Medicaid Home Care: How to Navigate Medicaid Managed Care to Get the Services Your Client Needs

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Webinar Logistics

- Everyone is on mute.
- You can post questions in the **Q&A, not chat please**
- **We will send out a copy of the slides** and a recording of the presentation to everyone who registered.
- You are welcome to share these materials with others!

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ABOUT NYLAG

The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services, financial counseling, and engages in policy advocacy efforts to help people experiencing poverty.

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The Evelyn Frank Legal Resources Program

Focuses on fighting for older adults and people with disabilities, ensuring access to health care and home care services to age safely in the community. Services include:

- **Counseling** client on Medicaid, Medicare and home care eligibility and services.
- **Training** legal, social services and health care professionals about changes in health care programs and how to best serve the health and long-term care needs of older adults and people with disabilities.
- **Representing** clients in denials and reduction of Medicaid, Medicare Savings Program and Medicaid Home Care.
- **Assisting clients with accessing Medicaid home care** through Managed Long Term Care plans.

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EFLRP Services (continued)

- Educating the public through the website: www.nyhealthaccess.org/

- Policy Updates
- Consumer Materials
- Expansive resources on coverage criteria and eligibility

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Yellow Brick Roadmap

- Personal Care and Consumer Directed Personal Assistance Overview
- Request and Appeal Process Overview
- Homecare Authorization Standards
- How Are Hours Determined?
- Key Tools in Homecare Advocacy
- Initial Requests for More Hours
- Focus on Reductions

PERSONAL CARE AND CONSUMER DIRECTED PERSONAL ASSISTANCE

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Steps to Access Medicaid Home Care

Financial Eligibility for Medicaid

- Determined either by LDSS/HRA or NYSOH

Eligible for Medicaid Home Care Services

- Determined through NY Independent Assessor Program

Authorization of Home Care Services

- Authorized by either LDSS/HRA or Managed Care Plan

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Medicaid covered Community Based Long Term Care Services

- Adult day health care
- Limited licensed home care
- Private-duty nursing
- Hospice in the community
- Hospice residence program
- Assisted Living Program
- ***Consumer Directed Personal Assistance Program***
- Certified Home Health Agency services
- Residential Treatment facility care
- Personal emergency response system (PERS)
- ***Personal Care Services***
- Managed Long Term Care in the Community
- Waiver and other services provided through Home and Community Based Services waiver program (TBI, OPWDD)

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Medicaid Personal Care

- Medicaid personal care includes assistance with activities of daily living (ADLs); the ADLs are:
  - Bathing
  - Dressing
  - Grooming
  - Toileting
  - Transferring
  - Walking/ambulation
  - Meal preparation
  - Eating
  - Medication reminding and set up
  - Routine skin care
- Actual services given will depend on the patient's needs
- Traditionally, "supervision" is not enough; any supervision given must be tied to safe performance of ADLs. Assistance with safe performance of ADLs by verbal cueing or physical assistance is included – this is not "safety monitoring," which, if it is the only help needed, is not covered. NYS DOH GIS 03 MA/003 .

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Personal Care
18 NYCRR 505.14

A personal care aide, employed by a Licensed Home Care Services Agency (LHCSA), works in your home or community to provide assistance with Activities Daily Living (ADLs) such as bathing, grooming, walking, toileting, transferring, eating, and housekeeping.

Personal care is paid for by the LDSS/HRA or a Medicaid managed care plan.

Consumer Directed Personal Assistance Program (CDPAP)
18 NYCRR 505.28

A program to hire and train your own personal assistant, including a family member or friend, to provide assistance with Activities of Daily Living (ADLs) and skilled needs in your home or community.

CDPAP is paid for by the LDSS/HRA or a Medicaid managed care plan via PPL.

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Dorothy and Auntie Em

Dorothy is the worst! She constantly gets swept away by tornadoes. Before the next one hits and Dorothy gets lost in Oz yet again, Dorothy wants to make sure Auntie Em has more homecare in her absence. How do you advise Dorothy?

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PROCESS OVERVIEW

Denials vs. Reductions

Two basic adverse actions trigger **appealable notices:**

1. Denials: Plan refuses to provide something you or your provider asked for – usually an increase in hours, but not necessarily

2. Reductions: Plan takes away what you had

- **Fewer services**, e.g., personal care, day care, other services
- **Discontinuation of services** (this is distinct from a disenrollment)

Reductions are eligible for aid continuing (AC):

- Services will be reduced in < 2 weeks: SCARY!!!!
- Aid continuing prevents this if you appeal fast enough
- Have two chances to get AC—after Initial Adverse Determination (IAD) and after Final Adverse Determination (FAD)—file Plan Appeal after IAD and then Fair Hearing after FAD, ON TIME.

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Process of seeking new service, increase in service, or fending off a reduction in service

Denials

Request
- Plan has 14 calendar days/72 hours if fast tracked, to issue a decision.

Denial
- Initial Adverse Determination or Coverage **Decision Letter** (if MAP)

Internal Appeal
- Member requests internal appeal
- 60 days to appeal – Plan has 30 days to decide/72 hours if fast tracked

Second Denial
- Final Adverse Determination or Appeal **Decision Letter** (if MAP)

Second Level Appeal
- Fair hearing? (120-day deadline)
- External appeal? (4-month deadline)

Reductions

Reduction
- Initial Adverse Determination or Coverage **Decision Letter** (if MAP)

Internal Appeal
- Deadline to appeal is 10 days for aid continuing*

Second Denial
- Final Adverse Determination or Appeal **Decision Letter** (if MAP)

Second Level Appeal
- Fair hearing – should get aid continuing* if requested within 10 days of notice

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*Aid continuing: services stay as is until appeal is decided

Tip sheet for making requests: http://health.wnylc.com/health/afile/202/723/

Some issues are not appealable by the consumer

Contract limits or disputes	E.g., Homecare agency leaves network, or won't pay overtime
Quality of care (grievance)	E.g., Aide always late, discomfort with aide, problems with agency
Staffing problems	
Plan refusal to reassess in facility prior to discharge	

HOMECARE AUTHORIZATION STANDARDS

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24-hour care is defined in regulation

- 2 types of 24-hour personal care for those who, because of medical condition, need help daily with **toileting, walking, transferring, turning and positioning, or feeding overnight.**
  - For CDPAP add **skilled nursing** and **home health aide** tasks to this list

- **Split Shift** – "uninterrupted care, by **more than one personal care aide**, for more than 16 hours in a calendar day for a patient who …needs assistance with such frequency that a live-in 24-hour PCA would be unlikely to obtain, on a regular basis, **5 hours daily of uninterrupted sleep** during the aide's eight hour period of sleep."
- **Live-in** – "care by **one personal care aide** for a patient …whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, **five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.**"
  - Home must have adequate sleeping accommodations for aide. 18 NYCRR 505.14(b)(2)(iii)(c)

GIS 15 MA/024 (12/2015), 18 NYCRR 505.14(a), (b)(3)(ii)(b), 18 NYCRR 505.28(b) MLTC Policy 15.09

https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm

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Less Than 24 Hour Care

- Regulations are not as specific. Plans can use a “task-based assessment” with **certain important restrictions.**
- Plan will use an assessment tool, identify the ADLs a patient needs assistance with, estimate the duration and frequency of need.
- This formula will lead to an authorization of hours.

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Span of Time

Plan must cover SPAN OF TIME in which needs arise. NYS DOH GIS 03 MA/003 --"… a care plan must … [meet] the patient's scheduled and unscheduled day and nighttime personal care needs." FH 7297626N , 7311117H

MLTC Policy 16.07 "All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and **whether needed assistance can be scheduled or may occur at unpredictable times during the day or night.** All plans must assure that the plan of care that is developed can **meet any unscheduled or recurring daytime or nighttime needs** that the enrollee may have for assistance." (emphasis added)

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Span of Time Cont.

- ***Unscheduled needs***: walking, toileting, transferring
- ***Scheduled needs***: turning/positioning, medication reminders, meals, snacks, bathing, dressing, preparing for bed, getting up in the morning.
- Review patient's daily schedule to use in the MD letter.

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Safety Monitoring

- "**Safety monitoring**" is not a standalone personal care task that you can receive "credit" for, but time must be allotted for assistance that ensures safe performance of ADLs.
  - A patient will never get more hours authorized for "safety" – an aide to make sure patient doesn't wander away, forget to turn off the stove, etc.
  - Similarly, no hours will be authorized for companionship or to alleviate anxiety.
  - All hours authorized must be connected to an activity of daily living.
    - Assistance may be verbal cueing,

    not only hands-on,

Informal Help Must be Voluntary

- Plans MAY include the voluntary assistance of informal supports in authorizing services.
- 12 OHIP-ADM-01 -"…informal caregivers …support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.";
- GIS 97 MA/033 ("…contribution of family members or friends… cannot be coerced or required in any manner whatsoever." FH #: 7085459Y (9/16/2015); 7111878L (10/16/2015).
- Have family member state clearly in writing the times they are available and willing to provide care.

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Mayer-3

- **Mayer -3:** If client has 24-hour needs, even if family covers all nighttime shifts, the plan my NOT use “task-based assessment” to calculate the number of hours. They must cover the full span of time family is not available. 18 NYCRR 505.14(b)(2)(iii)(b); GIS 97 MA 033, FH 7145223P and 7254996Z. **See DOH MLTC Policy 16.07**

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HOW MUCH HOME CARE? HOW ARE HOURS DETERMINED?

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Uniform Assessment System (UAS)

- Conducted by RN in home or via telehealth (video conference). Assessment takes ~2 hours – review of social, emotional, and functional needs.
- Plan reviews the UAS and uses their proprietary tasking tool to make authorization of plan of care.

Bathing - How takes bath or shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR.	**Extensive assistance - Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks**
Personal hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS:	**Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight**
Dressing Upper Body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.	**Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight**
Dressing Lower Body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.	**Extensive assistance - Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks**
Walking - How walks between location on same floor indoors:	**Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight**
Locomotion - how moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair:	**Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight**
Transfer toilet - How moves on and off toilet or commode:	**Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight**
Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjust clothes EXCLUDE TRANSFER ON AND OFF TOILET:	**Extensive assistance - Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks**
Bed mobility - How moves to and from lying position, turns side to side, and positions body while in bed:	**Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight**
Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition):	**Supervision - Oversight/cueing**
rimary mode of locomotion indoors:	**Walking, uses assistive device, e.g., cane, crutch, pushing wheelchair**

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Example of Tasking Tool

Task		UAS Section (Code)	UAS Response	Min Per Task	Times / Day	Max Times / Week	Minutes / Week	Codes / Comments	
LEVEL 2								**Comments (for Level 3, 2, 1):**	Max# for Times / Day
Dressing - Lower Body	(Minimal Assist)	F (1 - 3)		5					1
	(Max Assist)	F (4 - 6)	5	7.5	2	14	105		2
Managing Medication		F (1 - 6)	4	10	1	7	70		1
Eating	(Minimal Assist)	F (1 - 3)		5					3
	(Max Assist)	F (4 - 6)	4	20	3	21	420		3
Toilet Use	(Setup help only)	F (1)		10					1
	(Minimal Assist)	F (2 - 3)		30					1
	(Moderate Assist)	F (4 - 5)	5	15	3	21	315		6

KEY TOOLS IN HOME CARE ADVOCACY

Key Tools: Forms and MD Letters

- Two forms to have on file for home care clients to make it easier for you to act on client's behalf
  - HIPAA Release – allows doctors and insurance companies to talk to you about patient
    - http://www.nycourts.gov/forms/Hipaa_fillable.pdf
  - Managed Care Authorization – tells managed care plan that client asked you to talk to the plan
    - http://www.wnylc.com/health/download/646/
    - Note: no specific form required though a plan may have its own prescribed form; NYLAG created this one for client convenience
- A good letter from a doctor or clear medical records are the cornerstone of most good home care cases.
- Letters from family/friends can also be helpful

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Key Tools: Create a Paper Trail!

Document every communication with the MLTC

1. When possible submit things in writing and keep proof of submission (i.e., certified tracking slip, fax confirmation), and keep copies of everything sent to client in writing including postmarked envelopes

2. Email is an option—recommended that you set delivery confirmations on your email program, if possible

3. If by phone, note name of person you spoke to, title, extension, date and time of call, have a witness if possible (call with client), and take notes of discussion. Follow up in writing!

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Key Tools: Why Paper Trail?

- All managed care plans must respond to requests for services and requests for plan appeals within set timeframes per federal regulation.

- Assume every request is a future fair hearing; build the record as much as you can before the Final Adverse Determination

- Documentation helps build a successful case for a hearing:
  - a paper trail helps avoid or resolve factual disputes (e.g., what information was provided to the plan leading up to the hearing, especially up to the plan appeal; that a plan appeal was requested and when; how many homecare hours were requested; that a client was beneficiary to a case involving shared hours aka “mutual”)

- Similarly, if you resolve a case informally before a hearing, you want to get the authorization from the plan in writing, review it for accuracy, and then send a copy to the hearing office with your hearing cancellation, in case the plan reneges on its promise and you need to ask for the hearing to be reopened

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How a provider can help with a request

- At the request stage, if you can include a letter from a doctor, do so!
- Should assume request will be denied and Plan Appeal will be needed.
  - Even perfect requests for services need to be appealed
  - The earlier you start building the record, the stronger your case will be
  - Good MD letter now helps case later

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Medical Letters - Elements

1. On letterhead
2. Signed and dated
3. Length of time patient has seen MD & date of last visit
4. Specify amount of hours needed
   - If 24, specify live in or split shift
   - If less than 24, consider asking for more than needed but explain why asking for those hours on daily basis
5. Discuss diagnoses (**DON'T STOP HERE**)
6. Explain how the diagnoses impair patient's performance of ADLs based on all information known to the provider
   - Focus on concrete, hands-on help that is needed
   - Concrete includes verbal cues and reminders, but lead with things that patient need hands-on help with
   - Avoid words like "supervision" or "safety monitoring"
7. Optional: delay in granting increase will result in harm
8. Optional: it is a hardship for the patient to travel due to their physical impairments listed above

Medical Letters - Elements

- Why aren't diagnoses enough? Must connect the effect of the diagnoses on the ADLs to connect to the medical necessity definition!
  - E.g., per the regulation, *Live-in 24-hour personal care services* means "the provision of care…for a patient who, **because of the patient's medical condition**, **needs assistance**…."
  - Which ADLs are the most important? The regulation tells us: "…during a calendar day with toileting, walking, transferring, turning and positioning, or feeding…"

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Diagnoses Are Not Enough! Link It Up!

- **Diagnosis** – What is the medical condition that leads to the functional impairment?
- **Impairment** – What is the ADL that the client cannot safely perform independently? What are the risks of attempting to perform the ADL without help?
- **Assistance** – What type of assistance would/does client need to safely perform the ADL (or have it performed for him/her)?

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[redacted] needs help with ADLs and household tasks due to functional limitations, gait instability, and weakness caused by gradual deconditioning.

- Mobility: Patient uses a rolling walker due to suffering from gait abnormality, which has unfortunately gotten worse. As a result, [redacted] is not walking much at all in his home, and spends much of his time sitting due to arthritis and lower back pain. His mobility is so impaired that sometimes he leaves the door unlocked for the home attendant because getting up to answer the door is so burdensome. This creates obvious safety concerns.

- Bathing / toileting: [redacted] is dependent on hands-on assistance for bathing. He needs help with maintaining his balance as he steps in and out of the bath. Due to history of prostate cancer, [redacted] often needs HHA assistance due to catheter bag leaks. The catheter bag needs to be changed on a regular basis to prevent UTIs; however, due to lack of mobility the bag often overflows and the bed needs to be cleaned the next morning.

- Dressing: [redacted] has difficulty buttoning shirts, putting on socks and shoes, and reaching into his closet. These tasks are further complicated by arthritis related pain.

- Meals [redacted] cannot prepare or reheat meals, as these tasks are too labor-intensive. As a result, he needs assistance with all 3 meals of the day. He finds that the home attendant does not have enough time to assist with this and other tasks during the time allotted each day.

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Ms. [redacted] is 86 years old and living with dementia, diabetes, diabetic neuropathy, hypertension and osteoarthritis. Her sole source of support is her daughter, who pre pours her medications, administers her insulin and directs her care. However, she also needs help all day and night with the following tasks due to her cognitive impairment caused by the dementia and functional limitations and chronic pain caused by her arthritic and diabetic neuropathy.

- Toileting: She is incontinent of bladder and bowel, unable to change her pullup which puts her at increased risk of UTIs.
- Transferring: She cannot transfer herself to different positions i.e. sitting up, standing up or even turning over in her sleep.
- Walking: She cannot walk on her own, she uses a walker indoors and a wheelchair outdoors, and requires assistance with both.
- Meals: She cannot prepare or reheat meals as these tasks are too complicated.
- Bathing: She is totally dependent on help for bathing.
- Turning and positioning: She cannot turn and position herself in bed when she has pain; she has had skin breakdown in recent weeks.

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Medical Documentation

- Goal is to be able to show client's needs—no rule that this must be done in a letter
- Can use medical home visit notes instead of a letter but those notes should:
  - Be original and not be retyped later by someone else
  - Be legible
  - Discuss as much of the above as possible but zero in on the diagnoses that cause functional limitations justifying the need for homecare
- Progress notes or hospital discharge paperwork
  - Discharge paperwork very often contains limited info; zero in on documents that justify increased hours

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Personal Statements of Support from Family/Friends

04/02/2025

My name is [redacted]. I am the wife of [redacted]. My husband suffered a stroke that has impacted all his left side of his body. He cannot help himself with anything. He cannot walk and he is bedbound 24/7. He cannot go to the bathroom on his own and he uses diapers all the time. He is unable to change his own diaper. He also cannot turn and reposition his own body. He needs to have his diaper changed at least 5-6 times per day. He can notify me when he must urinate, but he cannot notify me when he poops because he does not feel it. He receives his food in bed. He has Parkinsons on his right-side g it does not allow him to grab his plates or cups. He cannot get out of bed by himself, I help the home attendant use the Hoyer Lift. I also assist the home attendant when I can but not a lot. I have my own health problems that do not permit me to help my husband. I am 76 years old, and I am very weak. I have carpal tunnel and it causes me a lot of pain in my hands, arms, and shoulders. I have neglected my own care to care for my husband. I have missed doctor appointments because I could not leave my husband home alone. When the home attendant leaves I am home alone with my husband. The home attendant leaves him in his bed because I cannot move him by myself. I try to take care of my husband's skin when I cannot change his diaper, but it is very difficult for me. I ask this court to please understand that my husband has bodily needs that I cannot assist with and that they authorize the services he needs to live a life with dignity.

Sincerely,

[redacted]

- Letters from family should mention the member's diagnosis and the type of assistance the member needs
- Focus on concrete, hands-on help that is needed
- Avoid words like "supervision" or "safety monitoring"

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Sample Personal Statement by Appellant

05 13 2018

My name is [redacted]

I have been diagnosed w/ CKD, HFpEF (LOF 45-50%), non-obstructive CAD, atrial fibrillation (pace maker), severe mitral regurgitation post-MitraClip, pulmonary HTN, gastroparesis, GERD, colitis, Charcot arthropathy of the right foot with: total collapse of the longitudinal arch with prominent bony deformity on the plantar medial aspect of the mid-foot, complete urinary incontinence.

Due to the above-mentioned conditions, I require total assistance with the following activities of daily living:

Bathing. I need help transferring in and out of the tub/shower, washing up, drying my body, and reapplying bandages. Personal hygiene, hair brushing, brushing teeth, washing hands + face, nail care, skin-care, including applying lotion on back, legs, + feet. Dressing upper body: putting on bra, shirt, jacket, + sweaters. Dressing lower body: putting on undergarments/diapers, socks, support stockings, shoes, + pants. I cannot actually walk unassisted, I ambulate around my home w/ a rollator + the assistance of my aide. My rollator does not fit in the bathroom + my aide must help me navigate the bathroom by holding me. When I am home alone I must toilet in my diaper until the aide returns the next morning. When moving around my apartment w/ the rollator my aide must assist me by walking behind me or beside me. This is made more difficult by the fact that I have heart failure and I tire easily and have activity fatigue.

- This letter mentions all of the member's pertinent biographical data.
- Handwritten letters enhance credibility even if not the member's handwriting.
- Member lists the ADLs they need help with and further explains how the help with each ADL is needed.

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Sample Personal Statement by Appellant Cont.

Although I have stability bars in my bathroom, I am still insecure sitting + standing from the toilet because not only do I have balance issues but my hands have pseudo gout + they go numb + I just had carpel tunnel surgery + my right hand has a trick finger + my hands are weak.
When I need to toilet I go to the bathroom w/ the assistance of my aide. She helps me get into the bathroom, helps lower my undergarments/ diaper + pants + helps me sit on the toilet. After I toilet, she helps me stand up from the toilet + helps to clean me. She then pulls up my undergarments/diaper + pants + helps me wash my hands before helping me exit the bathroom. If I can't make it to the bathroom + I have an incontinence episode, my aide must help me change my diaper. She takes me to my bedroom + changes me. When the aide leaves I cannot toilet by myself without putting myself in danger. I cannot ambulate to the bathroom, nor change my own diaper due to the aforementioned issues of balance + hand weakness. Further, I have an electric bed but I cannot move myself on it w/o the assistance of my aide. I have spinal stenosis and I am in a lot of pain. My aide helps me get in and out of the bed, when I am home alone, I cannot get out of the bed. Although I can feed myself, I cannot participate in my food preparation. My aide prepares my meals + when she goes home for the night she must leave me food by my bed in case I need sustenance or water at night. I cannot go to the kitchen by myself to get these things because of my unsteadiness + weakness. I take medications in the daytime + evening. However, if I need to take a pain medication at night, I cannot open the bottle by myself. My aide must leave them on the table but I still struggle to grab them due to hand issues.

- The member explains how medical equipment/supplies does not meet their needs.

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Sample Personal Statement by Appellant Cont.

It is very frightening to be alone at night knowing I cannot complete any of my activities of daily living. Even managing the covers / blankets on my bed is very tiring. I often drop things & cannot pick them up. I can't see in the dark. It is undignified to be left in a wet diaper at night & dangerous due to the possibility of getting sores or even a UTI.

I ask that you please authorize the 24 hour split-shift case as I cannot at the age 90, complete my activities of daily living as I once did.

With thanks,

[redacted]

- The member includes a final plea and asks for hours they need

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Personal Statement from Aide

Home Attendant [redacted]
Code: [redacted]

Started my shift from Sept 7 – Sept 9, 2025
Shift: Sun 11AM thru Wed 11AM

Sent: Nov 9, 2025

I am the home care attendant of Ms. [redacted]. In the morning the lady starts her day with slight stiffness in her joints, as the lady always wakes up feeling sore and says she feels she cannot walk steadily. We then proceed to bathe her, which takes a long time because she is afraid of slipping. "For this reason," she doesn't always want to bathe because she is sleepy, and then I make her breakfast and must help her eat because she can't do it alone since she could choke. I help her little by little during the three days I spend with her. After her breakfast, I have to remind her to take her pills (medicine), which have already been crushed into powder, then take her to the bathroom (I have to lift her up, carry her, and clean her) since she cannot do it on her own.

Every 30-35 minutes she asks to go to the bathroom. I take her for a walk before lunch, and then after lunch I have to take her to the bathroom again.

Sometimes in her walker, sometimes in her wheelchair. She can't go every day because of her neurological condition and now her incontinence, so we can't go out into the hallway very often.

In the afternoons, I soak her feet and give her light massages because she complains a lot about pain in her feet, hands, and back. She falls asleep for a little while. She always asks for help because she always feels like she is going to fall, and sometimes she remains immobile for fear of falling.

Due to her condition (dementia/Alzheimer's), she sometimes forgets that she has urinated and asks to do so again. She also wets herself. After dinner at 7 p.m., I have to get her ready for bed, put her diapers on, and she feels uncomfortable because she has irritation between her legs.

Because of the diapers, at around 10-11 PM, I put her to bed, and then she calls me to ask for help going to the bathroom. Sometimes she wets herself, and I have to change her diapers, sheets, and clothes again. She asks for help at 2 AM, 3 AM, 4 AM, and sometimes at 6 AM. She asks me to make her something to eat because she can't sleep anymore. She requires a lot of assistance at night, which is difficult because I don't sleep due to her bladder incontinence and body pain. She doesn't sleep, and neither do I. I have to stay alert because she may try to get up.

My sleep is very interrupted, and it is very exhausting because the lady has many health problems.

- Mentions all the tasks the aide assists the member with
- Includes that the aide is not sleeping the required 5 hours of sleep.
- Includes logs of the number of times the aide must get up overnight to assist the member.

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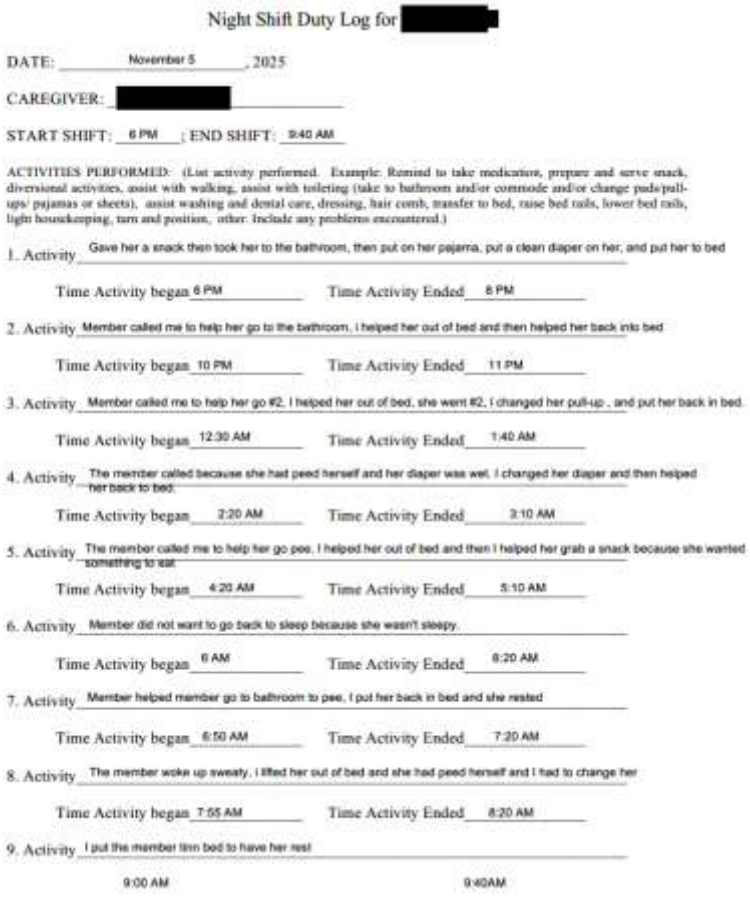
Night Logs



Night Shift Duty Log for [redacted]

DATE: November 5, 2025

CAREGIVER: [redacted]

START SHIFT: 6 PM ; END SHIFT: 9:40 AM

ACTIVITIES PERFORMED: (List activity performed. Example: Remind to take medication, prepare and serve snack, diversional activities, assist with walking, assist with toileting (take to bathroom and/or commode and/or change pads/pull-ups/ pajamas or sheets), assist washing and dental care, dressing, hair comb, transfer to bed, raise bed rails, lower bed rails, light housekeeping, turn and position, other. Include any problems encountered.)

1. Activity: Gave her a snack then took her to the bathroom, then put on her pajama, put a clean diaper on her, and put her to bed
   Time Activity began: 6 PM Time Activity Ended: 8 PM
2. Activity: Member called me to help her go to the bathroom, I helped her out of bed and then helped her back into bed
   Time Activity began: 10 PM Time Activity Ended: 11 PM
3. Activity: Member called me to help her go #2, I helped her out of bed, she went #2, I changed her pull-up , and put her back in bed.
   Time Activity began: 12:30 AM Time Activity Ended: 1:40 AM
4. Activity: The member called because she had peed herself and her diaper was wet, I changed her diaper and then helped her back to bed.
   Time Activity began: 2:20 AM Time Activity Ended: 3:10 AM
5. Activity: The member called me to help her go pee, I helped her out of bed and then I helped her grab a snack because she wanted something to eat
   Time Activity began: 4:20 AM Time Activity Ended: 5:10 AM
6. Activity: Member did not want to go back to sleep because she wasn't sleepy.
   Time Activity began: 6 AM Time Activity Ended: 6:20 AM
7. Activity: Member helped member go to bathroom to pee, I put her back in bed and she rested
   Time Activity began: 6:50 AM Time Activity Ended: 7:20 AM
8. Activity: The member woke up sweaty, I lifted her out of bed and she had peed herself and I had to change her
   Time Activity began: 7:55 AM Time Activity Ended: 8:20 AM
9. Activity: I put the member linn bed to have her rest
   9:00 AM 9:40AM

- Especially important if the member is trying to show a need for 24-hour split shift care
- 3+ night's worth of logs
- Do not mention safety and supervision
- Do not mention behavioral issues

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INITIAL REQUESTS FOR MORE HOURS

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Submitting the Request for More Hours

- Must request be in writing? NO – can be made orally too, to the assessor nurse, or by phone to the care manager.
- **However, submitting in writing is BETTER**. It allows you to avoid any disputes later about what was actually requested.
  - E.g., Plan may interpret a general request for 24-hour care as live-in even if split shift is what is needed
- If a request is made orally, resubmit in writing and send it in ASAP clarifying and confirming the request was made.
- Requests should be submitted to the plan via fax, or email, or certified – be able to prove date received by the plan
- **KEEP FAX CONFIRMATION!**

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When must Plan send "Initial Adverse Determination" notice denying request for service authorization?

Type of Request	Maximum time for Plan to Decide
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info*.
Expedited (see next slide for criteria)	**72 hours from receipt of request,** though plan may extend up to 14 calendar days if needs more info.*

- **14-day extension applies** if the plan can justify that it needs additional info and the extension is in enrollee's interest.
- When Plan decides to extend the deadline to review, it must send the member a letter indicating the same.

42 C.F.R. 438.210(d)
** posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_ext_notice.htm

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When must plan Expedite Request for Increase or a New Service?

- If the plan determines that delay would **seriously jeopardize** the enrollee's **life or health or ability to attain, maintain, or regain maximum function.**
- **Member or provider must specifically ASK that request be expedited** and explain why criteria apply in this case.
- Support by provider is important. If provider indicates delay meets criteria above, regulation says plan **must** expedite it. Regulation gives plan more flexibility when the member requests expedited review.

42 CFR 438.210(d)(2)

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Process of seeking new service, increase in service, or fending off a reduction in service

Request

- Plan has 14 calendar days/72 hours if fast tracked, to issue a decision **as of 4/1/2026** (currently anticipated to change in January 2027)

Denial

- Initial Adverse Determination or Coverage **Decision Letter** (if MAP)

Internal Appeal

- Member requests internal appeal
- 60 days to appeal – Plan has 30 days to decide/72 hours if fast tracked

Second Denial

- Final Adverse Determination or Appeal **Decision Letter** (if MAP)

Second Level Appeal

- Fair hearing? (Deadline is 120 days)
- External appeal? (Deadline is 4 months)

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Tip sheet for making requests: http://health.wnylc.com/health/afile/202/723/

What does an initial denial notice look like?

MLTC and Mainstream Managed Care

ElderServe Health™
AT HOME (MLTC)

INITIAL ADVERSE DETERMINATION
DENIAL NOTICE

05/22/2026

[redacted]

Enrollee Number: [redacted]
Coverage Type: MLTC: Partial Capitation
Service: Personal Care Aide
Provider: Harbor Care, Llc
Plan Reference Number: [redacted]

Dear [redacted]

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **07/21/2026**. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-370-3600.

Why am I getting this notice?

On 05/11/2026, you or your provider asked for Personal Care Aide provided by Harbor Care, Llc.

You are getting this notice because ElderServe at Home has denied your request for services.

Before this decision from 02/01/2026 to 01/31/2027 the plan approved:

Code	Mods	Description	Frequency	Units
T1019	U1	PCA, 15 mins	Per week	70 Hours

Service Description	MON	TUE	WED	THU	FRI	SAT	SUN
PCA, 15 mins	10	10	10	10	10	10	10

Medicaid Advantage Plus ("MAP")

wellcare by FIDELIS CARE

Return Mail Only:
Member Services
PO Box 19166
Long Island City, NY 11101

Wellcare By Fidelis Care
25-01 Jackson Avenue
Long Island City, NY 11101
1-888-FIDELIS (1-888-343-3547)

April 16, 2026

[redacted]

COVERAGE DECISION LETTER

IMPORTANT: For help with this notice, contact **Wellcare Fidelis Dual Align (HMO D-SNP)** at 1-800-247-1477 (TTY: 711) ***OR the Independent Consumer Advocacy Network (ICAN)*** at 1-844-614-8800 (TTY: 711).

Name: [redacted]

Member's Plan: Wellcare Fidelis Dual Align (HMO D-SNP)
Enrollee number: [redacted]
Medicaid ID:
Reference#:
Date of Service:
Provider Name: Public Partnerships LLC
Requested Service: 84 hours per week of Consumer Directed Personal Care Assistance services

Wellcare Fidelis Dual Align (HMO D-SNP) is called "our plan" or "we" in this letter. We are a health plan that contracts with Medicare and New York State Medicaid Program to provide coverage for both programs. Our plan coordinates your Medicare and New York State Medicaid Program services and your doctors, hospitals, pharmacies, and other health care providers.

Our plan partially approved the medical services/item listed below:

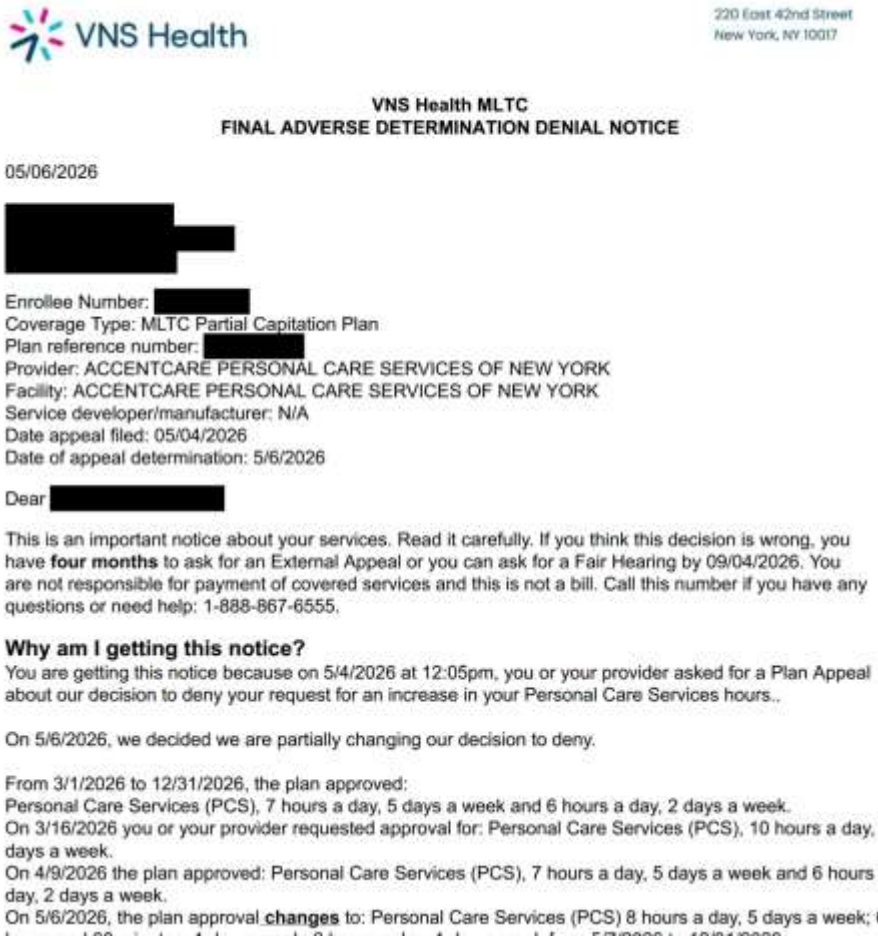
84 hours per week of Consumer Directed Personal Care Assistance services

Our plan made this decision because:

The request for 84 hours per week of Consumer Directed Personal Care Assistance services was partially approved. This decision was based on: You said you need escorts to medical appointments, help with transfers, and going to bathroom when personal assistant leaves, and more help bathing, dressing, grooming, meal

What does a final denial notice look like?

MLTC and Mainstream Managed Care



VNS Health

220 East 42nd Street
New York, NY 10017

VNS Health MLTC
FINAL ADVERSE DETERMINATION DENIAL NOTICE

05/06/2026

[redacted]

Enrollee Number: [redacted]
Coverage Type: MLTC Partial Capitation Plan
Plan reference number: [redacted]
Provider: ACCENTCARE PERSONAL CARE SERVICES OF NEW YORK
Facility: ACCENTCARE PERSONAL CARE SERVICES OF NEW YORK
Service developer/manufacturer: N/A
Date appeal filed: 05/04/2026
Date of appeal determination: 5/6/2026

Dear [redacted]

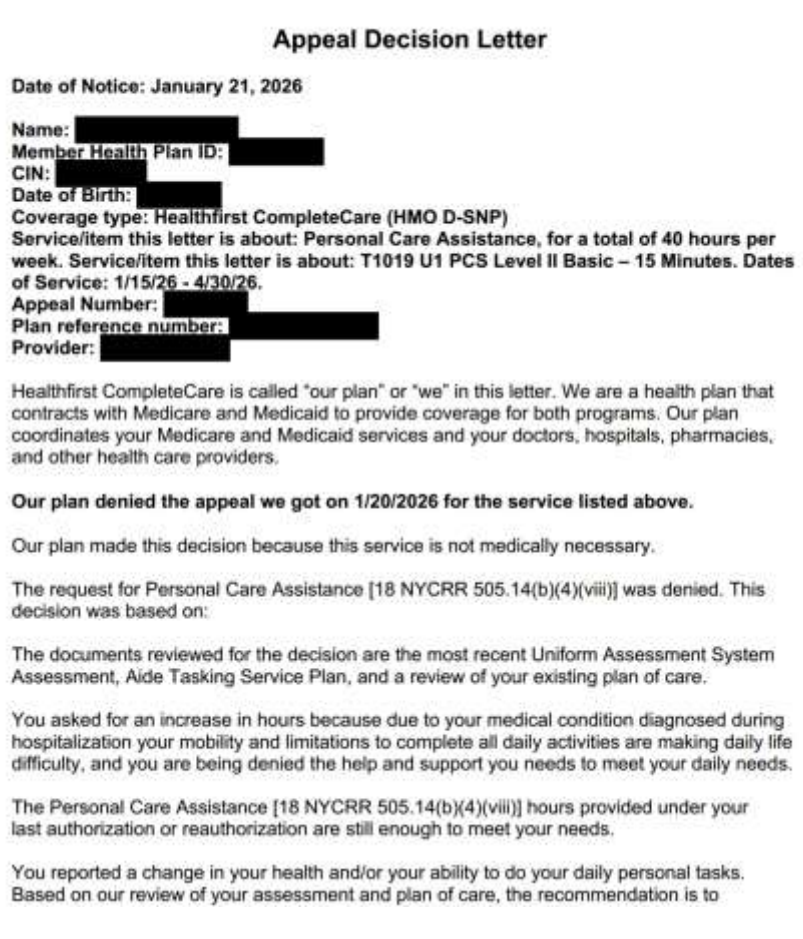
This is an important notice about your services. Read it carefully. If you think this decision is wrong, you have **four months** to ask for an External Appeal or you can ask for a Fair Hearing by 09/04/2026. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-888-867-6555.

Why am I getting this notice?
You are getting this notice because on 5/4/2026 at 12:05pm, you or your provider asked for a Plan Appeal about our decision to deny your request for an increase in your Personal Care Services hours..

On 5/6/2026, we decided we are partially changing our decision to deny.

From 3/1/2026 to 12/31/2026, the plan approved:
Personal Care Services (PCS), 7 hours a day, 5 days a week and 6 hours a day, 2 days a week.
On 3/16/2026 you or your provider requested approval for: Personal Care Services (PCS), 10 hours a day, 7 days a week.
On 4/9/2026 the plan approved: Personal Care Services (PCS), 7 hours a day, 5 days a week and 6 hours a day, 2 days a week.
On 5/6/2026, the plan approval **changes** to: Personal Care Services (PCS) 8 hours a day, 5 days a week; 6

Medicaid Advantage Plus ("MAP")



Appeal Decision Letter

Date of Notice: January 21, 2026

Name: [redacted]
Member Health Plan ID: [redacted]
CIN: [redacted]
Date of Birth: [redacted]
Coverage type: Healthfirst CompleteCare (HMO D-SNP)
Service/item this letter is about: Personal Care Assistance, for a total of 40 hours per week. Service/item this letter is about: T1019 U1 PCS Level II Basic – 15 Minutes. Dates of Service: 1/15/26 - 4/30/26.
Appeal Number: [redacted]
Plan reference number: [redacted]
Provider: [redacted]

Healthfirst CompleteCare is called "our plan" or "we" in this letter. We are a health plan that contracts with Medicare and Medicaid to provide coverage for both programs. Our plan coordinates your Medicare and Medicaid services and your doctors, hospitals, pharmacies, and other health care providers.

Our plan denied the appeal we got on 1/20/2026 for the service listed above.

Our plan made this decision because this service is not medically necessary.

The request for Personal Care Assistance [18 NYCRR 505.14(b)(4)(viii)] was denied. This decision was based on:

The documents reviewed for the decision are the most recent Uniform Assessment System Assessment, Aide Tasking Service Plan, and a review of your existing plan of care.

You asked for an increase in hours because due to your medical condition diagnosed during hospitalization your mobility and limitations to complete all daily activities are making daily life difficulty, and you are being denied the help and support you needs to meet your daily needs.

The Personal Care Assistance [18 NYCRR 505.14(b)(4)(viii)] hours provided under your last authorization or reauthorization are still enough to meet your needs.

You reported a change in your health and/or your ability to do your daily personal tasks. Based on our review of your assessment and plan of care, the recommendation is to

FOCUS ON REDUCTIONS

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Is it a reduction?

- When Dorothy returns to Kansas, **Scarecrow, Tin Man** and **Cowardly Lion** all receive calls from their homecare agency that their homecare services are being reduced or discontinued.
  - **Scarecrow** is in an MLTC plan, and his homecare hours will be reduced from 12 hours per day 7 days per week to 6 hours per day 7 days per week, starting Monday.
  - **Tin Man** is with the DSS while **Cowardly Lion** is in a Mainstream Managed Care plan, and their homecare hours are being discontinued altogether.
- Dorothy hitches a ride on another tornado to go back to Oz to help them all – but what should she do?

Reductions

- Reductions and discontinuances of Medicaid services require **timely** and **adequate** notice 18 NYCRR 358-3.3(a)(1)*
  - **Timely notice** is notice mailed (i.e., written!) to the consumer 10+ days prior to the effective date of the proposed reduction 18 NYCRR 358-2.23
  - **Adequate notice** has several requirements including naming the action, and identifying the specific reason for the reduction – see 18 NYCRR 358-2.2
    - 18 NYCRR 505.14(b)(4)(viii)(b) The social services district or MMCO must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services. The Department of Health may require the use of forms it develops or approves when providing such notice
    - 18 NYCRR 505.14(b)(4)(viii)(c) The social services district's or MMCO's reasons for its determination to deny, reduce or discontinue personal care services must be stated in the client notice.

18 NYCRR Part 358 is incorporated by reference into the Medicaid Managed Care fair hearing reg 18 NYCRR 360-10.8

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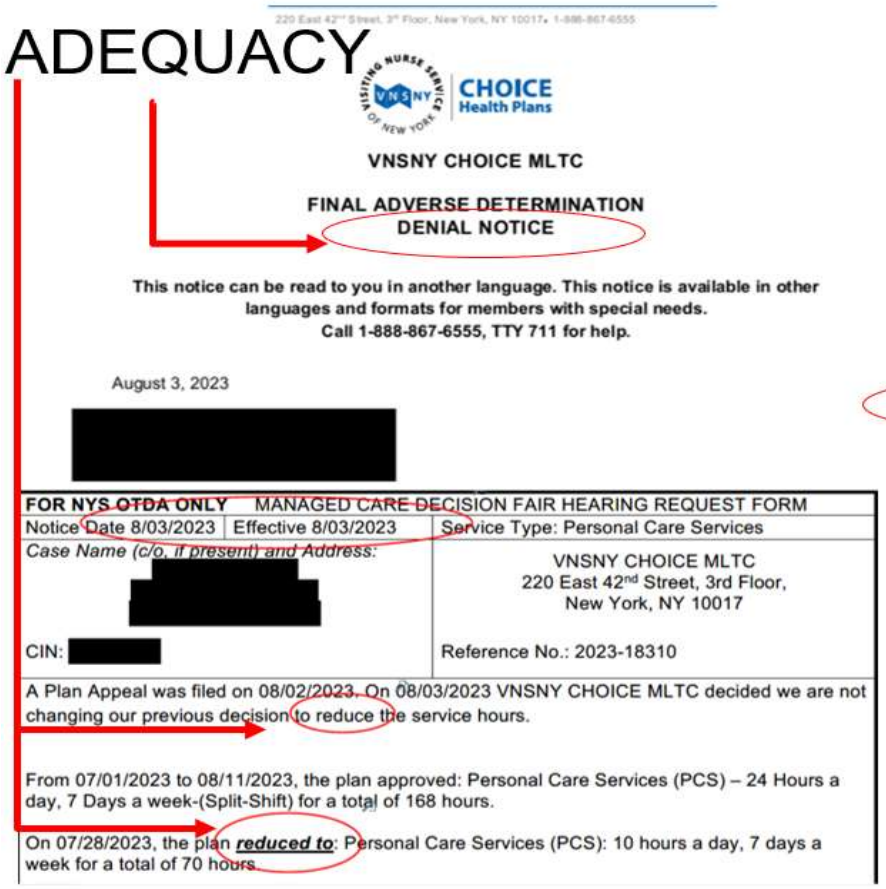
Reductions: Defective Notice



ADEQUACY

220 East 42nd Street, 3rd Floor, New York, NY 10017 • 1-888-867-6555

VISITING NURSE SERVICE OF NEW YORK | VNSNY CHOICE Health Plans

VNSNY CHOICE MLTC

FINAL ADVERSE DETERMINATION
DENIAL NOTICE

This notice can be read to you in another language. This notice is available in other languages and formats for members with special needs.
Call 1-888-867-6555, TTY 711 for help.

August 3, 2023

[redacted]

FOR NYS OTDA ONLY MANAGED CARE DECISION FAIR HEARING REQUEST FORM		
Notice Date 8/03/2023	Effective 8/03/2023	Service Type: Personal Care Services
Case Name (c/o, if present) and Address: [redacted]		VNSNY CHOICE MLTC 220 East 42nd Street, 3rd Floor, New York, NY 10017
CIN: [redacted]		Reference No.: 2023-18310

A Plan Appeal was filed on 08/02/2023. On 08/03/2023 VNSNY CHOICE MLTC decided we are not changing our previous decision to reduce the service hours.

From 07/01/2023 to 08/11/2023, the plan approved: Personal Care Services (PCS) – 24 Hours a day, 7 Days a week-(Split-Shift) for a total of 168 hours.

On 07/28/2023, the plan ***reduced to***: Personal Care Services (PCS): 10 hours a day, 7 days a week for a total of 70 hours.

TIMELINESS

FOR NYS OTDA ONLY MANAGED CARE DECISION FAIR HEARING REQUEST FORM

Notice Date: August 22, 2022	Effective July 26, 2022	Service Type: SDC
Case Name (c/o, if present) and Address: [redacted]		CENTERS PLAN FOR HEALTHY LIVING 75 VANDERBILT AVENUE STATEN ISLAND, NY 10304
CIN [redacted]		Reference No [redacted]

A Plan Appeal was filed on July 25, 2022. On August 22, 2022, the Grievance and Appeals Clinical Reviewer, on behalf of Centers Plan for Healthy Living, decided we are not changing our previous decision to stop your SDC services.

From June 1, 2022 to May 31, 2023, the plan approved:
SDC: Daily - 3 days a week - a total of 3 days per week.

On July 11, 2022, we decided to stop your SDC services on July 26, 2022.

On August 22, 2022, we have denied your Plan Appeal and:
On July 26, 2022, we will stop your SDC services.

Model notices
https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm

Specific reason for reduction must be given

- **MAYER v WING - Personal Care Services may not be reduced or terminated without a justification, which must be stated in the notice.** The agency reducing services (local district, MLTC or managed care plan) has the burden of proof to show a change in the individual's medical condition or circumstances justifies the reduction, or that a mistake was made in the original authorization, and certain other limited reasons

- **Big picture**: 18 NYCRR 505.14(b)(4)(viii)(a) The social services district or MMCO must deny or discontinue personal care services when such services are not medically necessary or are no longer medically necessary or when the social services district or MMCO reasonably expects that such services cannot maintain or continue to maintain the client's health and safety in his or her home

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Specific reason for reduction must be given

Mayer reasons (not exhaustive list)

- Medical, mental, economic, or social change rendering amount of services no longer appropriate (including services can no longer maintain consumer safely in their home)
- Mistake in the previous authorization
- Refusal to cooperate with assessment
- Needs can be met by new technology
- Consumer lives in a facility or gets services some other way
- Other services are more appropriate and cost effective

18 NYCRR 505.14 (b)(4)(viii)(c)(1)

- Social services districts and MMCOs that deny, reduce or discontinue services based on medical necessity in accordance with clause (*a*) of this subparagraph [cited on previous slide] must identify and document in the notice and in the client's plan of care the factors that demonstrate such services are not medically necessary or are no longer medically necessary. Any such denial or reduction in services must clearly indicate a clinical rationale that shows review of the client's specific clinical data and medical condition; the basis on which the client's needs do not meet specific benefit coverage criteria, if applicable; and be sufficient to enable judgment for possible appeal.

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-06.htm

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Some reductions may be less obvious

- **Mutual hours** – 2 or more people live together and have separate homecare authorizations but share either the larger authorization or a combo of the auths. 1 leaves the household and services are reduced immediately. Consumer requests increase, and the Plan denies it, ignoring that a reduction occurred.
- **Short term hospital or nursing home stay** – consumer has a right to reinstatement of hours from prior to inpatient stay. Reduction or discontinuance requires advance notice. GIS 96 MA-023
- **Transition from fee for service to managed care** – Consumer has continuity of care rights for 90 days following transition to managed care. At the end of 90 days the MCO can reduce services with advance written notice. **Mayer reason not required!**

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Some discontinuances may not be typical discontinuances

- Remember **Tin Man** is with the DSS while **Cowardly Lion** is in a Mainstream Managed Care Plan and their homecare hours are being discontinued altogether.
- This could be because Medicaid discontinued altogether.
- In these cases, when appealing, you must appeal the Medicaid discontinuance as well as the homecare discontinuance – 2 separate actions

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Some discontinuances may not be typical discontinuances, continued

- As mainstream members become eligible for Medicare due to age (65+) or disability they are required to disenroll from the mainstream plan to fee for service Medicaid, or switch to a new plan to continue their care
- Homecare recipients choose from one set of plans while non-homecare recipients choose from another
  - Mainstream managed care plans are required to report homecare recipients to the Department of Health
  - If the mainstream plan misreports **Cowardly Lion** as a non-homecare consumer, **Cowardly Lion** can potentially lose their services!

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Reinstatement of Services

Plans must **reinstate your services after a hospitalization** or rehab stay, at the same level you had previously

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Keep in Touch

Join our newsletter: https://go.nylag.org/Subscribe-to-EFLRP

EFLRP Intake

eflrp@nylag.org

Monday intake hotline from 10am-2pm—212-613-7310

Do not delay in requesting the fair hearing!

Other Legal Services

www.Lawhelpny.org

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THANK YOU

More information at nylag.org

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