

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 18, 2018

AGENCY: MAP

FH #: 7794493K

In the Matter of the Appeal of	:
	: DECISION
	AFTER
	: FAIR
	HEARING
from a determination by the New York City	:
Department of Social Services	:

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 September 13, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



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

Julia Rolfort, Centers Plan for Healthy Living, (Hearing: August 13, 2018)
Deborah Ferguson, Fair Hearing Specialist, (Hearing: September 13, 2018)

ISSUE

Was the Managed Long-Term Care Plan's determination dated June 29, 2018, to deny the increase of Appellant's Personal Care Services authorization from 59.5 hours weekly (8.5 hours/day daily, 7 days weekly) to 168 hours weekly (12 hours daily, 7 days weekly + 12 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 96, has been in receipt of Medicaid benefits provided through a Managed Long-Term Care Plan, Centers Plan for Healthy Living.
2. The Appellant resides alone in an apartment.

3. The Appellant currently receives Personal Care Services of 59.5 hours weekly (8.5 hours/day daily, 7 days weekly). The Appellant seeks personal care services hours of 168 hours weekly (12 hours daily, 7 days weekly + 12 hours daily, 7 days weekly).

4. On January 29, 2018, a nursing assessor completed a Uniform Assessment System ("UAS) evaluation of the Appellant's personal care needs.

5. On March 6, 2018, a nursing assessor completed a Uniform Assessment System ("UAS) evaluation of the Appellant's personal care needs. The evaluation indicated that the Appellant's decision making is *"Moderately impaired-Decisions consistently poor or unsafe; cues/supervision required at all times."* and that the Appellant has a *"short-term" memory problem."*

6. The March 6, 2018 evaluation also indicates that the Appellant has *"Total dependence* with "stairs"; requires *"maximal assistance"* with bathing; *"maximal assistance"* with *personal hygiene*; *"maximal assistance"* with *dressing upper and lower body*; *"maximal assistance"* with *walking*; *"maximal assistance"* with *"transfer toilet"*; *"maximal assistance"* with *toilet use*; *"maximal assistance"* with *bed mobility*; and *"extensive assistance"* with *"eating."* The evaluation has the Appellant as having *"Total dependence"* with *"locomotion."*

7. The March 6, 2018 evaluation also indicates that the Appellant is *"Occasionally incontinent"* of both urine and bowel, but notes that the Appellant *"wears pull-ups."* The evaluation indicates that the Appellant has *"dizziness"*, which was *"Exhibited on 1 of last 3 days"*, and *"Unsteady gait"*, which was *"Exhibited daily in last 3 days."* The evaluation further notes that *"Due to diminished energy, Unable to Finish normal day-to-day activities."*

8. The March 6, 2018 evaluation indicates that the Appellant has had an *"Inpatient acute hospital with overnight stay."* *"Member admitted to [REDACTED] from 2/25/2018 until 3/1/18 for a urinary tract infection. Member was treated and discharged with IV antibiotics in stable condition...."*

9. A Client Task sheet dated March 6, 2018 indicates that the Appellant has a *"History of falls (within the last 3 months)"*, and has had *"Recent hospitalizations (within the last 3 months)."*

10. By Initial Adverse Determination, dated June 12, 2018, the Managed Long-Term Care Plan determined to deny the increase of Appellant's Personal Care Services authorization from 59.5 hours weekly (8.5 hours/day daily, 7 days weekly) to 168 hours weekly (12 hours daily, 7 days weekly + 12 hours daily, 7 days weekly).

11. By Final Adverse Determination, dated June 29, 2018, the Managed Long-Term Care Plan determined to deny the Appellant's request to increase of Appellant's Personal Care Services authorization from 59.5 hours weekly (8.5 hours/day daily, 7 days weekly) to 168 hours weekly (12 hours daily, 7 days weekly + 12 hours daily, 7 days weekly).

12. On July 18, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

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.

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

Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). 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 Section 505.14; 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 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), dated December 30, 2015, effective December 23, 2015, provided:

The purpose of this policy directive is to inform Managed Long Term Care Plans (MLTCPs) of revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR § 505.14 and 18 NYCRR § 505.28, respectively. These revised regulations are effective on December 23, 2015.

These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous ("split-shift") PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, MLTCPs must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the New York State Register on December 23, 2015.

Regulatory changes for PCS and CDPA applicable to MLTCP's include:

1. The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

2. “Turning and positioning” is added as a specific Level II personal care function and as a CDPA function.

3. The definitions and eligibility requirements for “continuous personal care services,” “live-in 24-hour personal care services,” “continuous consumer directed personal assistance” and “live-in 24-hour consumer directed personal assistance” are revised as follows:

a. *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.

b. *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.

c. *Continuous consumer directed personal assistance* means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the consumer’s medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.

d. *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer’s medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.

4. Services shall not be authorized to the extent that the individual’s need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

5. The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of “some assistance” and “total assistance” are repealed.

6. The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

7. The social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

8. The regulations also revise the Department's regulations governing the content of notices for denials, reductions or discontinuances of PCS and CDPA. In subparagraph 505.14(b)(5)(v), the provisions governing social services districts' notices to recipients for whom districts have determined to deny, reduce or discontinue PCS are revised and reorganized. Paragraph 505.28(h)(5) is amended to provide additional detail regarding the content of social services district notices when the district denies, reduces or discontinues CDPA. All MLTCPs must ensure that their notices denying, reducing or discontinuing PCS or CDPA are consistent with these regulations and, in particular, include the specific reason for the action and, if applicable, the clinical rationale. All MLTCPs should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements.

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. 18 NYCRR 505.14(a)(2)

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. 18 NYCRR 505.14(a)(4)

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

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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 sub clauses (a)(1) through (a)(3) of this subparagraph. 18 NYCRR 505.14 (a)(3)(iii)(b)

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services, issued November 17, 2016, provides in relevant part that:

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

GIS message GIS 12 MA/ 026, dated October 3, 2012, provides that the Department has been directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicted and for Medicaid recipients whose only nighttime need is turning and positioning.

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It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following:

(1) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and

(2) voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.
2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.
3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.
4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

- The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;
- The specific task or tasks with which the person requires frequent assistance during the night;
- The frequency at which the person requires assistance with these tasks during the night;
- Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;
- The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;
- The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and
- Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

18 NYCRR 505.28 Consumer directed personal assistance program.

(a) Purpose. The consumer directed personal assistance program is intended to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.

(b) Definitions. The following definitions apply to this section:

(1) "consumer" means a medical assistance recipient who a social services district has determined eligible to participate in the consumer directed personal assistance program.

(2) "consumer directed personal assistance" means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

(3) "consumer directed personal assistant" means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative. A consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary.

(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14(a)(5) of this Part except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week

(e) Authorization process (6) Nothing in this subdivision precludes the provision of the consumer directed personal assistance program in combination with other services when a combination of

services can appropriately and adequately meet the consumer's needs; provided, however, that no duplication of Medicaid-funded services would result.

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits. 18 NYCRR 358-5.9(a)

Department policy regarding personal care services for managed care enrollees states in part that a mutual case is one where two or more members of the household receive care from the same personal care aide. Each case will be assessed individually and an authorization based on the number of hours the member requires to remain safely in the home will be determined. The assessment for the number of hours needed and the level of services may take into account what other services are provided in the home.

GIS message GIS 96 MA/019 advises of a federal court decision that applies to social services districts' reductions or discontinuations of personal care services. [Mayer et al. v. Wing, (S.D.N.Y.)] In general, the Mayer decision holds that a social services district must have a legitimate reason to reduce or discontinue a recipient's personal care services. Before reducing or discontinuing personal care services, the district must individually assess the recipient to determine whether the reduction or discontinuance is justified by State law or Department regulation. A social services district cannot reduce or discontinue a recipient's personal care services arbitrarily, capriciously or as part of a blanket, across-the-board reduction or discontinuance of services that does not consider each individual recipient's particular circumstances. This general principle is entirely consistent with the Department's policy.

The social services district must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services on forms required by the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements outlined in Part 358 of this Title. 18 NYCRR 505.14(b)(5)(v)(b)

The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice. Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

- (i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;
- (ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
- (iii) the client is not self-directing and has no one to assume those responsibilities;

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(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

(v) the client refused to cooperate in the required assessment;

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

(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

(2) Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

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

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

(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

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(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(b)

The Department's Managed Care Personal Care Services Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

- i. that were previously authorized, if any;
- ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
- iii. that are authorized for the new authorization period; and
- iv. the original authorization period and the new authorization period, as applicable.

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

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice

Reasons to deny personal care services must be reflected in the notices and include but are not limited to:

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;

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- (ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
- (iii) the client is not self-directing and has no one to assume those responsibilities;
- (iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;
- (v) the client refused to cooperate in the required assessment;
- (vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming. 18 NYCRR 505.14(b)(5)(v)(c)(1)

Reasons to reduce or discontinue personal care services must be reflected in the notices and include but are not limited to:

- (i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;
- (ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;
- (iii) the client refused to cooperate in the required reassessment;
- (iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
- (v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
- (vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(c)(2)

MLTC Policy 15.04: Interim Guidance for MLTC Partial Capitation Appeal Notices provides in relevant part:

Within Section 1.B. of Appendix K of the Partial Capitation Model Contract, there are four required notice templates relating to Expedited and Standard Appeals. This document describes how these notices will be affected by the elimination of the exhaustion requirement for internal appeals.

This guidance is effective immediately and will also be reflected in the forthcoming renewal

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of the partial capitation contracts for the period between January 1, 2015 and December 31, 2016....

Notice Template 4:

To reflect the elimination of the internal appeal exhaustion requirement, and related policy changes, plan appeal final determination notices must comply with the following: Final Determination Notices

The Contractor shall ensure that all notices are in writing and in easily understood language and are accessible to non-English speaking and visually impaired enrollees. Notices shall include that oral interpretation and alternate formats of written material for enrollees with special needs are available and how to access the alternate formats.

All notices must include up-to-date contact information for the Independent Consumer Advocacy Network (ICAN), along with the following statement: “You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals’ options. They can help you manage the appeal process. Contact ICAN to learn more about their services.”

A) Notice to the enrollee of Action Appeal Determinations shall be dated and include:

- 1) Date the action appeal was filed and a summary of the action appeal;
- 2) Date the action appeal process was completed;
- 3) The results and the reasons for the determination, including the clinical rationale, if any;
- 4) If the determination was not wholly in favor of the enrollee, and:
 - a) The contractor upheld its original action, a statement that reminds the enrollee of their right to request a fair hearing, including:
 - i) That a request for a fair hearing must have been made to the State within 60 calendar days of the initial action notice;
 - ii) The date by which such request must have been made; and
 - iii) If time remains for a fair hearing to be requested, instructions on how to request a fair hearing; or a statement that time to request a fair hearing has expired.
 - b) The contractor modified its original action in any way, a statement that the action appeal determination constitutes a new action, and the enrollee has a right to request a fair hearing, including:
 - i) That a request for a fair hearing must be made to the State within 60 calendar days of the date of the action appeal notice; and
 - ii) A completed NYSDOH standard “Managed Long Term Care Action Taken” notice for denial of benefits or for termination or reduction in benefits, as applicable, containing the enrollee’s fair hearing and aid continuing rights.
- 5) The right of the enrollee to contact the New York State Department of Health regarding his or her complaint, including the NYSDOH’s toll-free number for complaints; and
- 6) For action appeals involving personal care services, the number of hours per day, number of hours per week, and the personal care services function (Level I/Level II):
 - a) That were previously authorized, if any;
 - b) That were requested by the enrollee or their designee, if so specified in the request;

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- c) That are authorized for the new authorization period, if any; and
- d) The original authorization period and the new authorization period, as applicable.
- 7) For action appeals involving medical necessity or an experimental or investigational treatment, the notice must also include:
 - a) A clear statement that the notice constitutes the final adverse determination and specifically use the terms “medical necessity” or “experimental/investigational;”
 - b) The enrollee’s coverage type;
 - c) The procedure in question, and if available and applicable the name of the provider and developer/manufacturer of the health care service;
 - d) Statement that the enrollee is eligible to file an external appeal and the timeframe for filing, and if the action appeal was expedited, a statement that the enrollee may choose to file a standard action appeal with the contractor or file an external appeal;
 - e) A copy of the “Standard Description and Instructions for Health Care Consumers to Request an External Appeal” and the External Appeal application form;
 - f) The contractor’s contact person and telephone number;
 - g) The contact person, telephone number, company name and full address of the utilization review agent, if the determination was made by the agent; and
 - h) If the contractor has a second level internal review process, the notice shall contain instructions on how to file a second level action appeal and a statement in bold text that the timeframe for requesting an external appeal begins upon receipt of the final adverse determination of the first level action appeal, regardless of whether or not a second level of action appeal is requested, and that by choosing to request a second level action appeal, the time may expire for the enrollee to request an external appeal.

MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services provides:

On December 30, 2015, the Department notified all managed long term care (“MLTC”) plans of recent changes to the Department’s regulations governing personal care services (“PCS”) and consumer directed personal assistance (“CDPAS”), including revised regulatory provisions governing notices that deny PCS or CDPAS or propose to reduce or discontinue PCS or CDPAS. (See MLTC Policy 15.09 at http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm).

The purpose of this directive is to provide further guidance to MLTC plans concerning appropriate reasons and notice language to be used when proposing to reduce or discontinue PCS or CDPAS. In particular, it addresses notices that propose to reduce or discontinue PCS or CDPAS for either of 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.

A MLTC plan may not reduce or discontinue an enrollee’s PCS or CDPAS unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi), for PCS, and 18 NYCRR §§ 505.28(h)(5)(ii)(a) through (f), for CDPAS. Two such examples are discussed in greater detail below. The MLTC plan must

advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering the facts of the individual enrollee's circumstances and thus cannot reduce services as part of an "across-the-board" action that does not consider each individual enrollee's particular circumstances and need for assistance.

The general purpose of these requirements is to assure that the plan's notice accurately advises the enrollee, in plain comprehensible language, *what* the plan is proposing to change with regard to the enrollee's PCS or CDPAS and *why* the plan is proposing to make that change. The more specificity the plan's notice provides with regard to the specific change in the enrollee's services, the reason for the change, and why the prior services are no longer needed, the better able the plan will be to defend its proposed reduction or discontinuance at any fair hearing, at which the plan bears the burden of proof to support its proposed action (i.e. the plan must establish that its proposed reduction or discontinuance is correct).

A. Change in Enrollee's Medical or Mental Condition or Social Circumstances

In such a case, the Plan's notice must indicate:

☐ 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. If the reason for the proposed reduction or discontinuance is a change in one or more such conditions or circumstances, the plan's notice must not simply recite the underlined language in the previous sentence, which would impermissibly make it the enrollee's responsibility to figure out which particular condition or circumstance had changed. Such boilerplate recitations are inadequate. Instead, the plan's notice must:

- 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.

Example of a change in medical condition: The plan authorized an enrollee for personal care services. At the time of the assessment, the enrollee was recuperating from hip replacement surgery. As the enrollee recovered from her surgery, her medical condition improved. Specifically, the enrollee's hip has now healed sufficiently that she is now able to walk 30 feet alone. The physician's order documented this improvement in her medical condition. Due to the improvement in her medical condition, she no longer needs the previously authorized level and amount of assistance with personal care services. Accordingly, the enrollee no longer needs help ambulating inside her apartment.

Example of a change in social circumstances: The plan had authorized an enrollee for Level II personal care services, support with dressing. At the time of the initial authorization, the enrollee lived in her longtime residence with no family or friends who could help dress and undress. Her sister then moved next door and agreed to help with this task. Due to the change in the enrollee's social supports, she no longer needs the previously authorized amount of assistance for dressing and undressing.

B. Mistake

In such a case, the Plan's notice must indicate:

A mistake occurred in the previous PCS or CDPAS authorization or reauthorization. The 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.

Plans must adhere to the following guidelines when proposing to reduce or discontinue services based on a mistake that occurred in the previous assessment or reassessment:

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

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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.

Plans are reminded that enrollees are entitled to timely (i.e. 10-day prior notice) and adequate notice whenever plans propose to reduce or discontinue PCS or CDPAS or other services. All partially capitated plans must also use the State-mandated fair hearing notices. In additions, plans must comply promptly with all aid-continuing directives issued by the NYS Office of Temporary and Disability Assistance.

DISCUSSION

The evidence establishes that the Appellant, age 96, has been in receipt of Medicaid benefits provided through a Managed Long-Term Care Plan, Centers Plan for Healthy Living. The Appellant currently receives Personal Care Services of 59.5 hours weekly (8.5 hours/day daily, 7 days weekly). The Appellant seeks personal care services hours of 168 hours weekly (12 hours daily, 7 days weekly + 12 hours daily, 7 days weekly).

The Agency appeared on papers, and introduced into evidence a medical record, dated April 23, 2018, from one of the Appellant's treating physician's, which delineates the Appellant's medical conditions as: *Hypertensive heart disease with heart failure; Unspecified systolic (congestive) heart failure; Unspecified dementia without behavioral disturbance; Mixed hyperlipidemia; Hypothyroidism, unspecified; Constipation, unspecified; Benign prostatic hyperplasia without lower urinary tract symptoms; Body mass index; Other long term (current) drug therapy.*"

At the hearing, the Appellant's daughter and daughter-in law both testified that the Appellant has dementia, which is getting worse, and he resides alone, in a two-story house. They testified that they do not reside with the Appellant in his home. The daughter strongly stated that there has been no improvement in the Appellant's condition, but rather a decline, due to increased nighttime incontinence needs, and worsening balance.

The daughter stated that there is a chair lift in the home. The daughter-in-law stated that the Appellant is unable to balance himself, but he will not use the walker, unless he is told to use it. The daughter stated that the Appellant falls if no one is there to direct him to the walker. The daughter stated that in December 2017, the Appellant went upstairs, and they heard a bang. When she and her other sister reached upstairs, they saw that the Appellant had fallen into the bathtub, and sustained a gash on his head. The daughter stated that they took the Appellant to the ER, and he was admitted for one week. The daughter also stated that, in his mind, the Appellant can run, but of course, he cannot do so in reality, which adds additional pressure for someone to be watching him all of the time. The daughter further stated that the Appellant likes to walk at

nighttime, which is a hazard for him. She stated that the Appellant was in Rehab hospital for 3 to 5 weeks.

The Appellant's daughter stated that at night, the Appellant's needs increase because he has an enlarged prostate, and he therefore has to get up approximately once-per-hour to go to the bathroom. The daughter stated that he has to get up whether he actually ends up urinating, or it turns out to just be an urge to urinate. The daughter, and daughter-in-law both stated that someone must watch the Appellant at night to help him get out of bed. They testified that the Appellant wears pull-ups, and sometimes he gets to the bathroom in time, and sometimes he does not, and he is not able to clean himself.

The daughter stated that when the Appellant sits on the couch, 2 people are required to lift him off. The daughter stated that the Appellant had a Foley catheter when he had a urinary tract infection, but he used to pull it out, and it would bleed. The catheter is no longer required.

The Appellant's daughter-in-law stated that when he eats, the Appellant sometimes aspirates, and it is therefore necessary to cut-up the food in small pieces, and that the food must be soft.

The daughter stated that the rest of the family used to pay someone to stay with the Appellant for 12 to 15 hours daily, because when a family member is with the Appellant, they cannot get any sleep, due to his round-the-clock needs.

The MLTC Plan's UAS evaluations dated December 13, 2017, and June 26, 2018 were admitted into evidence. The evidence has been duly considered.

The testimony of the Appellant's daughters is credible because it is detailed, plausible, consistent, cross-corroborative, and the severity of the Appellant's dependence is supported by the MLTC Plan's own documentary evidence.

The Representative from the MLTC Pan indicated that additional hours appeared to be warranted, however, they would not consent to Split-Shift.

The credible record establishes that the Appellant's medical condition is declining, as a result of his nighttime needs increasing, so that he gets up approximately every hour to tend to those needs. The Agency's own UAS of March 6, 2018 indicates that the Appellant requires "*maximal assistance*" with toilet transfer. The maximal assistance is further complicated with the Appellant's balance and dizziness worsening. The Appellant's daughters credibly testified that they had to pay a service to take care of the Appellant because they could not get any sleep when there were the caretakers.

Based on the foregoing, the weight of the evidence establishes that the Appellant has nighttime toileting needs, which alone would require with such frequency of "*maximal assistance*" that not only are additional hours justified, but a Home Health Aide would be

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unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight-hour period of sleep.

The credible evidence establishes that the Appellant is entitled to a Personal Care Services authorization in the amount of 24hours, Split-Shift Care.

DECISION AND ORDER

The Appellant's Managed Long-Term Care Plan's determination dated June 29, 2018, not to increase the Personal Care Services authorization is not correct and is reversed.

1. The MLTCP is directed to provide the Appellant with an increased Personal Care Services authorization in the amount of 24-hour Split-Shift Care, effective immediately.

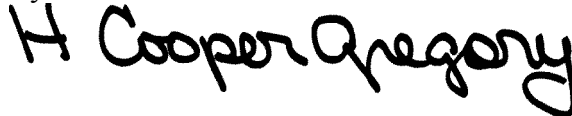
Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the MLTCP promptly to facilitate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

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

DATED: Albany, New York
11/06/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink that reads "H. Cooper Gregory". The signature is written in a cursive, flowing style.

Commissioner's Designee