
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 26, 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 (HealthFirst)

Joshua Pike, Esq., Fair Hearing Representative

ISSUE

Was the Appellant's Managed Care Provider's final determination dated July 30, 2015 to discontinue the Appellant's children's Personal Care Services hours in the amount of 20 hours weekly (4 hours daily, 5 days a 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 47, has been enrolled in a Managed Care Program and has received care and services on behalf of her 20-month-old children (triplets), including Personal Care Services, through a Medicaid Managed Care Plan operated by HealthFirst.

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2. The Appellant has been in receipt of Personal Care Services for her triplets in the amount of 20 hours weekly (4 hours daily, 5 days a week).

3. On June 17, 2015, HealthFirst completed a "Uniform Assessment System - New York Assessment (Comprehensive) Report" on the Appellant's triplets.

4. By "Initial Adverse Determination" dated July 9, 2015, HealthFirst determined to discontinue the Appellant's children's personal care services, effective July 20, 2015, on the grounds that,

"The plan is taking this action because the request did not have enough information to determine if the health care service is medically necessary. After a review of all information, including the most current assessment, as outlined below, HealthFirst is changing the services you currently receive. We are not approving any personal care assistance support. You live with your parents who are willing to provide support....."

5. The Appellant requested an internal review of this decision.

6. By notice dated July 30, 2015, HealthFirst denied the Appellant's appeal on the grounds that:

"Our Medical Director reviewed the clinical information provided. Based on this, it was determined that the request for 5 hours per week of personal care services is not medically necessary, and not approved for coverage. You are alert and receive Early intervention services. You live with your mother, father and two sisters who have agreed to assume that responsibility. Based on your current medical condition, this reassessment shows that your function level has not changed and the personal care services required to meet your current needs no longer justify 5 hours per week of personal care services."

7. On July 20, 2015, the Appellant requested this fair hearing to contest the Managed 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

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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.

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.

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.

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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.

Social Services Law §365-a(2)(e)(iv) provides 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.

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..."

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.

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.

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;
- (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)].

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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 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)

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.

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(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

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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.

DISCUSSION

The hearing record establishes that, on July 30, 2015, HealthFirst issued a Notice of Intent to discontinue Appellant's children's Personal Care Services. The "reason" section of the Notice of Final Adverse Determination states: "Our Medical Director reviewed the clinical information provided. Based on this, it was determined that the request for 5 hours per week of personal care services is not medically necessary, and not approved for coverage. You are alert and receive Early intervention services. You live with your mother, father and two sisters who have agreed to assume that responsibility. Based on your current medical condition, this reassessment shows that your function level has not changed and the personal care services required to meet your current needs no longer justify 5 hours per week of personal care services."

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

(1) the client's medical, mental, economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

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

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- (3) the client refused to cooperate with the required assessment of services;
- (4) a technological development renders certain services unnecessary or less time consuming;
- (5) the client can be more appropriately and cost-effectively served through other Medicaid programs and services;
- (6) the client's health and safety cannot be assured with the provision of personal care services;
- (7) the client's medical condition is not stable;
- (8) the client is not self-directing and has no one to assume those responsibilities;
- (9) the services the client needs exceed the personal care aide's scope of practice; and
- (10) the client resides in a facility or participates in another program or receives other services which are responsible for the provision of needed personal care services.

It must be emphasized that Federal regulations require that the State's contracts with managed plans must provide, among other things, that the services the managed care plan offer be furnished in an "amount, duration and scope" that is no less than the "amount, duration and scope" for the same services furnished to Medicaid fee-for-service recipients and that the managed care plan may place appropriate limits on services on the basis of medical necessity, but the criteria for determining medical necessity may be no more restrictive than that applicable to fee-for-service recipients. The adequacy of a Notice which is Mayer compliant, is equally applicable to Managed Care Plans as it is applicable to Medicaid fee-for-service recipients.

The Managed Care Plan's Notice by no means follows these guidelines. It cannot be ignored that Appellant's children were already in receipt of Personal Care Services when HealthFirst issued the Notice, meaning that some reference to a "change," or, perhaps, to a "mistake" would have been all the more appropriate. In other words, some reference to a change in Appellant's "medical," "mental," "economic" or "social" circumstances would have been more appropriate. The Managed Care Personal care guidelines had similarly advised in relevant part that a 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.

In addition, 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). HealthFirst's notice contains no law or regulations. Accordingly, HealthFirst's Notice is ruled to have not fully met adequacy standards for Personal Care Services discontinuance notices, and the determination is not sustained.

DECISION AND ORDER

The Managed Care Provider's final determination dated July 30, 2015 to discontinue the Appellant's children's Personal Care Services hours in the amount of 20 hours weekly (4 hours daily, 5 days a week), was not correct and is reversed.

1. HealthFirst is directed to cancel its final determination dated July 30, 2015 Discontinuance Notice.
2. HealthFirst is directed to continue to authorize Appellant's children to receive Personal Care Services in the amount of 20 hours weekly (4 hours daily, 5 days a week).

Should HealthFirst 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 that is Mayer's compliant, and to produce the complete case record at any subsequent fair hearing.

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

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

DATED: Albany, New York
09/11/2015

NEW YORK STATE DEPARTMENT
OF HEALTH

By



Commissioner's Designee