
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 August 31, 2015, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[REDACTED]

For the Managed Care Plan

David E. Miller, Esq., Fair Hearing Representative

ISSUE

Was the Appellant's Managed Care Plan's determination dated June 30, 2015 to reduce the Appellant's Personal Care Services authorization from the amount of 20 hours weekly to the amount of 6 hours weekly, provided under a task-based plan of care, correct?

FACT FINDING

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 35, has been authorized to receive Personal Care Services in the amount of 20 hours weekly, provided under a task-based plan of care. The aforesaid Personal Care Services are provided to the Appellant through the Appellant's Managed Care Plan – [REDACTED].

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2. By Notice dated June 30, 2015 which was signed by [REDACTED], the Appellant's Managed Care Plan – [REDACTED] advised the Appellant of its determination to reduce the Appellant's Personal Care Services from 20 hours weekly, provided under a task-based plan of care to 6 hours weekly, provided under a task-based plan of care, effective July 13, 2015.

3. On July 10, 2015, the Appellant requested this telephone fair hearing.

APPLICABLE LAW

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.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

GIS 11 MA/009 provides that effective August 1, 2011, personal care services for non-dual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract. This change will not affect CDPAP until *July 1, 2012*. Districts are advised that, at this time, PERS authorizations will remain the responsibility of the LDSS. PERS will be added into the MCO benefit package as of January 1, 2012 and further direction will be provided as the implementation of this initiative moves forward.

Case management responsibilities related to the delivery of personal care services will be the responsibility of the MCO. For assistance with needs unrelated to the delivery of personal care services but required to maintain the individual safely in the community, the MCO will collaborate with the LDSS for assistance with the needs unrelated to the delivery of personal care. A contact list of appropriate local district resources should be shared with the local district's MCO liaison for distribution to MCOs. MCOs will be responsible for the case management activities as defined in 505.14(g) with the LDSS maintaining its responsibilities related to Adult Protective Services (APS). APS professional staff has primary responsibility for case management for a patient who meets the requirements for the intervention and admission to APS. The MCO staff would assist the APS staff with arranging the provision of PCS when necessary.

Pursuant to Social Services Law §365-a(2)(e) Medicaid provides personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.

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..."

(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.

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.

The Medicaid Managed Care Model Contract advises in part regarding covered services:

Personal Care Services (MMC only, effective August 1, 2011)

- a) Personal care services (PCS), as defined by 18 NYCRR §505.14(a), are the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the Enrollee's health and safety in his or her own home. The service must be ordered by a physician or nurse practitioner, and there must be a medical need for the service. Enrollees receiving PCS must have a stable medical condition that is not expected to exhibit sudden deterioration or improvement; does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; is such that a physically disabled individual in need of routine supportive assistance does not need skilled professional care in the home; or the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. Enrollees receiving PCS must be self-directing, which shall mean that the Enrollee is capable of making choices about his or her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choices. Enrollees who are non self-

directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive PCS, except under the following conditions:

- i) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household;
 - ii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household;
 - iii) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The LDSS may be the outside agency.
- b) Personal care services are authorized as Level I (environmental and nutritional functions) or Level II (personal care, environmental and nutritional functions) with specific number of hours per day and days per week the PCS are to be provided. Authorization for solely Level I services may not exceed eight (8) hours per week.

The Department's guidelines regarding provision of personal care services through managed care plans provide in relevant part:

II. 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. Note: When a request for PCS is made, the MCO must provide the member with information about the Consumer Directed Personal Assistance Program ("CDPAP") using the brochure provided by SDOH. There is a further discussion about CDPAP below.

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. NOTE: All assessments will be conducted using the Uniform Assessment Tool when it becomes available.

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.

III. 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

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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.

Regulation 358-5.9(a) provides:

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

DISCUSSION

The record developed in this hearing establishes that by Notice dated June 30, 2015 signed by [REDACTED], the Appellant's Managed Care Plan – [REDACTED] had advised the Appellant of its determination to reduce the Appellant's Personal Care Services from 20 hours weekly, provided under a task-based plan of care to 6 hours weekly, provided under a task-based plan of care, effective July 13, 2015. In stating a reason, said notice did not use any of the "appropriate" reasons listed in subsection (e) of the Guidelines for Authorization of Personal Care in Managed Care. Such "appropriate" reasons are succinct statements relating either to the existence of an error in a previous assessment, or some change in the medical or social situation of the patient.

In the present hearing, the Plan's attorney contended that the Plan had made a mistake in a prior assessment of Appellant's eligibility. Nonetheless, the Notice failed to state any such thing. Instead, the reasons stated on the Notice are far more rambling than any on the list of "appropriate" notices, and fail to indicate what might have been wrong with the current authorization or what might have changed. The stated reasons on the notice are:

"You live alone and have no family members living nearby who are able to provide support. Your recent home assessment was done on 08/08/15 of your activity of daily living abilities including your medical history and current diagnoses. You are a 34 year old female. You have a history of asthma, depression, hypertension, chronic obstructive pulmonary disease and osteoarthritis, which impairs your ability to perform certain functions for yourself. This assessment and current information about your health and

circumstances was used to determine your need for eligible services including personal care assistance. Your assessment showed that you are alert and fully oriented. You are able to describe an emergency plan. Your assessment showed that you are not homebound. You use a cane or walker inside and outside the home. You are independent with personal hygiene. You need supervision with walking and bathing. You need limited assistance with toileting, dressing upper body and dressing lower body. You need extensive, maximal or total assistance with any other daily living activities. You are continent of bladder. The assessment indicates that you also need Level 1 support with following tasks such as housekeeping and simple meal preparation. The tasks include making and changing beds, dusting and vacuuming the rooms you use, light cleaning of the kitchen, your bedroom and bathroom, dishwashing, keeping track of needed supplies, shopping for your needs, doing your laundry, paying your bills, preparing your meals and running essential errands.”

At the hearing, the Plan’s attorney, in an effort to settle this issue with Appellant, advised Appellant of the Plan’s proposal to withdraw its June 30, 2015 determination; authorize Appellant to receive Personal Care Services in the amount of 18 hours weekly, provided under a task-based plan of care; and advise Appellant in writing of the Plan’s new authorization. In doing so, the Plan’s attorney stated his interpretation of law that time the Plan had been allotting for “additional findings” in Appellant’s Plan of care was not legally permitted. The Administrative Law Judge made no comment regarding this legal argument by the Plan’s counsel.

A review of the hearing record makes clear that the Plan’s Notice is, as already pointed out, inadequate. Also, as to the attorney’s contention concerning “additional findings,” fee for service Medicaid allows a reasonable number of minutes a week for “other” and places no limit for unscheduled needs and help using medical supplies/equipment. Managed care providers are required to provide the same level of service as fee for service. Without evidence to the contrary, “additional findings” would seem to constitute unscheduled needs, or the equivalent of “other” in fee-for-service, or a run over of time that a computer program will not hold under the specific task slots, or else, permissible “span of time” allocation, or a combination of all of the above. Counsel’s argument stated to Appellant at the hearing has been considered but is rejected as unsupported by any law or Regulation pertaining to Personal care Services, and, also, because it does not comport with the history of the development of Personal Care Services which only introduced task-based assessments as a new methodology in or about year 1996, subject to the proviso that Plans of Care not be limited to minutes allocated in pre-set menus, where a patient has need for additional minutes or hours of care. Nor did the Plan’s Counsel, either orally or in prepared documents submitted for the hearing, establish an improvement in Appellant’s medical or social condition.

For the above stated reasons, the Plan’s determination is not sustained.

It is noted that, at the hearing, the Appellant indicated acceptance of the proffered lower hours (18 weekly). The Administrative Law Judge who conducted the hearing wrote a draft reflecting an accepted stipulation to provide said lesser hours, which are, albeit, more than the originally proposed 6 hours weekly stated in the Plan Notice at issue in this hearing. Yet, the

hearing transcript tends to suggest that Appellant may well have accepted the offered deal based upon the belief that the Plan's counsel was correct in stating that the Plan was not legally permitted to allot time to "additional findings." Even if it cannot be known to a certainty that Appellant based her acceptance of the resolution upon such statement of law, the transcript nonetheless demonstrates that there is a danger that this occurred, which offends the notions of due process underlying the Fair Hearing process. Since Counsel's legal contention was incorrect, and was not in way questioned or even discussed by the Administrative Law Judge, and, furthermore, because the Plan made use of an inadequate Notice and did not appear with evidence sufficient to establish that its determination was correct, the present decision is being issued in place of the draft initially prepared by the Administrative Law Judge.

DECISION AND ORDER

The Appellant's Managed Care Plan's determination dated June 30, 2015 to reduce the Appellant's Personal Care Services authorization from the amount of 20 hours weekly to the amount of 6 hours weekly, provided under a task-based plan of care was not correct and is reversed.

1. The Plan is directed to withdraw its June 30, 2015 Notice, to authorize Appellant to receive Personal Care Services in the amount of 20 hours weekly, provided under a task-based plan of care, and to restore Appellant's Personal Care Services to the just-mentioned amount of 20 hours weekly.

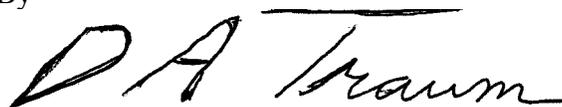
2. The Plan is directed to continue to authorize Appellant to receive Personal Care Services in the amount of 20 hours weekly.

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

DATED: Albany, New York
09/22/2015

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "D.A. Traumm". The signature is written in a cursive, flowing style with a horizontal line above the name.

Commissioner's Designee