STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 15, 2019
[redacted]
AGENCY: MAP
FH #: 7961821R

In the Matter of the Appeal of

[redacted]

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

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on July 17, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was the May 9, 2019 determination by the Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in the number of Personal Care Services from 31.5 hours weekly to 49 hours weekly, correct?

FINDINGS OF FACT

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

1. The Appellant, age 76, has been enrolled in and has received care and services, including Personal Care Services, through a Managed Long Term Care Plan operated by Centers Plan for Healthy Living (hereinafter referred to as "CPHL" or "the Plan").

2. The Appellant has been in receipt of Personal Care Services in the amount 4.5 hours per day, 7 days per week, totaling 31.5 hours weekly.

3. On September 25, 2018 and March 13, 2019, nursing assessors completed Uniform Assessment System New York (UAS-NY) Assessment (Comprehensive) Reports of the Appellant's personal care needs.

4. On April 9, 2019, a request was made on the Appellant's behalf to increase her Personal Care Services hours from 31.5 hours weekly to 7 hours per day, 7 days per week, or 49 hours weekly.

5. By Initial Adverse Determination dated April 18, 2019, CPHL advised the Appellant of its determination to deny the request made on the Appellant's behalf for an increase in Personal Care Services from 31.5 hours weekly to 49 hours weekly because the service is not medically necessary.

6. On May 8, 2019, an internal appeal to review CPHL's April 18, 2019 Initial Adverse Determination was requested.

7. By Final Adverse Determination dated May 9, 2019, CPHL advised the Appellant of its determination to uphold its initial determination to deny the request made on the Appellant's behalf for an increase in Personal Care Services from 31.5 hours weekly to 49 hours weekly because the service is not medically necessary. The notice stated:

> You requested an increase in hours to help you with daily activities.
>
> You recently underwent a follow-up face-to-face clinical assessment on March 13, 2019 utilizing the New York State Department of Health's Uniform Assessment System (UAS) Tool that showed may of your abilities to perform physical functioning (daily activities) stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on September 25, 2018.
>
> Your abilities to perform physical functioning (daily activities) stayed the same for dressing upper and lower body, personal hygiene (cleaning yourself), bathing, toilet use, meal preparation, medication management and ordinary housework.
>
> In summary, many of your abilities to perform physical functioning (daily activities) stayed the same; therefore, your hours stay the same at 4.5 hours per day, 7 days per week, for a total of 31.5 hours per week. Giving additional hours are not granted when tasks are not being provided, companionship, or for safety supervision.

8. On May 15, 2019, this fair hearing was requested.

APPLICABLE LAW

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides in part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their

purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides in part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of

health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

OFFICE OF HEALTH INSURANCE PROGRAMS

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

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I. Scope of the Personal Care Benefit

a. As required by federal regulations, the personal care services benefit afforded to MCO enrollees must be furnished in an amount, duration, and scope that is no less than the services furnished to Medicaid fee-for-service recipients.[42 CFR §438.210]…

i. The assessment process should evaluate and document when and to what degree the member requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the member's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

MLTC Policy memo 13.09(a): Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York, dated September 24, 2013 reminds Plans of MLTC Policy 13.09: Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York which in turn indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM). As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective October 1, 2013; the SAAM assessment must not be used for these new enrollees. Additionally, the UAS-NY must be used for all reassessments beginning October 1, 2013.

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

1. Terminations and Reductions…

iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

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

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

3. the member refused to cooperate with the required assessment of services;

4. a technological development renders certain services unnecessary or less time consuming;

5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;

6. the member's health and safety cannot be reasonably assured with the provision of personal care services;

7. the member's medical condition is not stable;

8. the member is not self-directing and has no one to assume those

responsibilities;

9. the services the member needs exceed the personal care aide's scope of practice.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services"' in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. **The notice must explain** the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) **The reasons for the action**...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

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

The GIS also provides "Districts are reminded that State policy, as reflected in the new regulations, requires that when districts determine to reduce, discontinue or deny personal care services, the client notice must identify the specific reason (whether a prior mistake in the authorization, the client's refusal to cooperate with the required assessment or other specific reason set forth in the regulations) that justifies the action. The client notice must also explain why the cited circumstance or event necessitates the reduction, discontinuance or denial of services."

GIS message GIS 96 MA/019 advises of a federal court decision that applies to social services districts' reductions or discontinuations of personal care services. [Mayer et al. v. Wing, (S.D.N.Y.)] In general, the Mayer decision holds that a social services district must have a legitimate reason to reduce or discontinue a recipient's personal care services. Before reducing or discontinuing personal care services, the district must individually assess the recipient to determine whether the reduction or discontinuance is justified by State law or Department regulation. A social services district cannot reduce or discontinue a recipient's personal care services arbitrarily, capriciously or as part of a blanket, across-the-board reduction or discontinuance of services that does not consider each individual recipient's particular circumstances. This general principle is entirely consistent with the Department's policy.

The social services district must notify the client in writing of its decision to authorize, reauthorize, increase, decrease, discontinue or deny personal care services on forms required by

the department. The client is entitled to a fair hearing and to have such services continued unchanged until the fair hearing decision is issued (aid-continuing) in accordance with the requirements outlined in Part 358 of this Title. 18 NYCRR 505.14(b)(5)(v)(b)

The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice.

The Department's Managed Care Personal Care Services Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;
ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
iii. that are authorized for the new authorization period; and
iv. the original authorization period and the new authorization period, as applicable.

All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice

Reasons to deny personal care services must be reflected in the notices and include but are not limited to: :

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;
(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
(iii) the client is not self-directing and has no one to assume those responsibilities;
(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;
(v) the client refused to cooperate in the required assessment;
(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming 18 NYCRR 505.14(b)(5)(v)(c)(1)

Reasons to reduce or discontinue personal care services must be reflected in the notices and include but are not limited to:

0i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

0ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

0iii) the client refused to cooperate in the required reassessment;

0iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

0v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

0vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify. 18 NYCRR 505.14(b)(5)(v)(c)(2)

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:

II. proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance Authorization or services.

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

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

Administrative Directive 92 ADM-49 clarifies State policy with regard to the requirement that an applicant for/ recipient of Personal Care Services have a stable health condition, and be able to self-direct, and be able to direct a Personal Care Services worker. The ADM reiterates that responsibility for making certain choices can be delegated to a self-directive individual, or to an organization.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. In relevant portion, this GIS Message states:

> Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed**.**

General Information Service message 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

Section 505.14(a)(1) of the regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home….".

(2) **Continuous personal care services** means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

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(4) **Live-in 24-hour personal care services** means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and 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.

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(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

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(b) The authorization for Level I services shall not exceed eight hours per week.

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(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning

(8) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

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

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

- a social assessment which must include a discussion with the patient to determine perception of his/her circumstances and preferences, an evaluation of the potential contribution of informal caregivers, such as family and friends, to the patient's care, and consideration of the number and kind of informal caregivers available to the patient, ability and motivation of informal caregivers to assist in care, extent of informal caregivers' potential involvement, availability of informal caregivers for future assistance, and acceptability to the patient of the informal caregivers' involvement in his/her care. The social assessment is completed by the Agency. When live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide.

- a nursing assessment. The nursing assessment is completed by a nurse from a certified home health agency or by a nurse employed by the local social services department or by a nurse employed by a voluntary or proprietary agency under contract with the local social services department. The nursing assessment must be completed within 5 working days of the request and must include the following:

  (1) a review and interpretation of the physician's order;

  (2) the primary diagnosis code;

  (3) an evaluation of the functions and tasks required by the patient;

  (4) the degree of assistance required for each function and task;

  (5) an evaluation whether adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, can meet the patient's need for assistance with personal care functions, and whether such equipment or supplies can be provided safely and cost-effectively.

  (6) the development of a plan of care in collaboration with the patient or his/her representative; and

  (7) recommendations for authorization of services.

- an assessment of the patient's appropriateness for hospice services and an assessment of the appropriateness and cost effectiveness of using adaptive or specialized medical equipment or supplies covered by the Medicaid Program including, but not limited to, bedside commodes, urinals, walkers, wheelchairs and insulin pens; and

Where there is a disagreement between the physician's order and the social, nursing and other required assessments, or there is a question about the level and amount of services to be provided, or if the case involves the provision of continuous Personal Care Services or live-in 24-hour personal care services as defined in paragraph (a)(2) and (a)(4), respectively, of this section, an independent medical review of the case must be completed by the local professional director, by a physician designated by the local professional director, or by a physician under contract with the Agency to review personal care services cases, who shall make the final determination about the level and amount of care to be provided.

Section 505.14(a)(3)(iii) of the regulations provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

Reauthorization for personal care services requires similar assessments as for the initial authorization; however a nursing assessment is not required for Level I services if the physician's order indicates that the patient's medical condition is unchanged. Reauthorization of Level II services must include an evaluation of the services provided during the previous authorization period and must include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

When there is a change in the patient's services needs which results solely from a change in his/her social circumstances, including, but not limited to, loss or withdrawal of support provided by informal caregivers, the social services department must review the social assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new physician's order and nursing assessment is not required.

When there is a change in the patient's services needs which results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the social services department must review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated.

When there is a change in the patient's services needs which results from a change in his/her medical condition, the social services department must obtain a new physician's order and a new nursing assessment and shall complete a new social assessment. If the patient's medical condition continues to require the provision of personal care services, and the nursing assessment cannot be obtained within five working days of the request from the local social services department, the local department may make changes in the authorization in accordance with the procedures specified in 18 NYCRR 505.14(b)(5)(iv).

DISCUSSION

The record establishes that the Appellant has been enrolled in, and has received care and services, including Personal Care Services, through a Managed Long Term Care health plan operated by Centers Plan for Healthy Living (hereinafter "CPHL" or "the Plan"). The record further establishes that the Appellant had been in receipt of a Personal Care Services authorization in the amount of 4.5 hours per day, 7 days per week, totaling 31.5 hours weekly.

On April 9, 2019, a request was made to increase the Appellant's personal care hours from 31.5 hours weekly to 7 hours per day, 7 days per week, totaling 49 hours weekly. Thereafter, on April 18, 2019, the Plan issued an Initial Adverse Determination advising the Appellant that the request for an increase in personal care hours to 49 hours weekly was denied on the grounds that the service was not medically necessary. Following an internal appeal, the Plan issued a Final Adverse Determination on May 9, 2019, advising the Appellant that it was upholding its Initial Adverse determination to deny the Appellant's request for an increase in personal care hours to 49 hours weekly.

It is uncontroverted that the Appellant suffers from a number of physical and mental impairments including, but not limited to, osteoarthritis, COPD, anxiety, pain and weakness. The Appellant also presents with diagnoses of heart disease, abnormalities of gait, tremors and urinary incontinence.

Pursuant to the May 9, 2019 Final Adverse Determination, it is the Plan's position that many of the Appellant's abilities to perform her activities of daily living remained the same, therefore her personal care needs can be met within the 31.5 Personal Care Services hours authorized per week. However, in support of its position, the Plan's representative also submitted a Medical Review Request Form completed on April 10, 2019 in which the Plan acknowledges the following:

> Section 3: Care Management Report
> 1. Care Manager Notes – Include brief description/summary of the Member (based on the last UAS-NY assessments).
>
> The member is a [redacted]. Member has COPD, anxiety, OA and weakness. Due to the OA the member has pain in her joints, shoulders, arms, hands and neck. She has a very difficult time performing any of her ADL's. The member has difficulty walking and therefore rarely leaves her home. The member is also always very anxious and is always very nervous that something will happen to her.
>
> 1a. Has there been an objective change in the Member's condition that is affecting his or her functional/cognitive needs? (Refer to Section F and include a comparison of the last two UAS-NY assessments if applicable.)

> The member's FLOC decreased from 13 to 18. The member also decreased from maximal assistance to total dependence in meal preparation, and house work. With shopping the member decrease [sic] from limited to total dependence. Member has had a decline in her ADL's.

The Plan's representative conceded that there were discrepancies between the Plan's determination to deny the Appellant's request for an increase in personal care services and the findings made in the April 10, 2019 Medical Review Request Form. Upon further questioning, the Plan's representative was unable to explain the substantial inconsistencies in the Plan's findings or provide any further evidence to support the validity of such discrepancies.

In response, the Appellant, and her representative, argued that the Appellant's personal care needs cannot be adequately met within the 4.5 hours authorized per day. It was discussed that the Appellant suffers from a herniated disk in her neck that severely impacts her mobility, and has difficulty using any assistive devices due to developing pain in her wrists. The Appellant's representative further contended that, because of the Appellant's physical limitations, she is unable to prepare any meals independently and, as her aide work from 1:00 p.m. to 5:30 p.m., she goes without breakfast, among other things.

In support of her claims, the Appellant submitted, via fax, a May 15, 2019 letter from her treating medical provider, [redacted], NP, in which she explains that the Appellant has chronic pain, herniated discs and repeated falls. The letter further states, in relevant part, "Failure to provide [the Appellant] with the requested Home Health Aid services may place her health at significant risk because she cannot ambulate without assistance… It will assist [the Appellant] to achieve or maintain maximum functional capacity in performing daily activities…" A similar letter from [redacted], NP, dated December 10, 2018, was also provided.

The Appellant's claims were considered and found credible in that they were consistent, forthright, and supported by corroborating documentation from her medical providers. Furthermore, review of the Plan's own evidence confirms that the Appellant requires total dependence in meal preparation, has difficulty walking or completing any ALD's, and has had an overall decline in her ADL's, all of which contradict the Plan's basis for denying the Appellant's request for additional personal care services hours. Based on a careful review of the totality of the record, the Plan's determination to deny the request to increase the Appellant's personal care services was improper. Accordingly, the Appellant's authorization should be increased 7 hours per day, 7 days per week, totaling 49 hours weekly.

DECISION AND ORDER

The May 9, 2019 determination by the Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the request for an increase in the Appellant's personal care hours to 49 hours weekly is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to immediately provide the Appellant with an authorization of Personal Care Services in the amount of 7 hours per day, 7 days per week.

2. Centers Plan for Healthy Living is directed to notify the Appellant in writing of the Plan's authorization increasing Personal Care Services to7 hours per day, 7 days per week.

Should the Plan 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 Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
07/25/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee