STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 8, 2015
[redacted]
AGENCY: MAP
FH #: 7120263Y

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 November 17, 2015, 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

Tyrece Harrell, Grievances and Appeals Department

ISSUE

Was the Managed Long-Term Care Plan's determination to reduce the Appellant's Personal Care Services (PCS) Authorization from 40 hours per week to 30 hours 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 86, is enrolled in a partially capitated managed long term care plan operated by CenterLight Healthcare (hereinafter, the "MLTC Plan"), and has been in receipt of an authorization for personal care services in the amount of 40 hours per week, authorized over 5 days weekly. She resides with her granddaughters (ages 26 and 31). The Appellant's 31-year-old granddaughter, who was authorized to speak on the Appellant's behalf for this fair hearing, gave birth to a baby two weeks before the date of this fair hearing. The Appellant's 61-year-old daughter is temporarily residing with the Appellant; however, she will be returning to

her home out-of-state within the next few weeks.

2. On July 16, 2015, the MLTC Plan completed an assessment of the Appellant's personal care needs for the current certification period. The nurse who performed the July 16, 2015 assessment determined that there has been no change in either the Appellant's ADL status (ability to perform activities of daily living), or to the Appellant's overall self-sufficiency since the previous assessment conducted on January 14, 2015.

3. By notice dated September 2, 2015, the MLTC Plan advised the Appellant of its determination to reduce the Appellant's PCS authorization, effective September 12, 2015, from 40 hours per week to 30 hours per week. The notice also advises that "[y]ou were receiving personal care services of 8 hours per day, 5 days per week for help with: bathing, dressing, grooming, transferring, walking, toileting, grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed by a nurse on **7/16/2015**. The assessment showed that you are able to perform personal grooming, dressing, and transferring, walking, toileting with limited assistance; you need assistance getting in and out of the tub. You ambulate using a walker or quad cane; therefore, the personal care services you received under the previous authorization are no longer medically necessary. A decrease to 6 hours per day, 5 days per week is recommended since you can safely manage toileting and your daughter is able to assist once [the] aide leaves."

4. On September 8, 2015, the Appellant's granddaughter requested this fair hearing on the Appellant's behalf.

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.

(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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--
(i) The enrollee and his or her representative;

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

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

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

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

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

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

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

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.
Note: 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.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

Pursuant to the New York State Department of Health Office of Health Insurance Programs MLTC Policy 15.03, 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 without first requesting an internal appeal of the determination.

The model contract for partially capitated MLTC plans advises that Social and environmental supports are services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Pursuant to Appendix G, Social and environmental supports may be provided through care management. Care management is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

Person Centered Service Plan (or plan of care) is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the Enrollee, as well as the person's functional level and support systems. Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be

clearly identified on the person centered service plan or elsewhere in the care management record.

MLTC policy memo 13.09(a) reminds Plans of MLTC Policy 13.09: *Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York* which 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**.

All SAAM assessments conducted from June 16, 2013 through September 30, 2013 must be submitted to the Department of Health by October 31, 2013 via the regular SAAM submission process.

MLTC policy memo 13.09(b) advises in part:

1. Is it permissible for an MLTC Plan to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.

No. All MLTC Plans (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC Plans to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

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:

(2) **Some or total assistance** shall be defined as follows:

(i) **Some assistance** shall mean that a specific function or task is performed and completed by the patient with help from another individual.

(ii) **Total assistance** shall mean that a specific function or task is performed and completed for the patient.

(3) **Continuous personal care services** means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

(5) **Live-in 24-hour personal care services** means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.

(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.

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to 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.

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. Accessing the benefit

a. Request for Service: A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request…

b. Nursing and Social Assessment:
   i. Initial assessment
   Once the request is received the MCO is responsible for arranging an assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.
   ii. Social Assessment
   In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment

performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated , whether the member's home has adequate sleeping accommodations for a personal care aide.

This nursing assessment and the social assessment can be completed at the same time. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139…

c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period the MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.

d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN and the personal care services worker to develop the plan of care based on the MCO's authorization.

II. Authorization and Notice Requirements for Personal Care Services

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

b. Timing of authorization review.
   i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
   ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

c. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).

d. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):
   i. that were previously authorized, if any;
   ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
   iii. that are authorized for the new authorization period; and
   iv. the original authorization period and the new authorization period, as applicable.

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.
    i. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).
    ii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.
    iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:
        1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
        2. a mistake occurred in the previous personal care services authorization;
        3. the member refused to cooperate with the required assessment of services;
        4. a technological development renders certain services unnecessary or less time consuming;
        5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
        6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
        7. the member's medical condition is not stable;
        8. the member is not self-directing and has no one to assume those responsibilities;
        9. the services the member needs exceed the personal care aide's scope of practice.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to

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

DISCUSSION

The hearing record establishes that the Appellant, age 86, suffers from several chronic medical conditions, including Alzheimer's disease, dizziness, osteoarthritis, hypertension, high cholesterol, and urinary incontinence. The Appellant has been in receipt of a Personal Care Services (PCS) authorization in the amount of 40 hours per week (8 hours per day, 5 days per week). She resides with her two granddaughters, one of whom is of the age 26, and employed full-time. Her other granddaughter (age 31), who requested this fair hearing on the Appellant's behalf, gave birth to a baby two weeks before the date of this hearing, and is a full-time student. The Appellant's daughter, age 61, is temporarily residing with the Appellant; however, she will be returning to her other home (outside the state of New York) within the next few weeks, where she will remain for an indefinite period of time.

On July 16, 2015, the MLTC Plan completed an assessment of the Appellant's personal care needs for the current certification period. The nurse who performed the July 16, 2015 assessment determined that there has been no change in either the Appellant's ADL status (ability to perform activities of daily living), or to the Appellant's overall self-sufficiency since the previous assessment conducted on January 14, 2015.

By notice dated September 2, 2015, the MLTC Plan advised the Appellant of its determination to reduce the Appellant's PCS authorization, effective September 12, 2015, from 40 hours per week to 30 hours per week. The notice also advises that "[y]ou were receiving personal care services of 8 hours per day, 5 days per week for help with: bathing, dressing, grooming, transferring, walking, toileting, grocery shopping, meal preparation, and light housekeeping. Your need for these services was reassessed by a nurse on **7/16/2015**. The assessment showed that you are able to perform personal grooming, dressing, and transferring, walking, toileting with limited assistance; you need assistance getting in and out of the tub. You ambulate using a walker or quad cane; therefore, the personal care services you received under the previous authorization are no longer medically necessary. A decrease to 6 hours per day, 5 days per week is recommended since you can safely manage toileting and your daughter is able to assist once [the] aide leaves."

At the hearing, the MLTC Plan representative submitted into evidence copies of the current Nursing Assessment conducted on July 16, 2015 (Plan Exhibit 3), and copies of the previous

Nursing Assessment, conducted on January 14, 2015 (Plan Exhibit 4). While the previous assessment describes the Appellant as having modified independence with respect to cognitive skills for daily decision making, the July 16, 2015 assessment notes that the Appellant is "minimally impaired", and makes "poor or unsafe decisions" in specific recurring situations which necessitates supervision.

Other than descriptions pertaining to the Appellant's cognitive skills (which note a slight decline in function), the July 16, 2015 assessment is nearly identical to the January 14, 2015 assessment, including "Care Goals Comments" on Page 1 or the Comprehensive Report, which states that the Appellant has no change in functional status since the last assessment. The Appellant's listed diagnoses are all chronic medical conditions, for which there are no known cures, and therefore, cannot be used to justify a claim of "improved circumstances" or similar reason for a reduction of PCS hours. It is noted that the MLTC Plan also failed to produce a copy of the tasking tool utilized to quantify the number of hours that the Plan has determined were sufficient to address the Appellant's Personal Care Services needs.

The Appellant's granddaughter stated at the hearing that the Appellant is dependent upon her personal care services aide for the following tasks: (1) meal preparation (the Appellant requires specially-prepared meals in accordance with her doctor-prescribed diet); (2) bathing; (3) toileting (the Appellant requires assistance with removing her garments, and cleaning herself after toileting or an incident of incontinence); (4) dressing of her upper and lower body; (5) application of lotion on her body; (6) walking indoors and outdoors; (7) transfers in and out of chairs, and in and out of her bed; (8) cleaning the Appellant's apartment; (9) doing laundry; (10) shopping; (11) reminding the Appellant to take her medications; and (12) accompanying the Appellant to her medical appointments.

The Appellant's representative's statements are supported by the record. In reviewing the July 16, 2015 Nursing Assessment upon which the Plan based its September 2, 2015 determination, it is evident that the MLTC Plan was aware of the Appellant's PCS needs, her medical conditions, her physical limitations, and the slight deterioration of the Appellant's cognitive abilities. The Plan's July 16, 2015 assessment reflects a slight deterioration in the circumstances upon which the MLTC Plan contended justified a reduction rather than an increase in her PCS authorization. Furthermore, the September 2, 2015 notice fails to provide an appropriate reason for the reduction in the Appellant's Personal Care Services Authorization. Finally, the MLTC Plan was unable to establish at the hearing the quantitative basis for its decision that the Appellant's PCS needs were capable of being met with the approved 30 hours per week.

For all of the above reasons, the MLTC Plan's determination cannot be sustained.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination to reduce the Appellant's Personal Care Services (PCS) Authorization from 40 hours per week to 30 hours per week is not correct and is reversed.

1. The MLTC Plan is directed to continue to restore Appellant's Personal Care Services authorization to the amount of 40 hours per week, authorized over 5 days weekly.

2. The MLTC Plan is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 40 hours per week, authorized over 5 days per week.

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

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

DATED: Albany, New York
12/02/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee