STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 29, 2018
[redacted]
AGENCY: MAP
FH #: 7730516J

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 June 1, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Long-Term Care Plan's determination to reduce the Appellant's Medical Assistance benefits based on its Notice of Intent dated March 26, 2018 correct?

Was the Managed Long-Term Care Plan's determination to reduce the Appellant's authorization of Personal Care Services in the amount of 24 hour, continuous care ("split-shift"), 7 days weekly to 9.5 hours daily, 7 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 91, is enrolled in a Managed Long-Term Care Plan (MLTC Plan) provided by Centers Plan for Healthy Living.

2. The Appellant has been in receipt of a Medical Assistance authorization, through her MLTC Plan, of personal care services in the amount of 24 hour, continuous care ("split-shift"), 7 days weekly Medical Assistance benefits.

3. On December 4, 2017, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs.

4. On January 2, 2018 a Continental Home Care Narrative (6 months) was conducted by a Registered Nurse of the Appellant's personal care needs.

5. By Initial Adverse Determination notice dated March 26, 2018, the Managed Long-Term Care Plan advised the Appellant of its determination to reduce the Appellant's personal care services Medical Assistance benefits on the grounds that: "The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool".

6. The Managed Long-Term Care Plan's Notice of Initial Adverse Determination dated March 26, 2018 was not mailed at least ten days prior to the effective date of the proposed action ("This action will take effect on 3/26/2018").

7. On March 29, 2018 the Appellant requested this fair hearing.

APPLICABLE LAW

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Public Assistance, Medical Assistance or Services; or has increased the Public Assistance grant; or has determined to change the amount of one of the items used in the calculation of a Public Assistance grant or Medical Assistance spenddown; or has determined that an individual is not eligible for an exemption from work requirements. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for a Public Assistance or Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Public Assistance or Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Public Assistance or Medical Assistance in another district.

In general, a SNAP recipient has a right to a timely and adequate adverse action notice when the Agency proposes to take any action to discontinue, suspend or reduce the recipient's

SNAP benefits during the certification period. 18 NYCRR 358-2.3; 18 NYCRR 358-3.3(b). An adequate, though not timely, action taken notice is required where the Agency has accepted or denied an application for SNAP benefits; or has increased the SNAP benefits; or has determined to change the amount of one of the items used in the calculation of the SNAP benefits. 18 NYCRR 358-3.3(b). However, pursuant to 18 NYCRR 358-3.3(e), there is no right to an adverse action notice when, for example, the change is the result of a mass change, the Agency determines that all members of the household have died or the household has moved from the district or when the household has failed to reapply at the end of the certification period.

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

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

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;
- the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued;
- a statement that a fair hearing must be requested separately from a conference;
- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services;

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

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

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

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

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

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

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

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

18 NYCRR 358-2.2

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 per week.

(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 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.

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.

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.

Change in the enrollee's medical or mental condition or social circumstances

- 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.

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 Appellant requested this hearing to review the Centers Plan for Healthy Living Managed Long-Term Care Plan's (MLTC Plan) Initial Adverse determination notice to reduce the Appellant's Medical Assistance benefits based on its Notice of Initial Adverse Determination dated March 26, 2018.

A review of the MLTC Plan's notice shows that it was not mailed at least ten days prior to the effective date of the proposed action as required by 18 NYCRR 358-2.23. These defects in the MLTC Plan's notice make it void and therefore, the MLTC Plan's determination to reduce the Appellant's Personal Care Services Medical Assistance benefits cannot be sustained.

The record also establishes that the Appellant, age 91, resides alone, has been in receipt of a Medical Assistance authorization through Center Plan for Healthy Living, ("MLTC Plan"), a Medical Assistance managed long term care plan, and has been in receipt of personal care services in the amount of 24 hour, continuous care ("split-shift"), 7 days weekly. The record further establishes that by initial adverse determination notice dated March 26, 2018, The MLTC Plan, Centers Plan for Healthy Living advised the Appellant of its determination to reduce the Appellant's personal care services authorization, effective March 26, 2018, from 24 hour, continuous care ("split-shift"), 7 days weekly to 9.5 hours daily, 7 days weekly on the grounds that; "The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool".

At the fair hearing, the MLTC Plan submitted the Centers Plan for Healthy Living Initial Adverse Determination dated March 26, 2018, marked as MLTC Plan Exhibit 2 into evidence. The MLTC Plan Initial Adverse Determination notice dated March 26, 2018, marked as Exhibit 2 states:

"Centers Plan for Healthy Living has determined that coverage for the above mentioned services will be reduced. This action will take effect on 3/26/2018. The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-BNY) and the plan's client tasking tool.

You have been enrolled with Centers Plan for Health Living (CPHL) since 12/01/2017 and have been receiving the following Personal Care Aide (PCA) services, twelve (12) hours during the day and twelve (12) hours during the night (split shifts) totaling one hundred sixty-eight (168) hours per week for 120 days as a Continuity of Care of your pre-existing service plan.

A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted by Centers Plan for Health Living (CPHL) on 12/04/2017 as your 120 days Continuity of Care is ending 03/31/2018. This assessment showed that you have demonstrated the following in your abilities to perform your Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs):
Walking, locomotion, Toilet Use, Meal Preparation Capacity, and Ordinary House Work Capacity tasked as Total Dependence: You depend completely upon someone else to complete all parts of this task. You do not participate in this task at all.
Dressing Upper and Lower Body, Personal Hygiene, Bed Mobility, Bathing, Transfer Toilet, Eating, Medication Management Capacity tasked as Maximal Assistance: You need physical help to complete most parts of this task, like someone to lean on or help you lift a body part, however you can complete some parts of this task by yourself.
Bladder Continence – Incontinent
Bowel Continence – Incontinent
Falls: you have reported no falls in the last 90 days.
Hospitalizations: you have reported No hospitalization within 90 days.

The current UAS-NY assessment conducted on 12/04/2017 demonstrated that your needs can be effectively met with nine and a half (9.5) hours per day, seven (7) days per week (Totaling sixty-six and a half (66.5) hours per week) of Personal Care Aide (PCA) services to complete the above-mentioned tasks.

Pursuant to the New York State Department of Health Continuity of Care Policy (Managed Long-Term Care (MLTC) Policy 17.02) you have been receiving (Personal care Aide (PCA) services, twelve (12) hours during the day and twelve (12) hours during the night (split twelve (12) shifts) totaling one hundred sixty-eight (168) hours per week. These services were provided as a continuity of your pre-existing service plan prior to your enrollment with Centers Plan for Healthy Living (CPHL) on 12/01/2017. These services have been in effect for at least one hundred (120) days, or until 03/31/2018.

Therefore, based on the most recent UAS-NY comprehensive assessment conducted on 12/04/2017, reflecting your current needs, your PCA services will be decreased from twelve (12) hours during the day and twelve (12) hours during the night (split twelve (12) shifts) totaling one hundred sixty-eight (168) hours per week to twenty-four (24) hours per day, seven (7) days per week live-in Personal Care Aide (PCA) services. This decrease will take effect as of 04/8/2018.

We will review your care again in June 2018 or earlier if any significant clinical changes in your condition occur.

Before this action, from 12/1/2017 to 3/31/2018, the plan approved:
12 Hours/Day Personal Care Aide Level 2, 7 per week, 12 Hours/Day Personal Care Aide Level 2, 7 per week, 168 Hours per week
Starting 3/26/2018, the plan approval changes to:
1 Days/Day Personal Care Aide Level 2- Live-In per diem, 7 day(s) per week
This means from 4/8/2018 to 6/30/2018, your health care is approved for:

1 Days/Day Personal Care Aide Level 2- Live-In per diem, 7 day(s) per week."

See MLTC Exhibit 2, Centers Plan for Health Living Initial Adverse Determination Notice dated March 26, 2018.

The MLTC Plan's total evidence packet that was submitted into evidence consisted of Waiver of Appearance Request dated June 1, 2018 marked as MLTC Plan Exhibit 1, MLTC Plan's Initial Adverse Determination Notice dated March 26, 2018 marked as MLTC Plan Exhibit 2, Uniform Assessment System New York (UAS) dated December 4, 2017 marked as MLTC Plan Exhibit 3 and Continental Home Care Narrative 6 months marked as MLTC Plan Exhibit 4.

The Appellant Representatives, Appellant's son and daughter, contended that the MLTC Plan's evidence packet was insufficient to support its determination to reduce the Appellant's 24 hour, 7 days weekly continuous care ("split-shift"). The Appellant Representative pointed out that the MLTC Plans basis for the determination was partially based on "the plan's client tasking tool", however, the MLTC Plan did not submit into evidence any client tasking tool documents.

Moreover, the Appellant Representatives, Appellant's son and daughter, contended that the MLTC Plan's evidence packet was also insufficient to support its determination to reduce the Appellant's 24 hour, 7 days weekly continuous care ("split-shift") because the MLTC Plan did not submit the prior UAS which the Appellant Representatives contended would have shown that the Appellant's medical conditions did not improve and therefore the MLTC Plan's notice to reduce personal care services is not supported by the MLTC Plan's evidence.

In addition, the Appellant Representatives, Appellant's son and daughter, contended that the MLTC Plan's Initial Adverse Determination Notice dated March 26, 2018 is defective on the grounds that it is not timely (the Notice date and effective date are the same date, March 26, 2018), but also, that the Notice is defective on the grounds that the notice is internally inconsistent. The Appellant Representatives pointed out, that on the first page of the Notice of Initial Adverse Determination dated March 26, 2018, the Notice advises the Appellant of a reduction of personal care services from 24 hour, 7 days weekly continuous care ("split-shift") to 9.5 hours daily, 7 days weekly, however, on page 2 of the MLTC Plan's same notice, the notice advises the Appellant of a reduction of personal care services from 24 hours , 7 days weekly continuous care ("split-shift"), to 24 hour live in, 7 days weekly.

All of the Appellant Representative's contentions are found persuasive and the Centers Plan for Healthy Living Initial Adverse Determination dated March 26, 2018 Notice is found to be defective on the multiple grounds that the notice is not timely (i.e., the Notice date and effective date are both March 26, 2018) and that the Notice is internally inconsistent in notifying the Appellant regarding the reduction; specifically, the previous and *new* amounts of assistance or benefits provided.

Furthermore, regarding Centers Plan for Healthy Living's determination, MLTC Policy 16.05, 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 Notice 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>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.

<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.

The Appellant Representatives, further contended that the MLTC Plan's evidence does not support a reduction in the Appellant's personal care services. In particular, the Appellant Representatives contended that the MLTC Plan's own evidence, the UAS dated December 4, 2017 does not indicate that the Appellant had an improvement in ADL status. A review of MLTC Plan's Exhibit 3, UAS dated 12/4/2017 indicates on page 5:

"Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago: No change

Overall self-sufficiency has changed significantly as compared to status 90 days ago, or since last assessment if less than 90 days: No change"

See MLTC Plan Exhibit 3, UAS dated December 4, 2017.

The Appellant Representatives both testified at the fair hearing, and both testified that the Appellant cannot do any activity of daily living without total assistance. In support of their contentions, they presented at the fair hearing a video of the Appellant. The video filmed the Appellant being lifted out of bed by a lift hoist machine, into a chair, to be fed and to have her hair combed. The Appellant Representatives also submitted into evidence night logs indicating that the night shift personal care attendant rolled the Appellant every 2 hours during the night to prevent bed sores and that the Appellant's diapers were changed every 3 hours during the night to prevent [redacted]. The logs indicate that the personal care attendant would not be able to obtain 5 hours of uninterrupted sleep which is required as per regulations.

The Appellant Representatives also stated that the Appellant's medical conditions have deteriorated and that the Appellant was hospitalized in May of 2018 and admitted into the hospital for a few days for a [redacted].

The Appellant Representatives contended that the MLTC Plan is incorrect in reducing the Appellant's 24 hour split shift care (2 x 12 hour split shift) because the Appellant requires total assistance in every activity of daily living In support of this contention they submitted into evidence a medical document from the Appellant's psychiatrist dated April 24, 2018 marked as Appellant Exhibit C which states:

"This letter is to inform you that Ms. [redacted] is under care of [redacted]v, M.D. for the treatment of:

Senile Dementia with Delusions and behavioral disturbances

Patient is presenting with significant loss of cognitive function and cognitive decline. She is presenting with loss of memory, orientation, attention and concentration as well as episodes of confusion. She is presenting with severe behavioral disturbances. Patients family is reporting she has frequent episodes of agitation and is prone to crying and screaming. In addition, patient is suffering from Congestive Heart Failure, Atrial Fibrilliation, Hyperlipedimiam, Hypo Thyroidism and Pressure Ulcers. Patient is bedridden and has urine and feces incontinence. She is in need of assistance with all routines, she is even unable to feed herself.

The nature and extent of patient's mental and medical health condition require her to be under constant professional supervision and in need of professional assistance. She is in need of active supervision during the night due to periods of agitation that would be best provided by 12/12 hour HHA assistance.

Patient is currently being prescribed the following medications:

Namenda XR 14 mg, 1 cap daily
Haloperidol 0.5 mg, 1 tab at bedtime
Aricept 10 mg, 1 tab at bedtime
Zoloft 50 mg, 1 tab daily

If you have any questions please do not hesitate to contact me at the above mentioned number.

Sincerely,

[redacted], M.D.
Board Certified Psychiatrist."

See Appellant Exhibit C, dated April 24, 2018 Dr[redacted].

The record establishes that, in the present case, the basis of MLTC Plan's determination of March 26, 2018 is, in pertinent part, that the Appellant "The plan is taking this action based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool". However, the MLTC Plan's determination of March 26, 2018 does not identify the

particular condition or circumstance - whether medical condition, mental condition, or social circumstance – that has changed since the last assessment or authorization that would possibly justify the MLTCP's determination and as required. Furthermore, the record establishes that MLTC Plan's determination of March 26, 2018 does not identify the specific material mistake that occurred in the previous assessment or reauthorization and explain why the prior services are not needed as a result of the mistake so as to possibly justify its determination and as required. Such failures violate MLTC Policy 16.05.

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). As such, Centers Plan for Health Living's determination of March 26, 2018 cannot be sustained.

DECISION AND ORDER

The determination by Centers Plan for Healthy Living, dated March 26, 2018, to reduce the amount of personal care services provided to the Appellant from 24 hour, 7 days weekly continuous care ("split-shift") to 9.5 hours, 7 days weekly is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to cancel its determination dated March 26, 2018 and restore the Appellant's Personal Care Services authorization to the amount of 24 hour, 7 days weekly continuous care ("split-shift").

2. Centers Plan for Healthy Living is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 24 hour, 7 days weekly continuous care ("split-shift").

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.

FH# 7730516J

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

DATED: Albany, New York
06/08/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee