STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 12, 2018
[redacted]
AGENCY: MAP
FH #: 7824278H

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on October 4, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was the September 6, 2018 determination of the Managed Long Term Care plan, Centers Plan for Healthy Living, to reduce the Appellant's Personal Care Services from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week (12 hours per day x 7 days per week; 12 hours per day x 4 days per week; 8 hours x 3 days per week), correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 83 has been in receipt of a Medical Assistance authorization of Medicaid, Managed Long Term Care services.

2. The Appellant is enrolled in a Managed Long Term Care Plan ("MLTC") provided by Centers Plan for Healthy Living ("Centers Plan").

3. The Appellant has been in receipt of a Medical Assistance authorization, via her MLTC plan, of personal care services in the amount of 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift").

4. On June 29, 2018, Centers Plan completed a Client Task Sheet: PCW/PCA Level II of the Appellant's personal care needs and recommended that the Appellant receive 24 hours per day, 7 days per week.

5. On August 17, 2018, Centers Plan completed a Client Task Sheet: PCW/PCA Level II of the Appellant's personal care needs and recommended that the Appellant receive 24 hours per day, 7 days per week.

6. On August 7, 2018, Centers Plan advised the Appellant by an Initial Adverse Determination Letter of its intent to reduce the Appellant's Personal Care Services Authorization from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week (12 hours per day x 7 days per week; 12 hours per day x 4 days per week; 8 hours x 3 days per week) on the grounds that "the health care service is not medically necessary."

7. An Internal Plan Appeal was requested to review Centers Plan's determination to reduce Appellant's Personal Care Services Authorization from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week (12 hours per day x 7 days per week; 12 hours per day x 4 days per week; 8 hours x 3 days per week) on the grounds that "the health care service is not medically necessary."

8. On September 6, 2018, Centers Plan advised the Appellant by Final Adverse Determination Letter, of its intent to uphold its determination to reduce Appellant's Personal Care Services Authorization from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week (12 hours per day x 7 days per week; 12 hours per day x 4 days per week; 8 hours x 3 days per week).

9. On September 12, 2018, this fair hearing was requested on the Appellant's behalf to contest Center Plan's determination.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Medical Assistance or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a)

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

Section 438.210 of 42 CFR Subpart D provides in part:

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

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

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

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

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

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

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as

medical necessity; or

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

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

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

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:
(A) The prevention, diagnosis, and treatment of health impairments.

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

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

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

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

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

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

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

Section 438.236 of 42 CFR Subpart D provides in part:

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

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

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

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

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

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

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

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

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

service;

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

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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I. Scope of the Personal Care Benefit

a. As required by federal regulations, the personal care services benefit afforded to MCO enrollees must be furnished in an amount, duration, and scope that is no less than the services furnished to Medicaid fee-for-service recipients.[42 CFR §438.210]…

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

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

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

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

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

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

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

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

e. Terminations and Reductions…

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

1. the client's medical, mental, economic or social circumstances

have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

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

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

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

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

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

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

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

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

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

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

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

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

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

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

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 438.404(b) of 42 CFR Subpart F provides in part:

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

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

(2) **The reasons for the action**...

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

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

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

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services

authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released 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. In relevant portion, this GIS Message states:

> 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**.**

DISCUSSION

The credible evidence establishes that the Appellant, age 83, has been in receipt of a Medical Assistance authorization of Medicaid and has been in receipt of Managed Long Term Care ("MLTC") provided by Centers Plan for Healthy Living ("Centers Plan"), her MLTC plan, of personal care services in the amount of 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift").

By Initial Adverse Determination Letter dated August 7, 2018, Centers Plan advised Appellant of its intent to reduce the Appellant's Personal Care Services Authorization from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week (12 hours per day x 7 days per week; 12 hours per day x 4 days per week; 8 hours x 3 days per week) on the grounds that "the health care service is not medically necessary." An Internal Plan Appeal was requested to review Centers Plan's determination to reduce Appellant's Personal Care Services Authorization from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week. On September 6, 2018, Centers Plan advised the Appellant by Final Adverse Determination Letter, of its intent to uphold its determination to reduce Appellant's Personal Care Services Authorization.

At the hearing, Centers Plan's Fair Hearing Representative submitted into evidence the Initial Adverse Determination notice that advised the Appellant in relevant part, "Centers Plan for Healthy Living (CPHL) has made a decision to reduce your Personal Care Aide (PCA) services due to duplication of services from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to eight (8) hours during the day and twelve (12) hours during the night, three (3) days a week: Tuesday, Thursday, and

Saturday, the days of which you attend Hemodialysis and twelve (12) hours during the day and twelve (12) hours during the night, four (4) days per week on non-Hemodialysis days: Sunday, Monday, Wednesday and Friday (Totaling one hundred-fifty-six (156) hours per week). We have been informed that you have receiving Hemodialysis every Tuesday, Thursday and Saturday. We have confirmed with Southern Manhattan Dialysis Center that you have been receiving Hemodialysis on Tuesdays, Thursdays and Saturdays, you **will not** need Personal Care Aide (PCA) services during this time."

Centers Plan's Fair Hearing Representative also submitted into evidence the Final Adverse Determination notice that further advised the Appellant of the determination to uphold the reduction as follows, "We made this decision because when you are at dialysis sessions, there is no need for personal care services. This decision is based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool."

First, in a relevant stage of Mayer v. Wing, agencies (including Managed Long Term Care Plans) were enjoined from reducing Personal Care Services, unless a Notice was issued including prescribed language. This injunction was incorporated into 18 NYCRR Section 505.14, and now applies as well to discontinuance. The approved reasons set forth in the amended Regulation, based upon the injunction in Mayer, are:

(1) 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;

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

(3) the client refused to cooperate with the required assessment of services;

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

(5) the client can be more appropriately and cost-effectively served through other Medicaid programs and services;

(6) the client's health and safety cannot be assured with the provision of personal care services;

(7) the client's medical condition is not stable;

(8) the client is not self-directing and has no one to assume those responsibilities;

(9) the services the client needs exceed the personal care aide's scope of practice; and

(10) the client resides in a facility or participates in another program or receives other

services which are responsible for the provision of needed personal care services.

It must be emphasized that Federal regulations require that the State's contracts with managed long term plans must provide, among other things, that the services the managed long term care plan offer be furnished in an "amount, duration and scope" that is no less than the "amount, duration and scope" for the same services furnished to Medicaid fee-for-service recipients and that the managed long care plan may place appropriate limits on services on the basis of medical necessity, but the criteria for determining medical necessity may be no more restrictive than that applicable to fee-for-service recipients. The adequacy of a Notice which is Mayer compliant, is equally applicable to Managed Long Term Care Plans as it is applicable to Medicaid fee-for-service recipients, which is why the Mayer's reasons are now incorporated in the NYS Department of Health Office of Health Insurance Programs, Guidelines for the Provision of Personal Care services in Medicaid Managed Long Term Care, in identical terms as Mayer's.

Centers Plan's reason for the reduction of the Appellant's personal care services was based on a rational of no longer medically necessary, yet, Centers Plan did not clearly indicate a clinical rationale that shows review of the Appellant's specific clinical data and medical condition; the basis on which a request for personal care services was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. Pursuant to regulations, if a 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. Centers Plan's Notice by no means follows these guidelines and is inadequate.

Secondly, Centers Plan stated that its decision was "…based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool." However, at the hearing, Centers Plan did not submit into evidence any NYS Department of Health Uniform Assessment as corroboration of its determination to reduce the Appellant's personal care services authorization. Thus, leaving the adequacy of the Notice in question aside, Centers Plan's failure to submit a UASNY assessment (comprehensive) report for the Appellant, although allegedly its decision was based on the NYS Department Health Uniform Assessment System (UAS-NY), contravenes the regulatory guidelines that mandate that denials, or reductions in services must clearly indicate a clinical rationale. Centers Plan's failure to include a UASNY assessment (comprehensive) reports for the Appellant does not allow a comparison to be made of appreciable differences in Appellant's change in activities of daily living status or over-all self-sufficiency within the last 90 (ninety) days or since last assessment such as to warrant a reduction and does not provide or document any basis upon which a reduction was warranted.

Third, Centers Plan maintained that the reduction was based on the fact that the Appellant attends dialysis and thus the provision of personal care service is duplicative. The Final Adverse Determination notice advised "We made this decision because when you are at dialysis sessions, there is no need for personal care services." However, review of the June 29, 2018 and August 17, 2018 Client Task Sheet: PCW/PCA Level II of the Appellant's personal care needs and recommended that the Appellant receive 24 hours per day, 7 days per week and reports that the

Appellant has “Total Dependence” on others for assistance with all her activities of daily living. Thus, based on the Centers Plan own hearing record, the contention that because the Appellant attends dialysis, the provision of personal care services is duplicative is not valid. Centers Plan did not submit any evidence that the Appellant receives personal care services from employees of the dialysis center, that the Appellant doesn't need personal care services while at the dialysis center, or that the Appellant's aide is prohibited from providing personal care services to the Appellant while the Appellant is at the dialysis center. Furthermore, as the hearing record has established, the Appellant has total dependence” on others for assistance including ambulation and transfers, Appellant’s personal care worker must assist the Appellant in a manner that entails supervision and ensures the Appellant’s safety in the course of carrying out those activities of daily living. An aide worker is not prohibited from providing safety and supervision in the course of conducting authorized task. Regulations mandate that safety supervision hours can accompany authorized tasks and should not be considered hours given by mistake. Pursuant to GIS 03 MA/03, 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**.”**

The hearing record included an August 17, 2018 letter from Appellant's medical provider that states, “(Appellant) is a hemodialysis patient at Southern Manhattan Dialysis due to her diagnosis of End State Renal Disease. (Appellant) is receiving dialysis three days a week, approximately three and a half hours at a time, as a life-sustaining chronic treatment. Following her treatment, (Appellant) is often left weak and debilitated. As a result of the life-threatening nature of her chronic illness, (Appellant) must also adhere to a strict renal diet, take necessary medications, and comply with hemodialysis treatment in order to maintain her health.” Additional evidence that Appellant requires personal care assistance while at the dialysis center is established by an August 17, 2018 a medical provider letter that further elaborates, “Patient (Appellant) had a PEG tube placed in her abdomen on 06/18/2018. Due to her neurological condition the patient requires a home health aide to be with her at all times. The patient has a tendency to pull out the PEG tube. She attempted to do this during her dialysis. The PEG is used to provide the patient with daily nutrition.”

The testimony and evidence adduced at the hearing have been duly reviewed. The record of the hearing establishes that the Appellant who attends life-sustaining dialysis treatments, does require the assistance of personal care attendant during her life maintenance dialysis treatments. She would require a companion to accompany her during trips to dialysis, stay with her during the dialysis treatment and accompany her during her trip home for the very reason that the dialysis center staff does not provide personal care services and thus, there is no duplication of services. The testimony and evidence adduced at the hearing have been duly reviewed. Centers Plan has not met its burden of proof to establish that its determination to reduce the Appellant’s personal care services was correct, therefore, the September 6, 2018 determination cannot be sustained.

DECISION AND ORDER

The September 6, 2018 determination of the Managed Long Term Care plan, Centers Plan for Healthy Living to reduce the Appellant's Personal Care Services from 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") to 156 hours per week (12 hours per day x 7 days per week; 12 hours per day x 4 days per week; 8 hours x 3 days per week), is not correct and is reversed

1. Centers Plan for Healthy Living, is directed to immediately restore the Appellant's Personal Care Services authorization back to 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift") and to take no further action upon the September 6, 2018 Initial Adverse Determination.

2. Centers Plan for Healthy Living is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 24 hours daily, 7 days weekly, continuous service provided by more than one Personal Care Services aide ("split shift").

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

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

DATED: Albany, New York
11/05/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's

Designee