STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 11, 2018
[redacted]
AGENCY: Nassau
FH #: 7757935Q

In the Matter of the Appeal of

[redacted]

from a determination by the Nassau County 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 July 13, 2018, in Nassau County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan

On papers only - Plan appearance waived by the Office of Administrative Hearings

ISSUES

Was the Appellant's request for a fair hearing to review the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase of her Personal Care Services authorization from 51 hours per week to 112 hours per week, timely?

Assuming the request was timely, was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase of her Personal Care Services authorization from 51 hours per week to 112 hours per week correct?

FACT FINDINGS

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 71, has been enrolled in a Medicaid Managed Long Term Care Plan through Centers Plan for Healthy Living (hereinafter, the "Plan") and has been in receipt of a Personal Care Services (hereinafter, "PCS") authorization.

2. The Appellant requested the Plan to increase her PCS authorization from 51 hours per week to 112 hours per week.

3. On February 6, 2018, the Plan's nurse completed a reassessment of the Appellant.

4 By Initial Adverse Determination, dated February 14, 2018, the Plan determined to deny the Appellant's request for an increase in in her PCS authorization from 51 hours per week to 112 hours per week based on the Plan's nurse's reassessment, but agreed to increase Appellant's PCS authorization to 62 hours per week.

5. The notice advised that the Appellant has 60 days from the date of this notice to ask for a fair hearing.

6. The Plan's Initial Adverse Determination was upheld on internal appeal.

7. On May 11, 2018, this fair hearing was requested, contesting the Plan's determination to deny a request for an increase in the Appellant's PCS authorization from 51 hours per week to 112 hours per week.

APPLICABLE LAW

Section 22.4 of the Social Services Law provides that, for actions other those concerning SNAP benefits, a request for a fair hearing to review an Agency's determination must be made within sixty days of the date of the Agency's action or failure to act.

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

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

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

GIS 01 MA/044 reminds districts that regulations provide that a determination to reduce, discontinue or deny a client's prior authorization must be stated in the client notice. The regulations set forth several examples of appropriate reasons and notice language to be used when reducing, discontinuing or denying services. 18 NYCRR 505.14(b)(5)(v)(c)(1)-(10).

For example, the new regulations provide that one reason for reducing or discontinuing personal care services is "the client's medical, mental, economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously". 18 NYCRR 505.14 (b)(5)(v)(c)(1). Consistent with the Court ruling in Mayer, the State requires that client notices citing this reason for reducing or discontinuing services must identify the specific medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction or discontinuation in services. The client notice must explain why the change in the client's circumstances results in the need for fewer hours of services.

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

In addition to clarifying requirements for client notices under Mayer, the Department's new regulations also reflect a Court ruling in Mayer regarding the use of task based assessments. 18 NYCRR 505.14(b)(5)(v)(d). Specifically, social services districts are prohibited from using task-based assessments when authorizing or reauthorizing personal care services for any recipient whom the district has determined needs 24 hour care, including continuous 24 hour services (split-shift), 24 hour live-in services or the equivalent provided by a combination of formal and informal supports or caregivers. In addition, the district's determination whether the recipient needs such 24 hour personal care must be made without regard to the availability of formal or informal supports or caregivers to assist in the provision of such care. For a further explanation of this requirement, districts should consult GIS message 97 MA/033, issued on November 26, 1997.

Federal Regulations (Title 42) state, in pertinent part:

§ 438.210 Coverage and authorization of services.

(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 § 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…

(c) ***Notice of adverse action***. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

(d) ***Timeframe for decisions.*** Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.*

(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

§438.404 Notice of action.

(a) ***Language and format requirements.*** The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.

(b) ***Content of notice.*** The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) ***Timing of notice.*** The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

§431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

§431.213 Exceptions from advance notice.

The agency may send a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a beneficiary;

(b) The agency receives a clear written statement signed by a beneficiary that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;

(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);

(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

(f) A change in the level of medical care is prescribed by the beneficiary's physician;

(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

§431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and

(b) The facts have been verified, if possible, through secondary sources.

18 NYCRR 360-10.8(e)(2)(i)(f)(11) provides, in part, that:

(e) Notices

…

(2) An MMCO or its management contractor shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing in a manner and form determined by the department whenever a notice of action is issued. For the purposes of this paragraph, *MMCO*

means an HMO, PHSP or HIV SNP. A notice of action that sets forth all of the information required by subparagraph (i) of this paragraph will be considered an adequate notice for the purposes of section 358-2.2 of this Title.

(i) The notice of action shall include:

…

(f) the enrollee's right to a fair hearing and the procedures for exercising this right, including:

…

(11) if an MMCO or its management contractor has determined to reduce, suspend, or terminate a service or benefit currently authorized: the circumstances under which the enrollee's benefits will be continued unchanged; how to request that benefits be continued; explanation that a request for an MMCO appeal is not a request for the enrollee to have benefits continue; and the circumstances under which the enrollee may be required to pay the costs of continued services. Such notice shall be issued within the timeframes required by federal regulations at 42 CFR 438.404(c)(1) and sections 358-2.23, 358-3.3(a)(1), and 358-3.3(d)(1) of this Title.

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. 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.

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;
- when the agency action or proposed action is a reduction, discontinuance, restriction or suspension of public assistance, medical assistance, SNAP benefits or services, the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued; that a fair hearing must be requested separately from a conference; and 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; and that participation in an agency conference does not affect the right to request a fair hearing;
- 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

Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

The Regulations at 18 NYCRR 505.14 discuss Personal Care Services and state, in pertinent part:

> (a) Definitions and scope of services.
>
> (1) Personal care services means 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, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.
>
> (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.
>
> (3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(i) The patient's medical condition shall be stable, which shall be defined as follows:

(a) the condition is not expected to exhibit sudden deterioration or improvement; and

(b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and

(c)(1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or

(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

(ii) The patient shall be self-directing, which shall mean that he/she is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. Patients who are nonself-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services, except under the following conditions:

(a) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or

(b) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

(c) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The local social services department may be the outside agency.

(iii)(a) Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient’s need for assistance can be met by 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.

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

(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.

General Information Service message 97 MA 033 includes a reminder concerning "statements of understanding". The GIS Message advises that the contribution of family members or friends to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever.

General Information Service Message GIS 3 MA/03 states:

The purpose of this GIS is to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies.

Social services districts, including those using locally developed task based assessment (TBA) instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patient's appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 N.Y.C.R.R.§ 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime

needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

When the district, in accordance with 505.14 (a)(4), has determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed**.**

Completion of accurate and comprehensive assessments is essential to safe and adequate care plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

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).

At a fair hearing concerning the denial of an application for assistance, the Appellant must establish that the Agency's denial of assistance was not correct. 18 NYCRR 358-5.9(a).

MLCT Policy 16.07 provides guidance to Managed Long Term Care Plans on the use of task-based assessment tools for Personal Care Services and states:

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance

services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.

If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring, supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates.

  NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

  Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such

cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night**.** A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

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

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at mltcworkgroup@health.ny.gov.

MLTC Policy 16.07.

General Information System Message GIS 13MA/015 states:

The purpose of this General Information System (GIS) message is to remind local departments of social services (LDSS) of action they should take when a fair hearing decision reverses a LDSS denial of a Medicaid application.

At a fair hearing to review a LDSS denial of a Medicaid application, the Medicaid applicant has the burden of proving that the LDSS's denial was incorrect. When the applicant prevails, the fair hearing decision will reverse the LDSS's denial. The LDSS cannot deny the application based on the reason that was set forth in the agency's denial that was reversed.

When a fair hearing reverses a LDSS denial of a Medicaid application and no remaining eligibility factors need to be considered, the LDSS must find the applicant eligible for Medicaid. The LDSS must find the applicant eligible for Medicaid even if the LDSS requests that the New York State Office of Temporary and Disability Assistance review the fair hearing decision to correct an error of law or fact. The original fair hearing decision is binding and must be complied with pending the review.

When a fair hearing decision reverses a LDSS denial of a Medicaid application and one or more remaining eligibility factors need to be considered, the LDSS must continue to process the application and issue a decision as soon as possible. In such cases, the applicant's original application date must be preserved.

DISCUSSION

At issue is the Plan's determination of February 14, 2018, as upheld on internal appeal, to deny the Appellant's request for an increase in her PCS authorization from 51 hours per week to 112 hours per week based on the Plan's nurse's reassessment, but to approve only an increase in the Appellant's PCS authorization to 62 hours per week.

Although the Plan's notice of February 14, 2018 advised the Appellant that a fair hearing must be requested within sixty days of the Plan's action, this fair hearing was not requested until May 11, 2018, which was more than 60 days after the Plan's action at issue here.

Appellant testified that the reason she did not timely request this fair hearing was because she never received the Plan's notice of February 14, 2018, which would have advised her of the 60-day time limitation to request a fair hearing and that she did not find out of the Plan's determination to deny her request until she spoke to her Plan case manager. This testimony shifted the burden upon the Plan to demonstrate that the notice was, in fact, mailed or otherwise provided to the Appellant. The Plan failed to submit any evidence at the hearing tending to

demonstrate that the notice was mailed to the Appellant and thus failed to rebut Appellant's assertion that the notice was not received by her. For this reason, a sufficient basis for tolling the statute of limitations was established.

On the merits, the Appellant is a 71-year old female who, as acknowledged by the Plan, suffers from, among other illnesses, Cauda Equina Syndrome post-stroke, which is characterized by weakness and/or loss of or altered sensation in legs. As a result, and as acknowledged by the Plan, Appellant's both legs are paralyzed and she is unable to walk and uses wheelchair to ambulate. However, due to osteoarthritis-caused weakness in her arms, she needs human assistance to do so. The Plan so recognized in its evidence packet submitted at the hearing, wherein it was further acknowledged by the Plan, and corroborated in the Appellant's physician notes, that Appellant is bedridden with total dependence in transfers in and out of bed to wheelchair and transfers to and from bedside commode; that Appellant is frequently incontinent of bladder and uses pull ups; that she is totally dependent on others for toilet transfers, toilet use, walking/locomotion, bathing, meal preparation and housework and requires maximal assistance with bed mobility, eating and personal hygiene. Appellant's testimony was entirely consistent with these findings.

The Plan's most recent nurse assessment was conducted on February 6, 2018. At that time, Appellant's spouse, who had been her primary caregiver, was hospitalized for two months and has since passed away on April 14, 2018. In any event, the Plan did not claim that Appellant's spouse provided, or was able and willing to provide, any assistance with Appellant's activities of daily living. The Plan did indicate in the summary that Appellant's son assists her after the aide leaves. However, it was established at the hearing that Appellant's son provides CDPAP assistance to Appellant, which comprises some of the PCS hours the Plan granted to the Appellant, but that he also works a second job and has to leave for work early in the morning, so she does not wake him up at night to be transferred from her bed onto a bedside commode, but, rather, relieves herself in a diaper, which then needs to be changed.

MLCT Policy 16.07 provides guidance to Managed Long Term Care Plans on the use of task-based assessment tools for PCS/CDPAP and states, in pertinent part, that all plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans **must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance**. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.

In this case, given the Appellant's medical condition, her resultant virtual inability to ambulate, transfer and to otherwise perform any of her IADLs and ADLs on her own, her frequent bladder incontinence (a need that, by definition, cannot be scheduled) and the

consequent need for frequent transfers to and from the bedside commode as well as frequent diaper changes when needed, indicate the need for the requested increase in PCS hours. The record establishes that the Plan has acknowledged the Appellant's condition, yet failed to account, as required by MLTC Policy 16.07, for Appellant's unscheduled frequent needs and her total dependence on others for ambulating and transferring.

The Plan is reminded that in accordance with State policy, when a fair hearing decision reverses a denial of an application or request and one or more remaining eligibility factors need to be considered, the Plan must continue to process the application or request and issue a decision as soon as possible.

The Plan is reminded that the State Regulations define continuous PCS as 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.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase of her Personal Care Services authorization from 51 hours per week to 112 hours per week is not correct and is reversed.

1. The Plan is directed to cancel its determination denying such request.

The Plan is reminded of its obligation pursuant to GIS 13/MA 015.

DATED: Albany, New York
07/19/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee