
In the Matter of the Appeal of
[REDACTED]

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

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**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 September 9, 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 (“Senior Health Partners”)

Richard Cohen, Esq., Fair Hearing Representative

ISSUE

Was the Appellant's Managed Long Term Care Plan's, Senior Health Partners', determination to reduce the Appellant's Personal Care Services authorization from 63 hours weekly (9 hours daily, 7 days a week), to 49 hours weekly, correct?

FINDINGS OF FACT

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

1. The Appellant, age 77, has been enrolled in and has received care and services, including Personal Care Services, through a Managed Long Term Care Plan operated by Senior Health Partners.

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2. The Appellant has been in receipt of Personal Care Services in the amount 63 hours weekly (9 hours daily, 7 days a week).

3. On November 26, 2014, a Senior Health Partners nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs, and recommended that the Appellant receive Personal Care Services in the amount of 24 hours daily, 7 days weekly, provided on a "sleep-in" basis.

4. On May 12, 2015, a Senior Health Partners nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs, and indicated "No change" in Appellant's ADL status as compared to 90 days ago or since last assessment if less than 90 days ago.

5. By notice dated June 15, 2015, effective June 25, 2015, Senior Health Partners determined to reduce the Appellant's Personal Care Services authorization from 63 hours weekly (9 hours daily, 7 days a week), to 49 hours weekly on the grounds that,

"After a review of all information , including the most current assessment, as outlined below, Healthfirst is changing the services you currently receive. We are approving a total of 49 hours per week for personal care assistance support. We are changing the services from the prior authorization because a mistake occurred in the previous personal care services authorization."

6. On July 2, 2015, the Appellant requested this fair hearing to contest the Managed Long Term Care 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 Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Regulations at 18 NYCRR 358-3.3(a)(1) states that, except as provided in subdivision (d) a recipient has a right to a timely and adequate notice when a social services agency:

- (i) proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance Authorization or services.

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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:

- the specific laws and/or regulations upon which the action is based;

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

In Mayer et al. v. Wing et al. (S.D.N.Y.), Plaintiffs challenged New York City's efforts to reduce their personal care services, authorized under fee-for-service Medicaid. The Court found that prior to issuing any reduction notice, the Agency must first identify some development that justifies altering a recipient's level of services. Specifically, the Agency was enjoined from reducing recipient's home care services unless the Agency's notice states that a reduction is justified because of any of a series of listed reasons. Effective October 31, 2001, relevant sections of 18 NYCRR 505.14(b) were amended to include the following requirements, consistent with the Mayer decision, for Agency determinations and notices of determination to reduce Personal Care Services, as to reasons for the Agency to select from when issuing relevant notices:

- (1) the clients 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;

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- (6) the clients health and safety cannot be assured with the provision of personal care services;
- (7) the clients 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 aides 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.

General Information System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

Districts were first advised of the Mayer case in May, 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24 hour care, including continuous 24 hour services ("split-shift"), 24 hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.

According to GIS 01 MA/ 044 "... the new regulations provide that one reason for reducing or discontinuing personal care services is "the client's medical, mental, economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously" [18 NYCRR 505.14 (b)(5)(v)(c)(1)]. Consistent with the Court ruling in Mayer, the State requires that client notices citing this reason for reducing or discontinuing services must identify the specific medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction or discontinuation in services. The client notice must explain why the change in the client's circumstances results in the need for fewer hours of services." (emphasis added)

The GIS also provides "Districts are reminded that State policy, as reflected in the new regulations, requires that when districts determine to reduce, discontinue or deny personal care

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services, the client notice must identify the specific reason (whether a prior mistake in the authorization, the client's refusal to cooperate with the required assessment or other specific reason set forth in the regulations) that justifies the action. The client notice must also explain why the cited circumstance or event necessitates the reduction, discontinuance or denial of services.” (emphasis added)

The below-attached managed care personal care guidelines had similarly advised in relevant part :

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. (emphasis added)

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

- i. Personal care services includes some or total assistance with:
 1. Level I functions as follows:
 - a. Making and changing beds ;
 - b. Dusting and vacuuming the rooms which the member uses;
 - c. Light cleaning of the kitchen, bedroom and bathroom;
 - d. Dishwashing;
 - e. Listing needed supplies;
 - f. Shopping for the member if no other arrangements are possible;
 - g. Member’s laundering, including necessary ironing and mending;
 - h. Payment of bills and other essential errands; and
 - i. Preparing meals, including simple modified diets.
 2. Level II personal care services include Level I functions listed above and the following personal care functions:
 - a. Bathing of the member in the bed, the tub or the shower;
 - b. Dressing;
 - c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
 - d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
 - e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
 - f. Transferring from bed to chair or wheelchair;

- g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
- h. Feeding
- i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
- j. Providing routine skin care;
- k. Using medical supplies and equipment such as walkers and wheelchairs; and
- l. Changing of simple dressings.

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.

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 438.404(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...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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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.”

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.

(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.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

- (a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or
- (b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

Section 505.14(b) of the Regulations provides that when a social services district receives a request for personal care services, it must determine whether the individual is eligible for Medical Assistance. The initial authorization for services shall be based on:

- a physician's order from the patient's physician based on the patient's current medical status as determined by a medical examination within 30 days of the request for Personal Care Services;

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- a social assessment which must include a discussion with the patient to determine perception of his/her circumstances and preferences, an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and consideration of the number and kind of informal caregivers available to the patient, ability and motivation of informal caregivers to assist in care, extent of informal caregivers' potential involvement, availability of informal caregivers for future assistance, and acceptability to the patient of the informal caregivers' involvement in his/her care. The social assessment is completed by the Agency. When live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide.
- a nursing assessment. The nursing assessment is completed by a nurse from a certified home health agency or by a nurse employed by the local social services department or by a nurse employed by a voluntary or proprietary agency under contract with the local social services department. The nursing assessment must be completed within 5 working days of the request and must include the following:
 - (1) a review and interpretation of the physician's order;
 - (2) the primary diagnosis code;
 - (3) an evaluation of the functions and tasks required by the patient;
 - (4) the degree of assistance required for each function and task;
 - (5) an evaluation whether adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, can meet the patient's need for assistance with personal care functions, and whether such equipment or supplies can be provided safely and cost-effectively.
 - (6) the development of a plan of care in collaboration with the patient or his/her representative; and
 - (7) recommendations for authorization of services.
- an assessment of the patient's appropriateness for hospice services and an assessment of the appropriateness and cost effectiveness of using adaptive or specialized medical equipment or supplies covered by the Medicaid Program including, but not limited to, bedside commodes, urinals, walkers, wheelchairs and insulin pens; and

Where there is a disagreement between the physician's order and the social, nursing and other required assessments, or there is a question about the level and amount of services to be provided, or if the case involves the provision of continuous Personal Care Services (i.e., uninterrupted care by more than one person), an independent medical review of the case must be completed by the local professional director, by a physician designated by the local professional

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director, or by a physician under contract with the Agency to review personal care services cases, who shall make the final determination about the level and amount of care to be provided.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

- (a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or
- (b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

GIS 03 MA/003 provides, in pertinent part:

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

DISCUSSION

The hearing record establishes that The Appellant's physician reported that the Appellant's diagnosis include hemiplegia (total or partial paralysis of one side of the body), diabetes and chronic pain. On June 15, 2015, Senior Health Partners issued a Notice of Intent to reduce Appellant's Personal Care Services. The "reason" section of the Notice states: "After a review of all information , including the most current assessment, as outlined below, Healthfirst is changing the services you currently receive. We are approving a total of 49 hours per week for personal care assistance support. We are changing the services from the prior authorization because a mistake occurred in the previous personal care services authorization."

Regulations at 18 NYCRR 358-3.3(a)(1) requires that an adequate notice must contain the **specific laws and/or regulations upon which the action is based** (emphasis added). Senior Health Partners' notice contains no law or regulations upon which its determination is based. Accordingly, Senior Health Partners' Notice is ruled to have not fully met adequacy standards for Personal Care Services discontinuance notices, and the determination is not sustained.

Leaving the adequacy of the Notice in question aside for a moment, Senior Health Partners' determination in this case should be examined on the merits because of the interesting determination it made to reduce the Appellant's Personal Care services because a mistake occurred in the prior authorization, which totally contradicts its own documentary evidence at

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this hearing. Senior Health Partners submitted a UASNY assessment (comprehensive) report for the Appellant dated November 26, 2014. The Senior Health Partners nursing assessor who completed the Assessment of the Appellant's personal care needs recommended that the Appellant receive Personal Care Services in the amount of 24 hours daily, 7 days weekly, provided on a "sleep-in" basis. The nurse, in the detailed report, concluded on page 21 of the November 26, 2014 assessment as follows:

“The member lives in a safe and clean environment with her daughter who is mentally challenged. The member is only able to ambulate with one person assist and she is put to bed when the aide leaves and she is not able to get up until the aide comes back in the morning. I believed that the member could benefit from live in PCW to assist her with toileting, bathing cooking and safety. The daughter that stays with her is unable to call 911 if a problem should arise in the middle of the night. Her other daughter does not lives close by.”

In addition, the May 12, 2015, Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs completed by another Senior Health Partners nursing assessor contains no appreciable difference when compared to the November 26, 2014 assessment. The nurse report of the Appellant's personal care needs, indicated “No change” in Appellant's ADL status as compared to 90 days ago or since last assessment if less than 90 days ago. On the “Overall self-sufficiency of Appellant as compared to 90 days ago or since last assessment if less than 90 days ago,” the nurse also indicates “No change.”

With the totality of the evidence presented, the only mistake Senior Health Partners has been able to establish it made, is that it did not increase the Appellant's Personal Care services as recommended by its own assessors. However, since the issue at this hearing is about reduction and not adequacy of Appellant's personal care services hours and the fact that Appellant's representative stated that they are not seeking an increase in hours at this time, that is a matter for another time.

For the above stated reasons, Senior Health Partners' determination to reduce the Appellant's Personal Care Services authorization from 63 hours weekly (9 hours daily, 7 days a week), to 49 hours weekly, cannot be sustained.

DECISION AND ORDER

The Appellant's Managed Long Term Care Plan's determination dated June 15, 2015 to reduce the Appellant's Personal Care Services authorization from 63 hours weekly (9 hours daily, 7 days a week), to 49 hours weekly, was not correct and is reversed.

1. Senior Health Partners is directed to restore the Appellant's Personal Care Services authorization to the amount of 63 hours weekly (9 hours daily, 7 days a week).

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2. Senior Health Partners is directed to continue to provide the Appellant with a Personal Care Services authorization in the amount of 63 hours weekly (9 hours daily, 7 days a week).

Should Senior Health Partners in the future determine to implement its previous action, it is directed to procure and review the Appellant's case record, to issue a new, timely, and adequate Notice of Intent, and to produce the complete case record at any subsequent fair hearing.

Should Senior Health Partners 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 Senior Health Partners promptly to facilitate such compliance.

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

DATED: Albany, New York
09/29/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee