STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 10, 2018
[redacted]
AGENCY: MAP
FH #: 7879298Q

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 9, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long-Term Care Plan (Centers Plan For Health Living)

Debra Fergeson, Fair Hearing Representative

ISSUE

Was the initial adverse determination dated November 12, 2018 and the final adverse determination dated November 27, 2018 by Centers Plan for Healthy Living, to reduce the amount of personal care services provided to the Appellant from twenty-four hours daily live in care for seven days weekly to 4.5 hours daily for seven days weekly 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 74, resides alone, has been in receipt of Medical Assistance benefits provided through Centers Plan For Healthy Living, a Medical Assistance managed long term care plan.

2. The Appellant has been in receipt of personal care services in the amount of twenty-four hours daily live in care for seven days weekly.

3. On May 31, 2018 Centers Plan For Healthy Living completed a "Client Task Sheet: PCW/PCA level II" for the Appellant indicating hours per day 4.5 and hours per week 31.5.

4. On June 1, 2018, Centers Plan For Healthy Living completed a "Uniform Assessment System" assessment for the Appellant.

5. On October 25, 2018 Centers Plan For Healthy Living completed a "Client Task Sheet: PCW/PCA level II" for the Appellant indicating hours per day 4.5 and hours per week 31.5.

6. On October 25, 2018, Centers Plan For Healthy Living completed a "Uniform Assessment System" assessment for the Appellant.

7. By Initial Adverse Determination notice dated November 12, 2018, Centers Plan For Healthy Living advised the Appellant of its determination to reduce the Appellant's personal care services' authorization, effective November 24, 2018, from twenty-four hours daily consisting of live in care for seven days weekly to 4.5 hours daily, seven days weekly total 31.5 hours per week. The notice also advised that the specific reason for this determination was because the health care service is not medically necessary.

8. On November 12, 2018, the Appellant filed an internal appeal with Centers Plan for Health Living Grievance and Appeals Department.

9. By Final Adverse Determination notice dated November 27, 2018, Centers Plan for Healthy Living advised the Appellant of its determination to uphold its Initial Adverse Determination to reduce the Appellant's personal care services' authorization, effective December 7, 2018, from twenty-four hours daily consisting of live in care for seven days weekly to 4.5 hours daily, seven days weekly total 31.5 hours per week. The notice also advised that the specific reason for this determination was because the health care service is not medically necessary.

10. On December 10, 2018, the Appellant requested this fair hearing to review Centers Plan for Healthy Living's determinations.

APPLICABLE LAW

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or

threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

The Medicaid Managed Care Model Contract delineates the terms by which Medicaid Managed Care Plans agree to cover specified healthcare services in accordance with New York State Medicaid Guidelines. Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

GIS 11 MA/009 provides that effective August 1, 2011, personal care services for non-dual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and

other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.
(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home...".

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

(2) 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.

(4) 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.

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

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

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;
(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours weekly.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

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

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

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

(13) changing of simple dressings.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

> arranging for the delivery of personal care services according to subdivision (c) of this section….
> monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

Section 505.14(a)(3)(iii)(a) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by any of the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

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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II. 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.

III. Authorization and Notice Requirements for Personal Care Services

e. 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.

f. 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).

g. 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).

h. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours daily, the number of hours weekly, 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.

i. 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.

. Section 505.14 Personal Care Services 18 NY ADC 505.14(5)(vi)(d)

The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services had been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of daily living functional potential;
- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);
- Urinary incontinence and indwelling catheter;
- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);
- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental Care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

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4480. PERSONAL CARE SERVICES

C. Scope of Services – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the

form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

As outlined in GIS 01 MA/044, the New York State Department of Health advises local Districts that when a determination is made to reduce, discontinue or deny personal care services, the notice must identify the specific reason that justifies the action, and explain why the stated reason justifies the reduction, discontinuance, or denial of such services.

MLTC Policy 16.05, provides further guidance to MLTC plans about appropriate reasons and notice language to be used when proposing to reduce or discontinue Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS). The MLTC Policy specifically addresses a reduction or discontinuance for 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.

The MLTC Policy notes that a plan cannot reduce or discontinue an enrollee's PCS or CSPAS without a legitimate reason, e.g. one of the reasons listed in 18 NYCRR 505.14(b)(5)(v)(c)(2)(i) [PCS] and 18 NYCRR 505.28(h)(5)(ii)(a)-(f) [CDPAS) The plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering that facts of the individual enrollee's circumstances and cannot reduce or discontinue services as part of an "across the board" action that does not consider each individual enrollee's particular circumstances and need for assistance. The plan's notice has to accurately advise the enrollee, in plain comprehensible language, ***what*** the plan is proposing to change concerning the enrollee's PCS or CDPAS and ***why*** the plan is making the change.

The MLTC Policy discusses in detail what a notice of reduction or discontinuance must contain for a change in the enrollee's medical or mental condition or social circumstances or for a mistake. Examples of specific notice language for these two circumstances are provided.

<u>Change in the enrollee's medical or mental condition or social circumstances</u>

- A plan must not simply recite a boilerplate reason such as: "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.
- A plan's notice must state the following:

    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.

Mistake

- A 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. Language such as: "A mistake occurred in the previous PCS or CDPAS authorization or reauthorization" is not sufficient.
- The notice must adhere to the following guidelines:

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.

MLTC Policy 16.06 date of issuance: November 17, 2016

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 Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The record establishes that the Appellant, 74 years old, has been in receipt of a Medical Assistance authorization through Centers Plan For Healthy Living (CPHL), a Medical Assistance managed long term care plan, and has been in receipt of personal care services in the amount of twenty-four hours daily Live In care for seven days weekly. The record further establishes that by Initial Adverse Determination notice dated November 12, 2018, and by Final Adverse Determination Notice dated November 27, 2018, CPHL advised the Appellant of its determination to reduce the Appellant's personal care services authorization, effective December 7, 2018 from twenty-four hours daily "Live In" care for seven days weekly to 4.5 hours daily, seven days weekly. The Appellant requested this fair hearing to challenge the Managed Long-Term Care Plan's determinations.

A review of The Initial Adverse Determination notice, dated November 12, 2018 by CPHL advised that the specific reason for this determination is:

"On 11/8/2018, Centers Plan for Healthy Living is taking this action because health care service is not medically necessary. Your Personal Care Aide Level 2 will be reduced because:

A Registered Nurse from Centers Plan for Healthy Living visited you in your home on 10/25/2018 and completed a face-to-face assessment, using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs.

Based on this assessment, it was identified that:

You are able to walk with the assistance of cane or walker.

You can transfer on and off the toilet and take care of your toileting needs with some physical touch and direction.

You are able to take care of your toileting needs without any assistance.

You are able to feed yourself with some direction once your meals are prepared by your Personal Care Aide.

You are able to direct your own care with some physical touch and direction. You can activate a Personal Emergency Response if necessary.

For Safety Monitoring or Supervision: you require safety monitoring and supervision as a standalone task.

You have been receiving Level II Personal Care Aide (PCA) twenty-four (24) hour Live-In hours per day, seven (7) days per week (totaling ninety-one (91) hours per week). Doctors notes were thoroughly reviewed by Centers Plan for Healthy Living. Based on clinical documentation presented, your current Personal Care Aide Services will be decreased to four and a half (4.5) hours per day, seven (7) days per week (totaling thirty-one and a half (31.5) hours per week) are appropriately and safely meeting your personal care needs. This is enough time to complete the above-mentioned tasks and adequately meet your needs. This change will take effect as of 11/20/2018.

Centers Plan for Healthy Living will continue to assess your health care needs."

See *MLTC Plan Exhibit 1, Initial Adverse Determination dated November 12, 2018 by Centers Plan for Health Living.*

A review of The Managed Long-Term Care Plan's Final Adverse Determination Notice dated November 27, 2018 by CPHL advised that the specific reason for this determination is:

"We made this decision because the service is not medically necessary. You no longer meet the criteria for your current level of service because:

You are a 74-year old woman who lives alone in a one-bedroom apartment in an elevator building for senior citizens. **You have a supportive family that is involved in all aspects of your care.** Your past medical history includes osteoarthritis, coronary artery disease, diabetes, and chronic [redacted]. Progress notes from a visit to your physicians' office on October 4, 2018 indicate that the [redacted] has resolved.

The New York State Department of Health's Uniform Assessment System (UAS)-NY) from October 25, 2018 was reviewed and the following was noted: 1) You are alert and oriented to person, place, and time. There is no cognitive, communication, or mood disturbance: 2) You are totally dependent for shopping and housework; 3) you require maximal assistance for meal preparation; 4) You require extensive assistance for transportation and stairs: 5) You require limited assistance for finance, phone use, medications, bathing, hygiene, dressing upper and lower body, locomotion, toileting, bed mobility and walking; 6) You are able to complete a 4 meter walk in 10 seconds, and can ambulate from 150-299 feet; 7) There were no falls or hospitalizations in the preceding 90 days.

Based upon review of the record, a 24-hour live-in PCA, 7 days per week, is not medically necessary. Your needs can be met with 4.5 hours of PCA services, 7 days per week. Denial is upheld.

This decision is based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool."

See *MLTC Plan Exhibit 3, Final Adverse Determination dated November 27, 2018 by Centers Plan for Health Living.*

At the Fair Hearing, the Appellant's Representative contended that the Centers Plan For Healthy Living's evidence was insufficient to establish any justification to reduce the Appellant's Personal Care Services.

In particular, the Appellant's Representative pointed out that Centers Plan For Healthy Living's own evidence does not support Centers Plan For Healthy Living's determination that: "You have a supportive family that is involved in all aspects of your care." The Appellant's Representative indicated that The Center Plan's For Healthy Living's June 1, 2018 "Uniform Assessment System" assessment and the October 25, 2018 "Uniform Assessment System" assessment for the Appellant both indicate regarding the Appellant's social supports: "No informal helper". In addition, the Appellant's Representative pointed out that the Managed Long Term Care Plan partially based its determinations on the premise "Progress notes from a visit to your physicians' office on October 4, 2018 indicate that the [redacted] has resolved", however, the Managed Long Term Care Plan did not submit into evidence any progress notes from an Appellant visit to the Appellant's physician's office on October 4, 2018 indicating that the Appellant's [redacted] has resolved. The Appellant's Representative (Appellant's daughter) testified that the Appellant's [redacted] has not resolved and has become worse.

Furthermore, the Appellant's Representative contended that the Appellant has not had a change in social circumstances to justify a reduction in personal care services. The Appellant's Representative-daughter testified that she works full time and contrary to the Managed Long Term Care Plan's assertion, the Appellant's Representative, nor any family member is "involved in all aspects of your care.". As such, the record does not demonstrate an improvement or change in the Appellant's situation so as to justify a reduction in her services. The Appellant's Representative's contention that Centers Plan For Healthy Living's evidence was insufficient to

establish any justification under the law to reduce the Appellant's Personal Care Services is found persuasive.

In addition, the Appellant's Representative persuasively contended that Centers Plan For Healthy Living Initial Adverse Determination Notice dated November 12, 2018 and November 27, 2018 are defective on the grounds that utilizing a Tasking Tool or UAS as a basis to reduce Personal Care Services for a person receiving 24 hour Live In Personal Care Services, violates Section 505.14 Personal Care Services 18 NY ADC 505.14 (5)(vi)(d), which only authorizing utilizing a "span of time" and not a task based assessment to be used to reduce personal care services regarding a recipient of 24 hour Live In personal care services. Section 505.14 Personal Care Services 18 NY ADC 505.14(5)(vi)(d) states:

"The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services had been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers."

See cited supra, Section 505.14 Personal Care Services 18 NY ADC 505.14

Moreover, the Appellant's Representative also persuasively contended that Centers Plan For Healthy Living's Initial Adverse Determination dated November 12, 2018 and the Centers Plan For Healthy Living Final Adverse Determination dated November 27, 2018 are also defective on the grounds of being in violation of MLTC Policy 16.05 and MLTC Policy 16.06

MLTC Policy 16.05 and MLTC Policy 16.06, provides guidance to MLTC plans about appropriate reasons and notice language to be used when proposing to reduce or discontinue Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS). The MLTC Policy notes that a plan cannot reduce or discontinue an enrollee's PCS or CSPAS without a legitimate reason, e.g. one of the reasons listed in 18 NYCRR 505.14(b)(5)(v)(c)(2)(i) [PCS] and 18 NYCRR 505.28(h)(5)(ii)(a)-(f) [CDPAS). The plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering that facts of the individual enrollee's circumstances and cannot reduce or discontinue services as part of an "across the board" action that does not consider each individual enrollee's particular circumstances and need for assistance. The plan's notice has to accurately advise the enrollee, in plain comprehensible language, ***what*** the plan is proposing to change concerning the enrollee's PCS or CDPAS and ***why*** the plan is making the change. Furthermore, the MLTC Policy discusses in detail what a notice of reduction or discontinuance must contain for a change in the enrollee's medical or mental condition or social circumstances or for a mistake. Examples of specific notice language for these two circumstances are provided.

<u>Mistake</u>

- A 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. Language such as: "A mistake occurred in the previous PCS or CDPAS authorization or reauthorization" is not sufficient.

- The notice must adhere to the following guidelines:

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.

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.

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.

Lastly, the Appellant's Representative testified that the Appellant's [redacted] has not resolved and that the Appellant has unscheduled toileting needs day and night. In support of the Appellant's claim, the Appellant's Representative submitted over 300 pages of current medical documents spanning 2016 to present, from NYU Langone hospital indicating that the Appellant's medical conditions have deteriorated.

See *Appellant Exhibit A*, dated from 2016 to present NYU Langone Health System pages 1 to 300.

The record establishes that the basis of Centers Plan For Healthy Living's Initial Adverse Determination dated November 12, 2018 and the record establishes that the basis of Centers Plan for Health Living's Final Adverse Determination dated November 27, 2018 based, in pertinent part, that "*A Registered Nurse from Centers Plan for Healthy Living visited you in your home on 10/25/2018 and completed a face-to face-assessment, using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general needs*". However, Centers Plan For Healthy Living's Initial Adverse Determination dated November 12, 2018 and Centers Plan For Healthy Living's Final Adverse Determination dated November 27, 2018, do not identify any of the required reasons to justify a reduction of Personal Care Services pursuant to MLTC Policy 16.05 and MLTC Policy 16.06.

The Appellant's Representative contended that Centers Plan For Healthy Living's Initial Adverse Determination dated November 12, 2018 and that Centers Plan for Healthy Living's Final Adverse Determination dated November 27, 2018 do not indicate that the Appellant's medical or mental condition or social circumstances changed or that a mistake occurred in the previous Personal Care Services authorization to possibly justify its determinations as required; are defective notices and such failures violate MLTC Policy 16.05 and MLTC Policy 16.06. The Appellant's Representative's contentions that the Centers Plan For Healthy Living's Initial Adverse Determination Notice dated November 12, 2018 and that the Centers Plan For Healthy Living Final Adverse Determination dated November 27, 2018 are defective are found persuasive.

See cited supra, MLTC Policy 16.06 Date of Issuance: November 17, 2016

The Centers Plan For Healthy Living UAS dated October 25, 2018, indicates that the Appellant, aged 74 is diagnosed with: [redacted].

In addition, Centers Plan For Healthy Living UAS dated October 25, 2018 indicates that the Appellant requires Total Assistance with: ordinary housework and shopping. The Appellant requires Maximum Assistance with: meal preparation. The Appellant requires Extensive Assistance with: stairs and transportation. The Appellant requires Limited Assistance with: managing medications, phone use, bathing, personal hygiene, dressing upper body, dressing lower body, walking, locomotion, toilet use, and bed mobility.

The record establishes that the Appellant's medical conditions have worsened. The record also establishes that the Appellant does not have "a supportive family that is involved in all aspects of your care" and accordingly, The Managed Long Term Care Plan, Centers Plan for Healthy Living did not have sufficient evidence to establish a basis for the reduction in the Appellant's Personal Care Services.

Based upon the foregoing, Centers Plan For Healthy Living did not meet its burden of proof as required by 18 NYCRR 358-5.9(a). Accordingly, Centers Plan For Healthy Living's Initial Adverse Determination dated November 12, 2018 and Centers Plan for Health Living Final Adverse Determination dated November 27, 2018 cannot be sustained.

DECISION AND ORDER

The Initial Adverse Determination by Centers Plan For Healthy Living dated November 12, 2018, and The Final Adverse Determination by Centers Plan For Healthy Living dated November 27, 2018 to reduce the amount of personal care services provided to the Appellant

from twenty-four hours daily Live In care for seven days weekly to 4.5 hours daily, seven days weekly is not correct and is reversed.

1. Centers Plan For Healthy Living is directed to cancel its Initial Adverse Determination dated November 12, 2018; its Final Adverse Determination Notice dated November 27, 2018 and restore the Appellant's Personal Care Services authorization to the amount of twenty-four hours daily Live In Care for seven days weekly.

2. Centers Plan For Healthy Living directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of twenty-four hours daily Live In care for seven days weekly.

Should Centers Plan For Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to Centers Plan For Healthy Living promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, Centers Plan For Healthy Living must comply immediately with the directives set forth above

DATED: Albany, New York
01/28/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee