bed mobility declined from extensive assistance where you need physical help to complete some parts of this task, like someone to lean on to or help to lift a body part, however you can complete most parts of this tasks by yourself to Maximal assistance, where you need physical help to complete most of this tasks. Personal hygiene and dressing upper body declined from limited assistance to extensive assistance. Meal preparation, eating and managing finances showed no change and pain control reported moderate intermittent pain that is controlled by therapeutic regimen. Stairs Capacity and transportation showed decline from extensive assistance to maximal assistance.

4. By Notice of Initial Adverse Determination dated December 22, 2017, effective December 22, 2017, the Plan determined to deny the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from six (6) hours per day, seven (7) days per week totaling forty-two (42) hours per week to six (8) hours per day, seven (7) days per week totaling fifty-six (56) hours per week. The Plan modified its Initial Determination, increasing the Appellant's PCS by 1 hour and Appellant's PCA services will be partially increased to seven (7) hours a day, to seven (7) days per week (totaling forty -nine (49) hours per week. This is sufficient to amount of time to complete the listed tasks.

5. The Appellant's Representative requested an internal appeal on behalf of the Appellant.

6. On January 2, 2018, the Appellant requested this fair hearing to contest the Plan's determination.

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 and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Medical Assistance or Services, the 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 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 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...

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. Scope of the Personal Care Benefit

a. As required by federal regulations, the personal care services benefit afforded to

MCO enrollees must be furnished in an amount, duration, and scope that is no less than the services furnished to Medicaid fee-for-service recipients. [42 CFR §438.210] …

i. The assessment process should evaluate and document when and to what degree the member requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the member's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

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 further provides, in part, that:

(2) **Some or total assistance** shall be defined as follows:

(i) Some assistance shall mean that a specific function or task is performed and completed by the patient with help from another individual.

(ii) Total assistance shall mean that a specific function or task is performed and completed for the patient.

MLTC Policy memo 13.09(a): Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York, dated September 24, 2013 reminds Plans of MLTC Policy 13.09: Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York which in turn indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM). As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective October 1, 2013; the SAAM assessment must not be used for these new enrollees. Additionally, the UAS-NY must be used for all reassessments beginning October 1, 2013.

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.

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

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

For all MLTC partial capitation plan decisions made on or after July 1, 2015, that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately.

This change in policy has the following effects:
1) enrollees are no longer required to exhaust their plan's internal appeals processes before obtaining a State fair hearing;
2) aid-continuing is no longer available if the enrollee asks only for an internal appeal of a plan's proposed reduction or discontinuance of services and does not also timely request a State fair hearing;
3) to obtain aid-continuing, enrollees must request a State fair hearing within 10 days of the date of the Managed Long Term Care Action Taken notice;
4) enrollees do not need to specifically request aid-continuing to obtain it, but they may tell OTDA that they specifically decline it; and
5) the 60 day deadline to request a State fair hearing begins on the date of the Managed Long Term Care Action Taken notice.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

e. Terminations and Reductions…

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

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care

services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

2. a mistake occurred in the previous personal care services authorization;

3. the member refused to cooperate with the required assessment of services;

4. a technological development renders certain services unnecessary or less time consuming;

5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;

6. the member's health and safety cannot be reasonably assured with the provision of personal care services;

7. the member's medical condition is not stable;

8. the member is not self-directing and has no one to assume those responsibilities;

9. the services the member needs exceed the personal care aide's scope of practice.

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.

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

According to GIS 01 MA/ 044 "… the new regulations provide that one reason for reducing or discontinuing personal care services is "the client's medical, mental, 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 than they were previously" [18 NYCRR 505.14 (b)(5)(v)(c)(1)].

Consistent with the Court ruling in Mayer, the State requires that client notices citing this reason for reducing or discontinuing services must identify the specific medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction or discontinuation in services. The client notice must explain why the change in the client's circumstances results in the need for fewer hours of services."

The GIS also provides "Districts are reminded that State policy, as reflected in the new regulations, requires that when districts determine to reduce, discontinue or deny personal care services, the client notice must identify the specific reason (whether a prior mistake in the authorization, the client's refusal to cooperate with the required assessment or other specific reason set forth in the regulations) that justifies the action. The client notice must also explain why the cited circumstance or event necessitates the reduction, discontinuance or denial of services."

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.

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: :

0i) 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;

0ii) 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;

0iii) the client refused to cooperate in the required reassessment;

0iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

0v) 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

0vi) 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)

Regulations at 18 NYCRR 358-3.3(a)(1) states that, except as provided in subdivision (d) a recipient has a right to a timely and adequate notice when a social services agency:

II. proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance Authorization or services.

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:

f. the specific laws and/or regulations upon which the action is based;

By Dear Health Plan Administrator Letter dated March 2, 2015, the Department advised in

relevant part that in an effort to improve the frequency and consistency of compliance with State and Federal notice content requirements the Department has developed two model notices: the Model Managed Long Term Care (MLTC) Initial Adverse Determination and the Model Managed Long Term Care Action Taken - Denial, Reduction or Termination of Benefits (211). Development of model notices will foster enrollee comprehension, reduce the size and length of a typical notice, create one fair hearing notice, and streamline review of such notices during compliance reviews and operational surveys. Plans are required to implement processes to utilize these models **by 5/15/15**. The Department will conduct a training session shortly. This directive is applicable to MLTC Partial Cap and Medicaid Advantage Plus (MAP) plans. Model notices for PACE plans will be forthcoming.

This communication contains detailed information on the use of these models, approval procedures, and deadlines. Please be sure to share this information with appropriate staff in your organization.

Model MLTC Initial Adverse Determination Notice

This model notice was developed for all administrative and medical necessity Actions, except for Actions based on a restriction to benefits. The model contains gray placeholder fields for both static (unchanging) plan-specific information, such as the time allowed to file an appeal, and dynamic fields that change with each Action notice. It is important that plans create mechanisms to ensure the various dynamic placeholders are utilized correctly to match the Action being taken. The model only addresses content requirements, all other notice procedures and requirements such as determination timeframes, provider notice, translations, special needs formats, clinical peer/health professional review, etc., remain the same.

As a reminder, the clinical rationale MUST:

 State the enrollee and the nature of his/her medical condition;

 State the medical service, treatment or procedure in question;

 State the basis or bases on which the plan/utilization review agent determined that the service, treatment or procedure is or was not medically necessary, experimental/investigational, or not materially different from an alternate in-network service, which demonstrates that the plan/agent considered enrollee-specific clinical information in its determination.

 Be sufficiently specific to enable the enrollee and the enrollee's health care provider to make an informed judgment regarding

1) whether or not to appeal the adverse determination, and 2) the grounds for such an appeal; and

 Be written in easily understood language.

Managed Long Term Care Action Taken – Denial, Reduction or Termination of Benefits (211) (LDSS-4687 02/15)

This model notice is designed to ensure enrollees are made aware of their due process rights and must be included with the Model MLTC Initial Adverse Determination Notice and all other Action notices, including those for restrictions to benefits. Considerable input from the advocate community was solicited to help clarify the language, *e.g.* regarding aid continuing rights for services that are stopped, reduced, or restricted. Plans must develop mechanisms to ensure the form is appropriately completed for the Action being taken.

Below is a list of certain new and noteworthy aspects of this model notice:

 The “MLTC reference number” may be any number the plan utilizes to track actions, authorizations, or notices.

 “will not be increased” checkbox is to be utilized when an enrollee asks for more of a service

during an authorization period, but the increase is denied. This is particularly relevant for enrollees in receipt of CBLTCS or who are homebound.
 “detailed explanation of change in medical condition or social circumstances” This information MUST be included in the reason for denial if the Action determines to reduce or stop CBLTCS the enrollee has been receiving.
 “ADD SPECIFIC BENEFIT CITATION AS APPLICABLE; for common actions and their corresponding citations, see the citation reference table” The regulatory citations have been updated and cover most medically necessary decisions. However, where there are specific regulations or statutes that govern the Medicaid managed care benefit, the plan must complete this section with additional appropriate citations. The Department will be providing a reference table of common citations that apply to MLTC, such as 18 NYCRR 505.14(a) for personal care services. However, it is the duty of each plan to research and include appropriate citations for every form it sends. Deadline “Date+60” This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.
 Deadline “Date+60” This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.
 Essential action information is repeated in the box on the Fair Hearing Request Form sheet. This sheet is separate to allow the enrollee to request a fair hearing by mail and still retain their original notice. The information is repeated to facilitate OTDA processing of the fair hearing request

MLTC Policy 15.04: Interim Guidance for MLTC Partial Capitation Appeal Notices advises in 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.

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 Appellant, age 94, has been in receipt of Medical Assistance benefits, including Personal Care Services ("PCS") through a Managed Long-Term Care ("MLTC") Health Care Plan ("the Plan") operated by Centers Plan for Healthy Living. The Appellant had been in receipt of Personal Care Services in the amount of 42 hours per week.

On December 6, 2017, the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on December 6, 2017. A comparison of UAS-NY assessments completed on August 4, 2017 and December 6, 2017, showed some changes in your Activities of Daily Living in that your NFLOC scores showed decline from 20 on August 4, 2017 and 24 on December 6, 2017, bathing, dressing lower body, walking, locomotion toilet transfer, toilet use and bed mobility declined from extensive assistance where you need physical help to complete some parts of this task, like someone to lean on to or help to lift a body part, however you can complete most parts of this tasks by yourself to Maximal assistance, where you need physical help to complete most of this tasks. Personal hygiene and dressing upper body declined from limited assistance to extensive assistance. Meal preparation, eating and managing finances showed no change and pain control reported moderate intermittent pain that is controlled by therapeutic regimen. Stairs Capacity and transportation showed decline from extensive assistance to maximal assistance.

By Notice of Initial Adverse Determination dated December 22, 2017, effective December 22, 2017, the Plan determined to deny the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from six (6) hours per day, seven (7) days per week totaling forty-two (42) hours per week to eight (8) hours per day, seven (7) days per week totaling fifty-six (56) hours per week. The Plan modified its Initial Determination, increasing the Appellant's PCS by 1 hour and Appellant's PCA services will be partially increased to seven (7) hours a day, to seven (7) days per week (totaling forty -nine (49) hours per week. This is sufficient to amount of time to complete the listed tasks.

At the hearing, the Plan admitted that the Appellant showed some changes in her Activities of Daily Living in that your NFLOC scores showed decline from 20 on August 4, 2017 and 24, but instead incredibly contended that the PCS was for standalone safety monitoring, instead of the cueing/supervision noted in both UASD reports for the Appellant's successful performance

of ADLs. The credible evidence in this case establishes that the Plan's stated rationale does not comport with the steady decline in the Appellant's medical or mental condition

Also at the hearing, the Appellant's Representative credibly testified the Appellant suffers from dizziness or lightheadedness, shortness of breath and broken pubic bone due to a fall and cannot walk on her own and suffers from frequent incontinence and argued that she has night time needs requiring assistance.

The record having been duly considered, the Appellant having demonstrated a decline in health and social supports, no credible evidence exists to support the Plan's refusal to supply the increase from 42 to 56 hours per week and the Plan's determination to deny the same is unsustainable because the record demonstrates that Appellant has unscheduled needs that can require more time.

DECISION AND ORDER

The determination by the Appellant's Managed Centers Plan for Healthy Living to partially deny the request, on the Appellant's behalf, for an increase in personal care services 42 hours per week to 56 hours per week, was not correct and is reversed.

1. The Plan is directed to authorize the Appellant's PCS authorization for 56 hours per week (8 hours per day, 7 days per week).

2. The Plan is directed to notify the Appellant in writing when it has complied with the aforementioned directives.

Should the 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 Plan promptly to facilitate such compliance.

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

FH# 7675947L

DATED: Albany, New York
04/11/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee