STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 5, 2018
[redacted]
AGENCY: MAP
FH #: 7698354L

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 March 6, 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 (Visiting Nurse Service of New York Choice)

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the January 18, 2018 determination of Visiting Nurse Services of New York Choice, to reduce the Appellant's Personal Care Services authorization from 56 hours per week (8 hours per day, 7 days per week) to 42 hours per week, (6 hours per day, 7 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 sixty-three, has been in receipt of Medical Assistance benefits, and is enrolled in a partially capitated Managed Long Term Care Plan through Visiting Nurse Service of New York Choice (VNS).

2. The Appellant had been previously enrolled with VNS for the period from December 1, 2012 through November 30, 2017 and was in receipt of an authorization for Personal Care Services for 56 hours per week (8 hours per day, 7 days per week).

3. In or about November 2017, the Appellant voluntarily disenrolled from VNS and enrolled with Centers Plan for Healthy Living, LLC, (Centers Plan) another Managed Long Term Care Plan.

4. The Appellant was enrolled with Centers Plan for the period from December 1, 2017 through January 31, 2018 and was in receipt of an authorization for Personal Care Services for 56 hours per week (8 hours per day, 7 days per week).

5. In or about January 2018, the Appellant voluntarily disenrolled form Center Plan and reenrolled with VNS.

6. On January 11, 2018, a nursing assessor completed a Uniform Assessment System (UAS) evaluation of the Appellant's personal care needs.

7. On January 11, 2018, a nursing assessor also completed a HELPS Assessment Report in which the nurse determined that the Appellant had need of Personal Care Services for 33 hours per week over 7 days.

8. On January 18, 2018 VNS issued a Projected Service Plan providing for personal care service for 6 hours per day, 7 days per week (42 hours per week).

9. The January 18, 2018 Projected Service Plan states in part:

> As per approval, mbr [member] will be getting 7d x 6hrs = 42hrs of PCA [Personal Care Assistance] services from 9a-3p [9:00 am to 3:00 pm]. Mbr not satisfied 2/s but will still be enrolling w/ VNS Choice MLTC. Mbr requested to have the same aide from PIC [redacted] until CDPAS starts. Services to start effective 2/1/18.

10. On February 5, 2018, the Appellant requested this fair hearing.

11. On February 13, 2018 VNS issued a Summary of Authorized Services which included an authorization on an aid to continue basis, of 56 hours per week (8 hours per day, 7 days per week.)

APPLICABLE LAW

Part 438 of 49 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 49 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 49 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 49 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 49 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 49 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.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home…

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

***

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

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

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions shall include some or total assistance with the following:

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

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

(8) feeding;

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

(10) providing routine skin care;

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

(12) changing of simple dressings.

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

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

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- **the specific reasons for the action**;
- the specific laws and/or regulations upon which the action is based;

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

18 NYCRR 358-2.2

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

MLTC Policy 13.01: Transition of Care for Fee For Services Participants in Mandatory Counties
Date of Issuance: February 6, 2013, provides in part:

The purpose of this policy is to clarify that members transitioning from FFS Medicaid are afforded protections related to continuity of care.
The Partnership Plan terms and conditions (28 (d)) require:
Each enrollee who is receiving community-based long-term services and supports, as specified below, that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later.

Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R . § 438.404, mailed at least ten days before the proposed effective date of the change (as required by 42 C.F.R. § 431.211), that clearly articulates the enrollee's right to file an internal appeal (either expedited, if warranted, or standard), the right to have authorized services continue pending the resolution of the internal appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the internal appeal.

* * *

This policy applies to the following Medicaid fee-for-service community based long term care services and supports:

Personal care services;
Consumer directed personal assistance;
Home health services;
Private duty nursing; and
Adult day health care

Managed Long Term Care Policy 13.10: MLTC Policy Guidance – Communication with Recipients Seeking Enrollment and Continuity of Care
Date of Issuance: May 8, 2013 provides in part**:**

Effectively with the release of this policy, each enrollee who is receiving services must continue to receive those services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the Plan, whichever is later. In addition, the recipient / workers relationship shall be preserved for the same 90 days period. This change is the result of an amendment to the Special Terms and Conditions of the State's 1115 Waiver with CMS.

As a reminder, any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal.

* * *

This means that, for any individual receiving fee for service Medicaid community based long term services and supports and enrolling under any circumstance, the plan must provide 90 days of continuity of care.

MLTC Policy 13.13: Continuity of Care and Payment Requirements of MLTC Plans to LTHHCP Agencies Providing Care During the 90 Day Transition Period
Date of Issuance: May 30, 2013, provides:

The purpose of this policy guidance is to reiterate continuity of care policy for transitioning LTHHCP participants to MLTC and establish payment requirements for MLTC Plans when LTHHCP agencies are providing home care services to enrollees during the 90 day transition period.

As noted in previous policy documents, individuals transitioning from fee-for-service Medicaid to MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by the Plan, whichever is later. In addition, the patient/worker(s) relationship must be preserved for the same 90 day period. The worker in this case is defined as both professional and paraprofessional staff of the LTHHCP agency.

Each LTHHCP agency has an agency-specific rate associated with services provided to a LTHHCP participant. Preserving the patient/worker relationship will require MLTC plans to pay the LTHHCP agency their agency-specific fee-for-service Medicaid rate during the 90 day transition period for patients who are mandatorily enrolled into an MLTC.

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

DISCUSSION

The record in the matter establishes that the Appellant, age sixty-three, has been in receipt of Medical Assistance benefits, and is enrolled in a partially capitated Managed Long Term Care Plan through VNS. The record also establishes that the Appellant had been previously enrolled with VNS for the period from December 1, 2012 through November 30, 2017 and was in receipt of an authorization for Personal Care Services for 56 hours per week (8 hours per day, 7 days per week). In or about November 2017, the Appellant voluntarily disenrolled from VNS and enrolled with Centers Plan another Managed Long Term Care Plan, for the period from December 1, 2017 through January 31, 2018 and was in receipt of an authorization for Personal Care Services for 56 hours per week (8 hours per day, 7 days per week). In or about January

2018, the Appellant voluntarily disenrolled form Center Plan and reenrolled with VNS, effective February 1, 2018.

The record further establishes that on January 11, 2018, a nursing assessor completed a Uniform Assessment System (UAS) evaluation of the Appellant's personal care needs. On January 11, 2018, a nursing assessor also completed a HELPS Assessment Report in which the nurse determined that the Appellant had need of Personal Care Services for 33 hours per week over 7 days. On January 18, 2018 VNS issued a Projected Service Plan providing for personal care service for 6 hours per day, 7 days per week (42 hours per week). The January 18, 2018 Projected Service Plan states in part:

> As per approval, mbr [member] will be getting 7d x 6hrs = 42hrs of PCA [Personal Care Assistance] services from 9a-3p [9:00 am to 3:00 pm]. Mbr not satisfied 2/s but will still be enrolling w/ VNS Choice MLTC. Mbr requested to have the same aide from PIC [redacted] until CDPAS starts. Services to start effective 2/1/18.

On February 13, 2018 VNS issued a Summary of Authorized Services which included an authorization (presumably on an aid to continue basis) of 56 hours per week (8 hours per day, 7 days per week.)

VNS did not appear at the hearing, but submitted an evidence packet in lieu of appearance. The attorneys for VNS contended in a cover letter dated February 27, 2018 as follows:

> The above member [the Appellant] challenges through this fair hearing the Plan's determination to provide to [sic] 42 hours per week (6 x 7) of personal care services. The member voluntarily enrolled in the Plan after learning her projected services hours would be 42hours/week. If the member disagrees with those hours, she can request an increase from the Plan and wait for a decision from the Plan. The Plan has not stopped or reduced this member's hours, but evaluated a new enrollee. For that reason, we do not believe this issue is ripe for review.

The Plan's contention has been considered and is rejected. The Appellant, in transferring from one plan to another is entitled to a continuity of care, for at least 60 days, if not 90 days, or until a new evaluation is made, **whichever is later.**

Here the Appellant had been receiving 56 hours per week from VNS up until December 1, 2017. She continued to receive 56 hours per week from Center Plan from December 1, 2017 through January 31, 2018. When she re-enrolled with VNS, effective February 1, 2018, she should have been authorized for 56 hours per week for at least 60 days. The determination by VNS to provide only 42 hours per week constitutes a reduction in the Personal Care Service hours, requiring a timely and adequate notice of the reduction and a valid reason or reasons for such a reduction. VNS provide no such notice reducing the number of hours from 56 hours per

week to 42 hours per week and gave no reason for the reduction in hours other than they performed a new evaluation and found 42 hours per week to be sufficient.

For the foregoing reasons, the determination by VNS on or about January 18, 2018 to authorize 42 hours per week of personal care instead of 56 hours cannot be sustained.

DECISION AND ORDER

The January 18, 2018 determination of VNS to reduce the Appellant's Personal Care Services authorization from 56 hours per week (8 hours per day, 7 days per week) to 42 hours per week, (6 hours per day, 7 days per week) is not correct and is reversed.

Visiting Nurse Service of New York Choice is directed to:

1. Take no further action on the January 18, 2018 determination to reduce the Appellant's Personal Care Services authorization to 42 hours per week.

2. Continue to provide Personal Care Services to the Appellant for 56 hours per week (8 hours per day, 7 days per week).

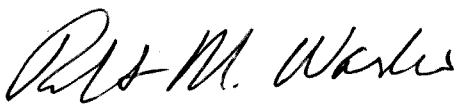
Should VNS need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to VNS promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, VNS must comply immediately with the directives set forth above.

DATED: Albany, New York
03/29/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee