STATE OF NEW YORK
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

REQUEST: October 19, 2022
CASE #: MA0383140
AGENCY: Monroe
FH #: 8517276Q

In the Matter of the Appeal of

Teresa Carroll

DECISION AFTER FAIR HEARING

from a determination by the Medicaid Certified Home Health Aide Agency, Excellent Home Care Services

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR (hereinafter Regulations), a fair hearing was held on March 2, 2023, in Monroe County, before Leslie Deutsch, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Teresa Carroll, Appellant (by telephone)
Richard Marchese Esq. (by telephone)

For the Medicaid Certified Home Health Aide Agency, University of Rochester Medicine Home Care ("URMHC")
Michelle Dalkepmer President, CEO, URMHC (by telephone)
Anoush Koroghlian Scott Esq. (by telephone)

For the Managed Long Term Care Plan (Fidelis)
Binny Seth Esq. (by telephone)
Kim Godfray (by telephone)

ISSUE

Was the determination to discontinue Appellant's Home Health Aide services 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 57, certified disabled, resides alone in Monroe County and is in receipt of Medical Assistance benefits. The Appellant is in receipt of Medicaid benefits managed by Fidelis ("MCP" or "The Plan" or "The Agency") a Long Term Managed Care Provider. The Appellant was authorized and in receipt of two levels of care pursuant to her physician's plan of care (Skilled Nursing Care once a month "SNC" and Home Health Aide "HHA" from a Certified Home Health Agency "CHHA" 2 x per day x 7 days per week). Fidelis contracted with University of Rochester Medicine Home Care ("URMHC") to provide the SNC and the CHHA services to the Appellant.

2. By Approval Notice dated August 31, 2022 MLTC Plan Fidelis ("The Plan") notified the Appellant that the Appellant was approved for:

"Coverage Type: Medicaid MLTC
Service: Authorized From Date: September 01, 2022
Authorized to Date: October 31, 2022
Code: **S9122**
Authorized Units: **473**
Home Health Aid (S9122 x 473 hours)
Provider: UR Medicine Home Care, Certified Services, Inc.
Plan Reference Number: 222371454

Dear Teresa Carroll:

You are getting this notice because your health plan has approved your Home Health Aid (S9122 x 473 hours).

On August 25, 2022 you asked Fidelis Care for the service listed above.

Fidelis Care has decided this service is medically necessary.

You or your provider requested approval for:
Home Health aid (S9122 x 473 hours)

On August 31, 2022, the plan approved:
Home health aid (S9122 x 473 hours)

This means from September 01, 2022 to October 31, 2022, your health care service is approved for:
Home health aid (S9122 x 473 hours)

We will review your care again within the next six months.

UR Medicine Home Care, Certified Services Inc., is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This approval does not guarantee payment. There are many things that are considered before a payment can be made. One of these is to make sure you were covered on the date the services took place. Another is to confirm that the services were covered by your contract that was in effect at the time.

If you would like to speak to Fidelis Care about this decision, please call 1-800-688 – 7422.

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

Vincent Marchello, MD
Chief Medical Officer

Cc: UR Medicine Home care, Certified Services. Inc."

3. By separate Approval Notice dated August 31, 2022, MLTC Plan Fidelis ("the Plan") notified the Appellant that the Appellant was approved for:

"Coverage Type: Medicaid – MLTC
Service: Authorized From Date: September 01, 2022
Authorized To Date: October 31, 2022
Code: T1030
Authorized Units: 14
Home skilled nursing visits (T1030 x 14 visits)
Provider: UR Medicine Home Care, Certified Services, Inc.
Plan Reference Number 222371394

Dear Teresa Carroll:

You are getting this notice because your health plan has approved your Home skilled nursing visits (T1030 x 14 visits).

On August 25, 2022 you asked Fidelis Care for the service listed above.

Fidelis Care has decided this service is a covered benefit.

You or your provider requested approval for:

Home skilled nursing visits (T1030 x 14 visits)

On August 31, 2022, the plan approved:
Home skilled nursing visits (T1030 x 14 visits)

This means from September 01, 2022 to October 31, 2022, your health care service is approved for:
Home skilled nursing visits (T1030 x 14 visits)

We will review your care again within the next six months.

UR Medicine Home Care, Certified Services, Inc. is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This Approval does not guarantee payment. There are many things that are considered before a payment can be made. One of these is to make sure you were covered on the date the services took place. Another is to confirm that the services were covered by your contract that was in effect at the time.

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Sincerely,

Vincent Marchello, MD
Chief Medical Officer

Cc: UR Medicine Home Care, Certified Services, Inc."

4. On or about October 5, 2022, URMHC sent a Notice to the Appellant, advising the Appellant:

"...we are writing to notify you that UR Medicine Home Care (URMHC) is no longer able to meet your personal care needs and must discharge you from our service. Notwithstanding, we will continue to provide you with medically required skilled-nursing care and services...."

5. On October 19, 2022, the Appellant requested this fair hearing.

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, or the source of funding and the amount deducted from the initial payment of supplemental security income as reimbursement of Public Assistance, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

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

In general, a SNAP recipient has a right to a timely and adequate adverse action notice when the Agency proposes to take any action to discontinue, suspend or reduce the recipient's SNAP benefits during the certification period. 18 NYCRR 358-2.3; 18 NYCRR 358-3.3(b). An adequate, though not timely, action taken notice is required where the Agency has accepted or denied an application for SNAP benefits; or has increased the SNAP benefits; or has determined to change the amount of one of the items used in the calculation of the SNAP benefits. 18 NYCRR 358-3.3(b). However, pursuant to 18 NYCRR 358-3.3(e), there is no right to an adverse action notice when, for example, the change is the result of a mass change, the Agency determines that all members of the household have died or the household has moved from the district or when the household has failed to reapply at the end of the certification period.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

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

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;
- the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued;
- a statement that a fair hearing must be requested separately from a conference;
- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services;
- a statement that participation in an agency conference does not affect the right to request a fair hearing;
- the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;

- an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;

- the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;

- the right to present written and oral evidence at the hearing;

- the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;

- information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and

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

18 NYCRR 358-2.2

Social Services Law section 365-a(2) states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" 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.

The Medicaid Managed Care Model Contract delineates the terms by which Medicaid Managed Care Plans agree to cover specified healthcare services in accordance with New York State Medicaid Guidelines. Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

<u>HOME HEALTH AIDE</u>

Section 365-a.2(d) Social Services Law specifies that "Medical Assistance" in New York State shall include home health services provided in a recipient's home and prescribed by a physician.

18 NYCRR Section 505.23 provides in relevant portions as follows:

(a)

(3) Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home other than a general hospital or an RHCF:

(i) nursing services provided on a part-time or intermittent basis by a certified home health agency or, if no certified home health agency is available, by a registered professional nurse or a licensed practical nurse acting under the direction of a recipient's physician;

(ii) physical therapy, occupational therapy, or speech pathology and audiology services; and

(iii) home health aide services, as defined in the regulations of the Department of Health, provided by a person who meets the training requirements of the Department of Health, is assigned by a registered professional nurse to provide home health aide services in accordance with a recipient's plan of care, and is supervised by a registered professional nurse from a certified home health agency or a therapist, in accordance with the regulations of the Department of Health.

(b) Provision of home health services.

(1) A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health (Article 7 of Subchapter C of Chapter V of Title 10 NYCRR) and with federal regulations governing home health services (42 C.F.R. 440.70 and Part 484). (42 CFR Part 430 to end, revised annually as of October 1, is published by the Office of the Federal Register, National Archives and Records Administration, and is available for public use and inspection at the Department of Social Services, 40 North Pearl St., Albany, New York 12243.)

(2) As part of the comprehensive assessment or reassessment that a certified home health agency must conduct for each recipient in accordance with the regulations of the Department of Health, a certified home health agency must complete the required home care assessment instrument.

The Model Contract for Mainstream Medicaid Managed Care, published by the New York State Department of Health, provides, in part, at Appendix K, that Managed Care Plans shall include Home Health Services (services of a Certified Home Health Aide) as a covered service.

Private Duty Nursing, or Licensed Practical Nursing

Section 505.8 of the Regulations provides, in pertinent part:

(a) Where nursing care may be provided. Nursing service as medically needed shall be provided to medical assistance recipients in the person's home or in a hospital.

(b) Who may provide nursing care.

(1) Nursing care to patients in New York State shall be provided by a person possessing a license and current registration from the New York State Education Department to practice as a registered professional nurse or licensed practical nurse.

(d) Nursing service in the home.

(1) For necessary nursing service to be provided in the person's home, full and primary use shall be made of the services of an approved home health agency, including a hospital-based home health agency.

(2) Such service shall be provided on a per visit basis and may include not only intermittent or part-time nursing service for the patient but also instructions to members of the patient's family in procedures necessary for the care of the patient.

(3) Service of a registered professional nurse or of a licensed practical nurse on a private practitioner basis may be provided to a patient in his own home only under the following circumstances:

(i) when there is no approved home health agency available to provide the intermittent or part-time nursing services needed by the patient;

(ii) when the patient is in need of individual and continuous nursing care beyond that available from an approved home health agency.

(e) Prior approval and prior authorization. Prior approval by the local professional director and prior authorization by the local social services official shall be required for nursing service provided in a person's home or in a hospital by a private practicing registered professional or licensed practical nurse, except that in an urgent situation the attending physician may order the service of such nurse for no more than two nursing days and immediately notify the local social services official and the appropriate medical director.

(f) Physician's written order required. All nursing services provided in the patient's home or in a hospital shall be in accordance with the attending physician's written order and plan of treatment, however, in extraordinary circumstances and for valid reasons which must be documented, nursing service in the home may be initiated by a home health agency before the physician sees the patient. A physician's written order is required for all such nursing services in excess of the initial two visits.

The Private Duty Nursing Manual Policy Guidelines states, in relevant part, all private duty nursing shall be in accordance with the attending physician's written order and treatment plan. It further states that approval for private duty nursing services shall be at the licensed practical nursing level unless:

(a) The physician's order specifically justifies in writing the reasons why registered nurse (RN) nurse services are necessary. In this case, the Medicaid Director or local designee must be in agreement.

(b) The required skills are outside the scope of practice for a licensed practical nurse (LPN) as determined by the NYSED.

Section 6902 of Article 139 of the Education Law distinguishes between the legal definitions of RNs and LPNs as follows:

The practice of the profession of nursing as a registered professional nurse (RN) is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.

The practice of nursing as a licensed practical nurse (LPN) is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations.

Furthermore, section 6901 of Article 139 of the Education Law provides the following definitions relating to the scope of practice of RNs:

1. "Diagnosing" in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis.
2. "Treating" means selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen, and execution of any prescribed medical regimen.
3. "Human Responses" means those signs, symptoms and processes which denote the individual's interaction with an actual or potential health problem.

Section 6902, cited above, does not include nursing diagnosis within the scope of practice of LPNs.

The New York State Education Department's Practice Information provides guidelines as to the scope of practice between RNs and LPNs. Said guidelines states that RNs executes medical orders from select authorized health care providers, function independently in providing nursing care in such areas as the ongoing surveillance and nursing intervention to rescue chronically ill persons from development of negative effects and secondary results of treatments.

It further provides that nursing diagnosis is interpreted as including patient assessment, that is, the collection and interpretation of patient clinical data, the development of nursing care goals and the subsequent establishment of a nursing care plan. Additionally, LPNs do not have assessment privileges; they may not interpret patient clinical data or act independently on such data; they may not triage; they may not create, initiate, or alter nursing care goals or establish nursing care plans. Under the direction of the RN, LPNs may administer medications, provide nursing treatments, and gather patient measurements, signs, and symptoms that can be used by the RN in making decisions about the nursing care of specific patients. However, they may not function independent of direction.

Informational Letter 08 OHIP/ INF-5 addresses frequently asked questions concerning private duty nursing services in the community through the Medicaid program. Guide to Accessing Medicaid Private Duty Nursing Services in the Community advises, in pertinent part:

How does a Medicaid client in the community obtain private duty nursing services?

In general, most new private duty nursing cases are Medicaid clients who have been discharged to the community from a hospital or a nursing facility. In those cases, the hospital or nursing facility discharge planner is primarily responsible for referring the Medicaid client to private duty nursing services, when appropriate. However, Medicaid clients already residing in the community, or their representatives, may also seek to obtain private duty nursing services.

The Model Contract for Mainstream Medicaid Managed Care, published by the New York State Department of Health, provides, in part, at Appendix K, that Managed Care Plans shall include Private Duty Nursing Services as a covered service.

Section 365-a.2(d) Social Services Law specifies that "Medical Assistance" in New York State shall include home health services provided in a recipient's home and prescribed by a physician.

18 NYCRR Section 505.23 provides in relevant portions as follows:

(a)

(3) Home health services mean the following services when prescribed by a physician and provided to an MA recipient in his or her home other than a general hospital or an RHCF:

(i) nursing services provided on a part-time or intermittent basis by a certified home health agency or, if no certified home health agency is available, by a registered professional nurse or a licensed practical nurse acting under the direction of a recipient's physician;

(ii) physical therapy, occupational therapy, or speech pathology and audiology services; and

(iii) home health aide services, as defined in the regulations of the Department of Health, provided by a person who meets the training requirements of the Department of Health, is assigned by a registered professional nurse to provide home health aide services in accordance with a recipient's plan of care, and is supervised by a registered professional nurse from a certified home health agency or a therapist, in accordance with the regulations of the Department of Health.

(b) Provision of home health services.

(1) A certified home health agency must provide home health services in accordance with applicable provisions of the regulations of the Department of Health (Article 7 of Subchapter C of Chapter V of Title 10 NYCRR) and with federal regulations governing home health services (42 C.F.R. 440.70 and Part 484). (42 CFR Part 430 to end, revised annually as of October 1, is published by the Office of the Federal Register, National Archives and Records Administration, and is available for public use and inspection at the Department of Social Services, 40 North Pearl St., Albany, New York 12243.)

(2) As part of the comprehensive assessment or reassessment that a certified home health agency must conduct for each recipient in accordance with the regulations of the Department of Health, a certified home health agency must complete the required home care assessment instrument.

***

(14) Referral to other appropriate long-term care services.

(i) The activities specified in sub clauses (a) (l) through (a) (5) of this subparagraph must be performed for each recipient who is awaiting referral to other appropriate long-term care services. The social services district and the certified home health agency must enter into an agreement that specifies which such activities will be performed by the district and which such activities will be performed by the agency. The social services district must inform the department which such activities will be performed by the district and which such activities will be performed by the agency.

(a) The following activities must be performed for each recipient who is awaiting referral to other appropriate long-term care services:

(1) complete all required admission documentation for each recipient awaiting referral to other appropriate long-term care services;

(2) file such documentation with all long-term care services providers of the level of care appropriate for the recipient that are located within 50 miles of the recipient's home;

(3) notify such long-term care services providers of the names and telephone numbers of professional staff available to provide additional information to such providers regarding the recipient's medical conditions or services needs;

(4) contact by telephone each week at least three RHCFs, other residential long-term care services or other non-residential long-term care services that provide the level of care appropriate for the recipient and that are located within 50 miles of the recipient's home to determine whether the level of care appropriate for the recipient is available; and

(5) rotate such telephone contacts weekly among all such long-term care services providers and maintain a record of such contacts.

(ii) When other appropriate long-term care services become available, the certified home health agency must notify the recipient and the recipient's physician that the services are available to the recipient. If the recipient accepts the other appropriate long-term care services, the certified home health agency must assist the recipient to obtain the services and discharge the recipient in accordance with the regulations of the Department of Health. If the recipient refuses to accept the services, the certified home health agency must notify the recipient's physician and the social services district and comply with appropriate regulations of the Department of Health.

10 NYCRR section 700.2(a) (15) defines "home health aide services" as meaning "health care tasks, personal hygiene services, housekeeping tasks and other related supportive services essential to the patient's health."

Regulations implementing the Revised Catanzano Implementation Plan were filed on April 11, 1996, effective immediately, as a series of appendices to 18 NYCRR 505.23 pursuant to an Order of the United States District Court, Western District of New York, in an action entitled "Catanzano et al. v. Dowling et al." 89 CV 1127L. The Order is limited to adverse actions taken contrary to a treating physician's orders with respect to home health services.

These Regulations establish detailed assessment, notice and related fair hearing procedures. Social services districts and certified home health agencies must follow these Regulations before denying, reducing or discontinuing a Medical Assistance recipient's home health services.

In an April 15, 2011 letter to CHHA's, the New York State Department of Health set forth policy guidelines with regard to a range of determinations that may have to be made by a CHHA with regard to a home health care applicant or recipient. In part, this Letter states:

[referencing the Catanzano Plan]

Recipients of home health services: Under the Plan, a home health services recipient includes each Medicaid recipient who is currently receiving home health services in his or her own home or in any other community setting in which home health services can be

provided and each hospitalized Medicaid recipient who received home health services immediately prior to hospitalization. Each home health services recipient has the right to a fair hearing notice from the social services district and the right to request a fair hearing with services to continue unchanged until the fair hearing decision is issued (aid-continuing) when the district's local professional director or designee agrees with the CHHA's decision to reduce the recipient's home health services or to discharge the recipient for certain reasons but the recipient's treating physician disagrees with the CHHA's proposed reduction or discharge.

When a CHHA, contrary to the treating physician's orders, proposes to reduce a recipient's home health services because the recipient's medical condition has improved, or for other reasons related to the recipient's health and safety, the CHHA must follow the Plan's provisions relating to CHHAs at Sections 206-211.

When a CHHA, contrary to the treating physician's orders, proposes to discharge a Medicaid recipient because the home health services ordered by the treating physician can no longer maintain the recipient's health and safety in the home for one or more of certain specified reasons, the CHHA must follow the Plan's provisions relating to CHHAs at Sections 200-205. These reasons are set forth at 10 NYCRR Sections 763.5(h)(1), 763.5(h)(4) or 763.5(h)(5). These provisions permit CHHAs to discharge patients who have met therapeutic goals, are non-compliant with the plan of care, or those whose health and safety can no longer be met in the home.

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.

DISCUSSION

The record establishes that the Appellant, age 57, certified disabled, resides alone in Monroe County, is in receipt of Medical Assistance benefits. The Appellant is in receipt of Medicaid benefits managed by Fidelis ("MCP") a Long Term Managed Care Provider. The Appellant was authorized and in receipt of two levels of care pursuant to her physician's plan of care (skilled nursing care once a month "SNC" and home health aide "HHA" from a Certified Home Health Agency "CHHA" 2 x per day x 7 days per week). Fidelis contracted with University of Rochester Medicine Home Care ("URMHC") to provide the CHHA services to the Appellant.

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Sincerely,

Vincent Marchello, MD
Chief Medical Officer

Cc: UR Medicine Home care, Certified Services. Inc."

3. By separate Approval Notice dated August 31, 2022, MLTC Plan Fidelis ("The Plan") notified the Appellant that the Appellant was approved for:

"Coverage Type: Medicaid – MLTC
Service: Authorized From Date: September 01, 2022
Authorized To Date: October 31, 2022
Code: T1030
Authorized Units: 14
Home skilled nursing visits (T1030 x 14 visits)
Provider: UR Medicine Home Care, Certified Services, Inc.
Plan Reference Number 222371394

Dear Teresa Carroll:

You are getting this notice because your health plan has approved your Home skilled nursing visits (T1030 x 14 visits).

On August 25, 2022 you asked Fidelis Care for the service listed above.

Fidelis Care has decided this service is a covered benefit.

You or your provider requested approval for:

Home skilled nursing visits (T1030 x 14 visits)

On August 31, 2022, the plan approved:
Home skilled nursing visits (T1030 x 14 visits)

This means from September 01, 2022 to October 31, 2022, your health care service is approved for:
Home skilled nursing visits (T1030 x 14 visits)

We will review your care again within the next six months.

UR Medicine Home Care, Certified Services, Inc. is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This Approval does not guarantee payment. There are many things that are considered before a payment can be made. One of these is to make sure you were covered on the date the services took place. Another is to confirm that the services were covered by your contract that was in effect at the time.

If you would like to speak to Fidelis Care about this decision, please call 1-800-688-7422.

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

Vincent Marchello, MD
Chief Medical Officer

Cc: UR Medicine Home Care, Certified Services, Inc."

At the fair hearing, the Fidelis Plan submitted an evidence packet that was accepted into the record. The Plan's evidence included a Uniform Assessment Comprehensive Report dated August 29, 2022 (finalized September 1, 2022) conducted by a Registered Nurse. The Plan's UAS finalized September 1, 2022 conducted by the Registered Nurse indicates the Appellant has Diagnoses of:

Candidiasis unspecified
Dietary calcium deficiency
Disorder of urinary system unspecified
Full incontinence of feces
Other cystostomy status
Other muscle spasm
Outlet dysfunction constipation
Pain unspecified
Personal history of urinary tract infections
Presence of urogenital implants
Quadriplegia unspecified (primary diagnosis)
Unspecified fall sequela
Unspecified injury at unspecified level of cervical spinal cord, initial encounter
Vitamin deficiency unspecified

The September 1, 2022 UAS also reported that the Appellant requires assistance with activities of daily living:

Total dependence (full performance by others during entire period):
Ordinary housework
Bathing
Dressing lower body
Transfer toilet
Toilet use
Bed mobility
stairs

Maximal Assistance (Help throughout task, but performs less than 50% of task on own):
Meal preparation
Personal hygiene
Eating

Extensive Assistance (Help throughout task, but performs 50% or more of task on own):
Managing medications
Phone use
Shopping
Transportation
Locomotion

The September 1, 2022 UAS also indicated:

Appellant's "primary mode of locomotion indoors: wheelchair, scooter

Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago: No change.

Overall self-sufficiency has changed significantly as compared to status 90 days ago, or since last assessment if less than 90 days: No change."

A review of the UAS also indicated in Section F Comments:

"Member is a quadriplegic, she requires the use of EZ pivot lift for all transfers. Member is non-weight bearing and non-ambulatory. Member is able to function at 2/c level in her home. She is able to extend BUE (L= with forehead > R = lower pinna), she has ROM to both elbows but non to wrists. Member uses an extended mouse for voice commands and had no difficulty in facilitating the virtual assessment. She is able to use the local bus system to get to the store to make purchases with assistance."

The record further established that the Appellant has been enrolled in Fidelis Managed Long Term Care plan since March 1, 2014. The Appellant was receiving HHA services and

registered nurse ("RN") services from vendor, University of Rochester Medicine Home Care ("URMHC"). Prior to mid September of 2022 the Appellant was receiving services:

Monday:

6:30 a.m.- 8:30 a.m. (2 hours)
Noon – 1pm (1 hour)
5:30 p.m. – 6:30 p.m. (1 hour)
10 PM – 12 midnight (2 hours)
Monday = 6 hours

Tuesday:
6:30 a.m. – 8:30 a.m. (2 hours)
Noon – 1 p.m. (1 hour)
5:30 p.m.- 6:30 pm (1 hour)
10 PM – 1 AM (bowl program) (3hours)
Tuesday = 7 hours

Wednesday:
6:30 a.m. – 8:30 a.m. (2 hours)
Noon – 1 pm (1 hour)
5:30 pm – 6:30 pm (hour)
10 PM – 12 midnight (2 hours)
Wednesday = 6 hours

Thursday:
6:30 a.m. – 8:30 a.m. (2 hours)
Noon – 1pm (1 hour)
5:30 p.m. – 6:30 p.m. (1 hour)
10 PM – 1AM (bowl program) (3 hours)
Thursday = 7 hours

Friday:
6:30 a.m. – 8:30 a.m. (2 hours)
10 PM – 12 midnight (2 hours)
Friday = 4 hours

Saturday:
7 am – 1 pm (6 hours)
10 pm – 12 am (2 hours)
Saturday = 8 hours

Alternating Saturday
AM (2 hours) The arrival time would depends on the people coming.
PM (1 hour) 10 PM – 11 PM

Sunday:
7 am – 1 pm (6 hours)
10 pm – 1 pm (bowel program) (3 hours)
Sunday = 9 hours

Alternating Sunday
AM (2 hours) The arrival time would depend on the people coming.
PM (3 hours) (bowel program) Regular aid back

The record further established that on or about September 13, 2022, the Appellant received an unsigned letter from URMHC stating:

"...Re: Personal Care Services

Dear Ms. Carroll:

Please take notice that due to the increase in the number of Home Health Aide visits requested to meet your personal care needs, the availability of home health support services has become limited. As a result, there are several visits in the upcoming weeks for which we are unable to secure aides to meet the requested coverage. Those dates and times are as follows:

Saturday (9/17) 7 am – 1pm; 10 pm – 12 am
Sunday (9/18) 7 am – 1 pm
Saturday (9/24) 7 am – 1 pm: 10 pm – 12 am
Sunday (9/25) 7 am – 2 pm: 10 pm – 12 am
Saturday (10/1) 7 am – 1 pm; 10 pm – 12 am
Sunday (10/2) 7 am – 1 pm
Saturday 10/5) 7 am – 1 pm; 10 pm – 12 am
Sunday (10/16) 7 am – 1 pm
Saturday (10/29) 7 am – 1 pm; 10 pm – 12 am
Sunday (10/30) am – 1 pm

We will continue to provide home health support services necessary to the extent necessary to address your minimally essential health and safety needs during this time. Please contact Christopher Nichols, your Fidelis Care Manager, as soon as possible. We will work with him and the local adult protective services program, as applicable, to help secure alternative options during the uncovered hours.

Should you have any questions you may contact Tatiana (Tanya) by telephone at 585-274-4380 or by electronic mail at Tatiana Calabria@urmc.rochester.edu

Sincerely,

UR Medicine Home Care

Cc: Nina Piazza
Christopher Nichols…"

The record further established that by Notice dated September 16, 2022, MLTC Plan Fidelis ("The Plan") advised the Appellant:

"…Approval Notice
Coverage Type: Medicaid- MLTC
Service: Authorized From Date: September 17, 2022
Authorized To Date: February 28, 2023
Code: **T1019U1**
Authorized Units: 1536
16 Hours/Week, 8 Hrs x 2 Days; **Personal Care Aide – Level 2**
Provider: Elite HHC, LLC
Plan Reference Number: 222580276

Dear Teresa Carroll:

You are getting this notice because your health plan has approved your 16 Hours/Week, 8 Hrs x 2 Days: **Personal Care Aide-Level 2**.

Fidelis Care has decided this service is medically necessary.

Before this decision, from January 1, 1753 (Sic) to January 01, 1753 (Sic), this service was approved for:
16 Hours/Week, 8 Hrs x 2 Days; Personal Care Aide – Level 2

On September 16, 2022, the plan approved:
16 Hours/Week, 8 Hrs x 2 Days; Personal Care Aide – Level 2

This means from September 17, 2022 to February 28, 2023, your health care service is approved for:
16 Hours/Week, 8 Hrs x 2 Days; Personal Care Aide- Level 2

We will review your care again within the next six months.

Elite HHC, LLC is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This approval does not guarantee payment. There are many things that are considered before a payment can be made. One of these is to make sure you were covered on the date the services took place. Another is to confirm that the services were covered by your contract that was in effect at the time.

If you would like to speak to Fidelis Care about this decision, please call 1-800-688-7422.

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

Vincent Marchello, MD
Chief Medical Officer

Cc: Elite HHC, LLC

The record further established that by Notice dated October 18, 2022, Fidelis MLTC Plan ("The Plan"), advised the Appellant:

"Approval Notice
Coverage Type: Medicaid- MLTC
Service: Authorized From Date: September 17, 2022
Authorized to Date: February 28, 2023
Code: G0162
Authorized Units: 1
1 RN Supervision
Provider: Elite HHC, LLC
Plan Reference Number: 222912262

Dear Teresa Carroll:

You are getting this notice because your health plan has approved your 1 RN Supervision. On September 13, 2022 you asked Fidelis Care for the service listed above.

Fidelis Care has decided this service is medically necessary.

You or your provider requested approval for;
1 RN Supervision

On October 189, 2022, the plan approved:
1RN Supervision

This means from September 17, 2022 to February 28, 2023, your health care service is approved for:
1 RN Supervision

We will review your care again within the next six months.

Elite HHC, LLC is a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.

This approval does not guarantee payment. There are many things that are considered before a payment can be made. One of these is to make sure you were covered on the date the services took place. Another is to confirm that the services were covered by your contract that was in effect at that time.

If you would like to speak to Fidelis Care about this decision, please call 1-800-688-7422.

You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

Vincent Marchello, MD
Chief Medical Officer

Cc: Elite HHC, LLC

The record further established that on or about October 5, 2022, URMHC sent a Notice to the Appellant advising the Appellant:

> "...We are writing to notify you that UR Medicine Home Care (URMHC) is no longer able to meet your personal care needs and must discharge you from our service. Notwithstanding, we will continue to provide you with medically required skilled-nursing care and services.
>
> As you know, URMHC has been providing services to you since on or about April 15, 1986, approximately 36 years. For many years after being admitted to our service, your condition was such that our staff was able to meet both your skilled nursing and personal care needs and provided you with all the home care services necessary to protect and promote your health and safety.
>
> Unfortunately, your personal care needs and requests for various non-skilled nursing services have expanded substantially to the point where the number of hours and the staff

necessary to meet those changing needs far exceed what we are able to provide. Specifically, although we are contracted to provide up to two hundred thirty-six (236) hours of home care services each month, you currently require mor than two hundred eighty (280) and sometimes close to there hundred (300) hours each month. That level of service coupled with the severely limited number of home health aides on our staff presents an extreme and undue burden on the agency and its staff, reducing our capability to meet your needs and fundamentally alters the nature of services we are able to provide to confidently assure your health and safety at home.

Fidelis agrees that an alternative provider must be secured to meet your personal care services needs and is working to secure placement with an alternative agency with the capability to provide the personal care services you need and desire. We will work with them to support a smooth transition and hope to have a new provider in place by October 21, 2022.

URMHC will continue to provide home health services to address your skilled nursing requirements, which include monthly foley catheter changes. That level of service will remain unchanged. We will also provide incidental related services to the extent necessary to address your minimally essential health and safety needs until such time as an alternative placement becomes available and such placement is made, or you make an informed choice to refuse such placement.

Should you have any questions please ask your legal representative to contact our legal counsel, Anoush Koroghlian-Scott at 518-462-0100.

Sincerely,

Michelle Dahlkemper, MBA, FACHE
President & Chief Executive Officer

Cc: Dr. Nina Piazza
Christopher Nicholis, Fidelis Care Manager…"

The record further established that URMHC sent a letter to the Plan, Fidelis dated October 31, 2022 that stated:

"Christopher Nichols, RN, BSN, MBA
Nurse Care Manager, MLTC
Fidelis Care
480 Cross Point Parkway
Getzville, New York 14068

Re: (illegible)

Dear Mr. Nichols:

I am writing to follow up on a recent request from Fidelis to re-admit (illegible) to our nursing service to manage her bowel regimen and monthly foley catheter care.

As you know, we worked closely in collaboration with you to discharge (illegible) from our service effective October 20, 2022. Unfortunately, over the past week circumstances have arisen including, but not limited to, the resignation of two (2) registered nurses, that would preclude us from re-admitting her to our service. We simply do not have the capacity to meet her needs.

Should you have questions, please contact me.

Sincerely,

Michelle Dahlkemper, MBA, FACHE
President and Chief Executive Officer

Cc: Kim Godfrey, Director
Nina Piazza, MD
Thomas Caprio, MD…"

At the fair hearing, the Attorney Representative, Anoush Koroghlian Scott, for URMHC submitted into evidence document dated February 20, 2023 that stated:

"…Preliminary Statement
As determined by the New York State Department of Health ("DOH") after full on-site and administrative investigation of the facts herein, URMHC did follow the law and complied with applicable regulatory requirements pertaining to this matter and safely discharged the Appellant effective on October 21, 2022. Notwithstanding, URMHC has re-admitted the Appellant for, is currently providing Appellant, and Appellant is currently receiving all skilled nursing care pursuant to the plan of care ordered by the Appellant's primary care physician.

Statement of Facts
Prior to October 21, 2022, URMHC provided two levels of care to the Appellant pursuant to her physician's plan of care as the same was in effect from time to time. Specifically, URMHC was providing (i) skilled nursing care once a month, primarily to inspect and change Appellant's foley catheter and attend to any wound care of other skilled needs as needed; and (ii) home health aide who visited twice a day to provide a variety of personal care and health-related services.

The personal care services were provided by a particular URMHC home health aide who was willing and able to work with the Appellant so long as certain contingencies such as bonus pay and security escorts for late night visits were in place. Other staff members have refused to work with the Appellant and in some cases left URMHC, citing the Appellant's extreme demands, constant criticism, and lack of cooperation. In 2022, URMHC contracted with Fidelis to provide up to 236 hours of service per month. Due to Appellant's unreasonable demands (which exceeded those set forth in the existing plan of care), URMHC was providing 50 to 70 additional hours each month to meet Appellant's extreme needs and assure the safety of staff during late night visits. (See Exhibit 1: Monthly staff hours dedicated to Appellant Jan.-Aug. 2022, Individual position salaries redacted).

In September 2022, URMHC determined that the staff necessary and the associated costs to meet Appellant's personal care needs far exceeded what URMHC was capable of providing. (See Exhibit 1) in short, the Appellant's service needs coupled with the fact that virtually no home health aides were willing to work with the Appellant, and the extraordinary costs, presented an undue burden on URMHC and its staff, impairing its capability to continue to provide personal care services to the Appellant.

On or about September 2022, URMHC commended discussions with the Appellant's primary care physician, URMHC's Medical Director, and met with the Appellant's Managed Long Term Care Case Manager at Fidelis pertaining to its determination that the Appellant's personal care service needed to be transferred from URMHC to an alternate service provider. Appellant's primary care physician did not disagree with the preposed transfer of care and Fidelis agreed to make arrangements to transfer Appellant's personal care service to an alternate service provider. By letter dated October 5, 2022, a copy of which was provided to Appellant and Appellant's primary care physician, URMHC provided written notice to Fidelis confirming its intent to discharge the appellant from URMHC service for personal care services (not skilled nursing) effective October 21, 2022. In that October 5, 2022, letter, URMHC also agreed to continue to provide such services until an alternate service provider was secured. (See Exhibit 2: Letter from URMHC dated October 5, 2022). From late September throughout October, URMHC proceeded to work diligently in consultation and collaboration with Fidelis Case Management to arrange for an secure an alternate care provider to meet the appellant's personal care needs after discharge on October 21, 2022.

Although URMHC did not intend to discharge the Appellant form skilled nursing service, and fully intended to continue to provide skilled nursing services to manage the Appellant's foley catheter maintenance and other incidental related skilled nursing services as necessary, Fidelis arranged and authorized all levels of services (Skilled and personal care services) to be provided by an alternative service provider after discharge. (See Exhibit 3; Exhibit D to Fidelis' submission (in pertinent part) authorizing skilled nursing visits from L. Woerner, inc. effective October 21, 2022). Accordingly, on October 19, 2022, Fidelis requested that URMHC provide records relating to the appellant's nursing care. When asked if Fidelis was transferring all care for the appellant

to another service provider, including skilled nursing care, Fidelis responded by electronic mail communication, "That is correct" and asked that the nursing records be faxed. (See Exhibit 4; E-mail communication from Oksana Avizova to Michelle Dahlkemper dated Wednesday, October 19, 2022, 12:55 p.m.) in full cooperation with Fidelis' case managers' requests, URMHC provided all clinical information necessary to facilitate and assure a smooth transition of all care without interruption. (See Exhibit 4: E-mail communication from Oksana Avizova to Michelle Dahlkemper dated October 21, 2022, 11:12 a.m. confirming receipt of requested records). Based upon the information available to URMHC, it believed in good faith that an alternate service provider was secured to provide both skilled nursing and personal care services for Appellant commending on October 21, 2022, upon discharged from URMHC. From October 21, 2022, through November 10, 2022, URMHC reasonably believed in good faith that an alternative certified home health agency ("CHHA") admitted the Appellant to its service and was providing all services to her pursuant to her plan of care.

On November 10, 2022, however, when DOH conducted an unannounced visit to investigate a complaint pertaining to Appellant's discharge, URMHC learned for the first time that there was an interruption in skilled nursing care. The DOH, without the benefit of all the facts, issued a preliminary finding of immediate jeopardy for failure to "ensure that services were in place through another Home Health Agency prior to discharging the patient."

URMHC was unaware and could not have reasonably known that there was an interruption in skilled nursing services before DOH informed them of that fact on November 10, 2022. Upon notice that there was an interruption in service, on or about November 11, 2022, URMHC immediately took steps to readmit the Appellant for skilled nursing care as original set forth in the letter dated October 5, 2022. URMHC conducted an admission assessment, admitted the Appellant through its internal health information systems, adopted, and initiated the plan of care ordered by the Appellant's physician and generated a case communication. (See Exhibits 5 and 6: Screen shot of admission; and "Home Health Certification and Plan of Care' effective 11 11 2022 and "Case Communication Report' dated 11 11 2022). However, upon trying to input the Appellant to CMS' system as "admitted," URMHC discovered that the Appellant was already **admitted** to HCR Home ("CHR") commencing on October 24, 2022. (See Exhibit 7: Notice of eligibility for the Appellant with service start date of October 24, 2022) It appears that sometime between October 21 and November 10, HCR determined that the Appellant required 24/7 care and was unsafe at home. (See Exhibit 8; E-mail correspondence from A. Crisafulli (at HCR) to K. Fontanes dated November 14, 2022, 10:13 a.m.) However, HCR did not remove the Appellant from its service until on or about November 11, 2022. URMHC did not know and could not have reasonably known that an alternate CHHA was not providing skilled care during period from October 21, 2022, through November 11, 2022. On November 11, 2022, the Appellant was successfully re-admitted to URMHC for skilled nursing care and continues to receive all skilled nursing care from URMHC consistent with the plan of care offered by her

physician to date. A copy of her current plan of care is attached. (See Exhibit 9: Plan of Care with start date of 01/10 23).

On November 14, 2022, URMHC provided additional documents to DOH. (See Exhibit 10; E-mail communication from M. Dahlkemper to K.Reichert and S. Davis dated November 14, 2022, 5:59 p.m.) On November 15, 2022, URMHC was instructed by DOH investigators to stop working on a plan of correction in response to the IJ because there was reason to believe that the preliminary finding of IJ was based upon inaccurate and incomplete information. By letter dated November 21, 2022, the DOH negated and expunged the preliminary finding of immediate jeopardy. Final notifications from the Federal Department of Health and Human Services Centers for Medicare and Medicaid Services and New York State department of Health indicating URMHC's "substantial compliance with Federal and State Regulations" were also issued on November 21, 2022. (See Exhibit 11: letter from NYS DOH signed by Karen Reichart, RN dated November 21, 2022, and corresponding NYSDOH and CMS notifications)

URMHC Complied with Appliable Regulatory Requirements to Discharge Appellant from Personal Care Services
As noted by Appellant's counsel, pursuant to 18 NYCRR Section 505.23,

When a CHHA determines that home health services ordered by the recipient's physician can no longer maintain an MA recipient's health and safety, the CHHA must consult with the physician. The CHHA may discharge the recipient if the recipient's physician provides the CHHA with a written statement that the recipient may be discharged or if the physician directs the CHHA to immediately comply with his oral statement the recipient may be discharged, in which event a written statement from the recipient's physician authorizing discharge shall be provided within seven days. When the recipient's physician does not provide the CHHA with such a written or oral statement agreeing to the discharge the CHHA must:

A. Refer the recipient's case to a CHHA that, after assessing the recipient, agrees to admit the recipient and provide home health services according to the physician's order and continue to provide home health services according to the physicians' order until the new CHHA has assessed and admitted the recipient; or
B. Refer the recipient's case to the Social Service district and continue to provide home health services according to the physician's order until notified otherwise by the Social Services district. 18 NYCRR 505.23.200.

As determined by the DOH, URMHC complied with applicable regulatory requirements in respect to the Appellant's discharge from URMHC pursuant to the letter dated October 5, 2022.

"When a CHHA determines that home health services ordered by the recipient's physician can no longer maintain an MA recipients health and safety, the CHHA must consult with the physician." As evidenced by the facts and documents submitted,

URMHC did not take any action unilaterally, but at all times consulted with the Appellant's physician and the URMHC's Medical Director, as well as her case managers at Fidelis.

The CHHA may discharge the recipient if the recipient's physician provides the CHHA with a written statement that the recipient may be discharged. As there was no intent to leave the appellant without services consistent with her plan of care, her physician did not provide a written statement authorizing discharge, but verbally indicated to Ms. Dahlkemper her understanding for the need to transfer personal care services to an alternative provider.

When the recipient's physician does not provide the CHHA with such a written or oral statement agreeing to the discharge the CHHA must refer the recipients case to ta CHHA that, after assessing the recipient, agrees to admit the recipient and provide home health services according to the physician's order and continue to provide home health services according to the physician's order until the new CHHA has assessed and admitted the recipient. URMHC worked collaboratively with Fidelis to secure an alternate service provider for the Appellant. An alternate service provider was identified and secured, and Appellant was authorized by Fidelis to receive not only personal care services, but also skilled nursing services form the alternate service provider. URMHC received notice that the Appellant was, in fact, **admitted** by the alternative service provider for home care services effective October 21, 2022. URMHC continued to provide home care services to the Appellant consistent with the plan of care up to October 21, 2022, the date she was apparently admitted by the alternate service provider to provide ethe same services. URMHC did not effectively discharge the Appellant from its service until it was clear to URMHC that the Appellant was admitted for service by an alternate CHHA, effective October 21, 2022. URMHC discharged the Appellant in good faith reliance on the credible information available to it that she was admitted for service by another CHHA. Indeed, when it discovered on November 10, 2022, that the alternate service provider did not admit the Appellant, URMHC immediately re-admitted the appellant for skilled nursing care.

The "Catanzano implantation Plan" cited by Appellant's attorney does not apply in this case. There was no denial, reduction, or discontinuance of home health services contrary to the Appellant's treating physician's order. No adverse action was taken contrary to the appellant's treating physicians' orders. URMHC continued to provide services during the transition to another CHHA, and in collaboration with Fidelis, initiated a discharge plan that assured a timely, safe, and appropriate transition for the patient as determined by DOH after comprehensive investigation of the facts. URMHC provided all services necessary until such time that an alternate service provider apparently admitted the Appellant. Currently, URMHC is providing all skilled nursing services ordered by the Appellant' physician and the remaining personal care and home health services are being provided and/or being offered by alternate service providers such that all levels of services are provided and/or made available to Appellant.

Conclusion.
DOH and CMS determined in writing that URMHC "safely discharged the patient' and did not violate appliable federal or state laws or regulations. Based upon the foregoing, this matter should be dismissed in its entirely.

Very truly yours,
LIPES MATHIAS LLP
Anoush Korghlian Scott
Enclosures
CC: Michelle Dahlkemper, MBA, FACHE, President & CEO URMHC
Binny Seth, legal counsel for Fidelis by email: binny.seth@ttlaw.om
Richard Marchese, legal counsel for Appellant by email: rmarchese @woodsoviatt.com"

At the fair hearing, the Appellant Representative submitted into evidence Legal Memorandum in Support of Relief Sought by the Appellant, dated January 27, 2023 that stated:

"...On September 13, 2022, Ms. Carroll received an unsigned letter form URMHC indicating that staffing issues were prohibiting them from providing services on weekends as they had been in the past. The letter indicated that "we will continue to provide home health support services necessary to the extent necessary to address your minimally essential health and safety needs during this time."

On October 5, 2022, Ms. Carroll received a letter from the President and Chief Executive Officer of UR Medicine informing her that "URMHC is no longer able to meet your personal care needs and must discharge you from our service." In that correspondence URMHC acknowledged that they had been providing services to Teresa since April of 1986 but that staffing shortages dictated the decision. The letter also indicated that Fidelis had agreed to find an alternate provider to provide personal care services and was working to secure placement with an alternative agency. On October 31, 2022, Christopher Nichols of Fidelis received correspondence from the President of UR Medicine indicating that, due to the resignation in part of two registered nurses that UR Medicine could not agree to re-admit Ms. Carroll to their nursing service to manage her bowel regiment and monthly Foley catheter care. The letter indicated that "We simply do not have the capacity to meet her needs." All three of these letters are attached for your review.

CHHAS are governed under both federal and New York State law. Extensive regulations governing the discharge of recipients of CHHA services are contained in 18 NYCRR Section 505.23. This regulation encompasses the "Catanzano Implementation Plan." The Catanzano Implementation Plan is the law of New York State and arose from the case of Catanzano v. Dowling 847 F. Supp. 1070 (W.D.N.Y. 1994), affirmed 60 F 3rd 113 (2nd Circuit 1995). The Catanzano case and its progeny resulted from a class action,

which culminated in an Order from Judge Larimer of the Western District of New York Federal court which set forth detailed instructions for CHHA's operating in New York State. The New York State Department of Health has affirmed that the Catanzano Implementation Plan governs CHHA discharge obligations and the rights that CHHA recipients have if a CHHA attempts to terminate their services. These include Fair Hearing rights. The April 15, 20-11 "Dear Administrator" letter from the Department of Health clearly spells out these Fair hearing requirements. In part, that "Dear Administrator" letter (attached) reads as follows:

"Because CHHAs receive Medicaid reimbursement for services provided, they are also required to comply with federal and state regulations that apply to all Medicaid providers. In addition, the courts have ruled that Medicaid recipients have the right to a State Fair Hearing to challenge certain proposed denials, reductions or discontinuances of home health services when those actions would be contrary to the recipients treating physician's order."

The Cantanzano Implementation Plan does not allow or call for any internal appeal. Because the Plan and the regulations relate directly to CHHA services, CHHA recipients, as Ms. Carroll, have the direct right to challenge the determination of a CHHA and the CHHA contractor (Fidelis) at an Administrative Fair hearing. This has been the law in New York State for well over twenty five years.

The actions taken by URMHC were clearly contrary to Ms. Carroll's physicians' orders and indeed no physician order was cited by URMHC in discharging Ms. Carroll. Section 201 of the Catanzano Implementation Plan incorporated in 18 NYC RR Section 505.23 reads as follows:

"When a CHHA determines that home health services ordered by the recipient's physician can no longer maintain MA recipient's health and safety, the CHHA must consult with the physician. The CHHA may discharge the recipient if the recipient's physician provides the CHHA with a written statement that the recipient may be discharged or if the physician directs the CHHA to immediately comply with his oral statement the recipient may be discharged, in which event a written statement form the physician authorizing discharge shall be provided within seven days. When the recipient's physician does not provide the CHHA with such a written or oral statemen agreeing to the discharge, the CHHA must:

A. refer the recipient's case to a CHHA that, after assessing the recipient, agrees to admit the recipient and provide home health services according to the physician's order and continue to provide home health services according to the physicians' order until the new CHHA has assessed and admitted the recipient; or
B. Refer the recipients case to the Social Service District and continue to provide home health services according to the physicians order until notified otherwise by the Social Services district." 18 NBYCRR 505.23.200.

Neither of the above occurred in this matter. Both Fidelis and URMHC, under the law of New York incorporated in the Catanzano Implementation Plan, had a duty to continue aid for Ms. Carroll, as she had been previously receiving unless and until another CHHHA agreed to pick up her case and offer the same services, or unless and until the matter was referred to the Social Services District so that the local professional medical director of the social Services district could weigh in on the matter, again as spelled out in the Catazano Implementation Plan. A copy of the Department regulations governing this matter are enclosed for your review.

Fair hearing decisions have repeatedly held that a lack of staffing does not relieve a managed care provider form their legal responsibility to provide authorized care services to a client. See FH # 7103015Y Rensselaer, Nov. 2015; FH # 7293959J Ulster, 2016; and FH # 7251087P, Monroe, June 2016 (involving this appellant!). Furthermore, the 2013 Model contract for Managed Long term Care provides as follows:

Article V Obligations of the contractor

A. Provision of Benefits

4. The Contractor shall maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through a network of contracted providers that meets the requirements in section D of Article VII of this contract. The contractor shall meet the standards required by 42 CFR 438.206 for availability of services: 42 CFR 438.207 for assurances of adequate capacity; and applicable sections of PHL and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the contractor agrees to adequately and timely furnish these services outside of the contractor's network for as long as the contractor is unable to provide them within the network.

Ms. Carroll was summarily dismissed by URMHC in violation of virtually all of her due process rights. Although we acknowledge that Fidelis has tried to provide adequate services to meet her needs, that is not what the law states. Fidelis, as the contractor managing her care, had an obligation to tell their contracted entity, URMCHA, to follow the law and continue aid for Ms. Caroll as they had been for over 30 years. Ms. Carroll was entitled to receive CHHA services an fidelis was required to use whatever means it deemed appropriate to ensure that she continued to receive those services until this matter was resolved fully in accordance with the Department regulations. If URMHC is having staffing issues, they should no longer operate as a Certified home Health Agency, and if they cannot fulfill their obligations to clients such as Ms. Carroll, frankly fidelis should no longer contract with them.

We are asking that Your Honor order Ms. Carrolls' services to be restored to the level she was receiving prior to the termination of services by URMHC/Fidelis and order that URMHCS through fidelis follow the law set forth in the Catanzano Implementation Plan. Thank you.

Very truly yours,
Woods Oviatt Gilman LLP
Richard A. Marchese, Jr.
RAM/asf
Enclosures
Cc: Ms. Teresa Carroll
Binny Seth, counsel for fidelis, by e-mail to: Binny.Seth@gtlaw.com"

At the fair hearing, the Appellant testified that the Notice dated Oct. 5, 2022 contained allegations that were incorrect and not true. The Appellant stated that contrary to the Notice dated Oct. 5, 2022, she did not request an increase in HHA hours; that she was not receiving 300 HHA hours; that she was always cooperative with her home health aides; that her medical conditions did not change; and that her levels of assistance in activities of daily living had not changed. Further the Appellant contended that she requested this fair hearing on October 19, 2022 because all of her Home Health Aide ("HHA") hours were discontinued. She further contended that replacing her HHA hours with PCS hours is a reduction of benefits because PCS workers cannot do what HHA workers are allowed and trained to do. Further the Appellant stated that the CHHA has the obligation to train workers; that on October 5, 2022 all of her HHA hours were discontinued and that URMHC had totally discontinued her HHA hours on October 5, 2022. The Appellant further testified that Fidelis had contracted with HRC Home Care ("HRC") to begin HHA services however, the CHHA, HRC, on the first day of service, on day one, stated they were not capable of providing services. The Appellant stated that Fidelis and URMCHA knew or should have known all of her HHA services were discontinued. The Appellant contended that Fidelis and UMHC had a duty to continue HHA services until a replacement was found. The Appellant stated that she made a formal complaint to DOH because prior to October 5, 2022 everything was fine with her Plan of Care and that her Home Health Aide services should not have been discontinued.

The evidence has been very carefully reviewed. It is found that the Agency's "Approval Notice" dated September 16, 2022 is a Reduction notice. The record established that the Appellant, was previously receiving, by "Approval Notice" dated August 31, 2022 had been authorized and was in receipt of Home Health Aid (S9122 x 473). By the Plan's "Approval Notice" dated Sept. 16, 2022, the Appellant was authorized to receive Personal Care Aid-Level 2 in the amount of 16 Hours/Week, 8 Hrs x 2 Days (T1019U1). The Plan's September 16, 2022 notice did not correctly identify the actions as a reduction from HHA (Home Health Aid) benefits to a reduction to PCA (Personal Care Services Aid) and in effect the Notice is a discontinuance of all of the Appellant's Home Health Aide ("HHA") services. These defects in the Plan's notice makes the notice void and therefore, the Plan's determination to discontinue the Appellant's HHA aide services cannot be sustained.

Moreover, the Plan's "Approval Notice" dated September 16, 2022, which was in effect a discontinuance notice, did not advise the Appellant of internal appeal rights. Furthermore, the Appellant did testify at the fair hearing, that she appealed to the Agency once her HHA services

were discontinued. Lastly, Courts have ruled that Medicaid recipients have the right to a State fair hearing to challenge certain proposed denials, reductions or discontinuances of home health services when those actions would be contrary to the recipients treating physician's orders. See Catanzaon v. Dowling 847 F. Supp. 1070 (W.D.N.Y. 1994) and that all Medicaid recipients have the right under state fair hearing regulations to request fair hearings and this right cannot be limited or interfered with in any way. See 18 NYCRR Section 358-3.1 Accordingly, the Appellant's request is not premature and the fair hearing will be held on the merits.

Even arguendo that the Agency's "Approval" Notice dated September 16, 2022, is not in effect a reduction nor in effect a discontinuance notice, the Appellant testified that indeed her HHA services were discontinued on October 5, 2022. Therefore, the Appellant's HHA services were discontinued without notice and the Agency's determination to discontinue the Appellant's HHA services without notice cannot be sustained.

The burden of proof shifts to the Agency when the Agency determines to reduce or discontinue benefits. The Fidelis Plan's own evidence, the Plan's September 1, 2022 UAS indicated that the Appellant had no change in medical condition and that the Appellant had no change in level of assistance in activities of daily living. The Appellant credibly testified that she did not request an increase of services; that she was cooperative with all Home Health Aides; that her medical conditions did not change; that she did not require higher level of assistance in any activities of daily living; that the level of care that she was receiving prior to mid September of 2022 was medically necessary and as per her physician's orders. The Appellant's testimony was found to be credible because she testified in a consistent, sincere and detailed manner.

The record further established that by letter dated October 5, 2022 from URMHC to the Appellant, URMHC informed the Appellant: "URMHC is no longer able to meet your personal care needs and must discharge you from our service." The letter does not state what medical condition, nor what social condition nor any condition changed necessitating "URMHC is no longer able to meet your personal care needs and must discharge you from our service." On this record, there was no evidence to support any change in the Appellant's condition warranting "URMHC is no longer able to meet your personal care needs and must discharge you form our service." Staffing problems is not a legal reason to discontinue Home Health Aide services.

The record further established that although URMHC as well as Fidelis attempted in good faith to secure other CHAA's (Certified Home Health Agency's) to provide other HHA (Home Health Aid) personnel to the Appellant; that URMHC as well as Fidelis knew or should have known that the Appellant was not in fact receiving HHA services at all (a discontinuance of Home Health Aid services contrary to her physicians orders and plan of care), these arguments and contentions are found unpersuasive because the law is clear, in that both Fidelis and URMHC, under the law of New York incorporated in the Catanzano Implementation Plan, had a duty, legal obligation to continue aid for the Appellant, as she had been previously receiving unless and until another CHHA agreed to pick up her case and offer the same services, or unless and until the matter was referred to the Social Services District so that the local professional medical director of the Social Services District could weigh in on this matter as spelled out in the Catazano Implementation Plan. The regulations require the Agency to provide the Appellant, as

a Medicaid recipient, the authorized Home Health Aid ("HHA") services. The Plan (Fidelis), and the CHHA (Certified Home Health Agency - University of Rochester Medical Health Center) is not excused from providing such services based upon an inability to find a provider. Moreover, the Agency must use whatever means it deems appropriate to ensure that the Appellant receives the services to which she is entitled. The Agency must consider whatever alternative means of providing the service. The Agency is directed to provide Home Skilled Nursing Services and Home Health Aide Services to the Appellant through whatever means available to ensure that the Appellant receives the care to which she is entitled.

DECISION AND ORDER

The CHHA's (University of Rochester Medical Health Center "URMHC") determination to discontinue Appellant's Home Health Aide Services was not correct and is reversed.

1. The CHHA (University of Rochester Medical Health Center "URMHC") is directed to restore Appellant's Home Health Aide Services to Home Health Aid (S9122 x 473 hours);

2. The CHHA (University of Rochester Medical Health Center "URMHC") is directed to restore Appellant's Home Skilled Nursing visits (T1030 x 14 visits);

3. The Agency is directed to provide immediate relief to the Appellant by providing all hours of service to the Appellant by whatever means the Agency deems available.

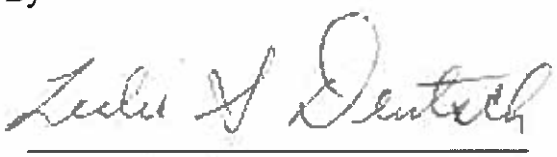
Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate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

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

FH# 8517276Q

DATED: Albany, New York
03/10/2023

NEW YORK STATE OFFICE OF
TEMPORARY AND DISABILITY ASSISTANCE
By



Leslie Deutsch

Commissioner's Designee