STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 10, 2019
[redacted]
AGENCY: MAP
FH #: 7894010K

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 February 4, 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

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan to not authorize Personal Care Services for twenty-four hour continuous care by more than one personal care aide for Appellant 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 88, is currently enrolled in a Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living. Appellant resides with her husband, age 90.

2. The Appellant had been in receipt of a mutual Personal Care Services Authorization, along with her husband, with Appellant receiving 9 hours a day, 7 days a week, totaling 63 hours a week, and with Appellant's husband receiving 5 hours a day, 7 days a week, 35 hours a week.

3. Appellant's daughter has requested 24 hour continuous care by more than one aide Personal Care Services from the MLTCP on Appellant's behalf.

4. On May 17, 2018 and on September 27, 2018, the MLTCP prepared Uniform Assessment System-NY evaluations, using the standard forms, regarding the Appellant's personal care needs.

5. By initial adverse determination notice, dated October 8, 2018, the Appellant's request for an increase was partially denied, with Appellant's Personal Care Services Authorization only raised to 19 hours a day, 7 days a week, 133 hours a week. The MLTCP noted that Appellant's husband meanwhile received 5 hours a day, 7 days a week, 35 hours weekly.

6. By final adverse determination notice dated October 15, 2018, the MLTCP informed Appellant "we are not changing our decision to deny your request for an increase in home care services…*As a result of this appeal, you are approved for 24 hours a day 7 days a week in a skilled nursing facility*.[italics added]" It was also noted that Appellant is bedbound and suffers from dementia.

7. On January 10, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

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

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

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

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

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

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

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

(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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department’s satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor’s network for as long as the Contractor is unable to provide them within the network.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding; and nutritional and

environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home.

Section 505.14(a) of the Regulations provides in part that:

(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.

(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.

(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.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

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

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph 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 of 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.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

arranging for the delivery of personal care services according to subdivision (c) of this section.

monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

The Model Contract for Partial Capitation Managed Long-Term Care Plans in New York State, Section D, states, in part, at page 35:

> The Contractor's care management system shall ensure that care provided is adequate to meet the needs of individual Enrollees and is appropriately coordinated, and shall consist of both automated information systems and operational policies and procedures.

Appendix K of the above-mentioned Contract provides, in part:

> Grievance – An expression of dissatisfaction by the member or provider on member's behalf about care and treatment that does not amount to a change in scope, amount or duration of service. A grievance can be verbal or in writing. Plans cannot require that members put grievances in writing. Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the grievance, and if the grievance pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

By contrast, an Appeal is a request for a review of an action taken by a plan.

Appendix J of the above-mentioned Contract provides, in part:

> Action is a denial or a limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-

service outside the plan); or failure to make a grievance or grievance appeal determination within required timeframes.

18 NYCRR 358-3.1 explains the Right to a fair hearing.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

Administrative Directive 92 ADM-49 provides in pertinent part:

B. Health and Safety of Recipient

Personal care services may only be authorized when the district reasonably expects that the recipient's health and safety can be maintained in the home. This determination must consider the following:

1. Stability of the Recipient's Medical Condition

The assessing nurse has primary responsibility for determining stability of the recipient's medical condition. The recipient and/or any informal caregiver should be given the opportunity to be involved in this determination. The determination should be based on information included in the nursing assessment and a review of the physician's order. In situations where there is a question about this determination, the assessing nurse may wish to involve the case manager or obtain consultation from the

> local professional director or his/her designee….
> If the recipient's medical condition is not stable, the provision of personal care services is inappropriate unless a determination is made that the provision of personal care services in combination with the intervention of appropriate skilled nursing services, home health aide and/or therapy can adequately meet the recipient's needs.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides that the Department has been directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicted and for Medicaid recipients whose only nighttime need is turning and positioning.

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

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

. 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 358-5.9 of the Regulations provide in part:

(a) 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.

DISCUSSION

The Appellant, age 88, is currently enrolled in a Medicaid Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living. The Appellant had been in receipt of a mutual Personal Care Services Authorization, along with her husband, with Appellant receiving 9 hours a day, 7 days a week, totaling 63 hours a week, and with Appellant's husband receiving 5 hours a day, 7 days a week, 35 hours a week. By initial adverse determination notice, dated October 8, 2018, the Appellant's request for an increase was partially denied, with Appellant's Personal Care Services Authorization only raised to 19 hours a day, 7 days a week, 133 hours a week. The MLTCP noted that Appellant's husband meanwhile received 5 hours a day, 7 days a week, 35 hours weekly. By final adverse determination notice dated October 15, 2018, the MLTCP informed Appellant "we are not changing our decision to deny your request for an increase in home care services….As a result of this appeal, you are approved for 24 hours a day 7 days a week in a skilled nursing facility." This hearing was requested on behalf of Appellant for review.

Appellant's daughter stated she ordinarily has been satisfied with the care currently given to her mother. The 19 hours a day authorized for Appellant, combined with the 5 hours a day provided to Appellant's husband, have been sufficient, according to the daughter. The problem for the daughter has been on a few days when Appellant's husband has been hospitalized and 5 hours a day of Personal Care Services is cut temporarily.

The record does reflect Appellant is in quite bad shape. It is uncontested that Appellant is bedbound and suffers from dementia, leaving her only alert and oriented x 2. The UAS reports state that Appellant's "Decisions consistently poor or unsafe; cues/supervision required at all times." Appellant further had a fall only months before, leading to a hip fracture and greater impairment. The September, 2018 nurse evaluation noted that Appellant's ADL (activities of daily living) status has declined and her self-sufficiency has deteriorated.

Appellant has been diagnosed with dementia, coronary heart disease, depression, osteoporosis, both constipation and diarrhea alternatively, dizziness and giddiness, hypertension, GERD, history of falling, insomnia, overactive bladder, unspecified pain, history of malignant

neoplasm, polyneuropathy, presence of dentures, pressure ulcer, osteoarthritis, hypercholesterolemia, shortness of breath, fractured femur, xerosis cutis, Vitamin D deficiency, and weakness.

Appellant has total dependence for meal preparation, housework, finances, stairs, shopping, transportation, bathing, hygiene, dressing upper body, dressing lower body, walking, locomotion, transfer toilet, toilet use, and bed mobility and needs maximal assistance for eating, phone use, and medications. Appellant also needs a Hoyer lift to be moved. Moreover, for a number of tasks, Appellant was found to need "Weight-bearing support by 2 [plus] helpers." To assure her safety, Appellant needs a higher level of care than a single home attendant can provide.

Additionally, Appellant's daughter provided documentation to show Appellant's husband's condition has been deteriorating. This means that any shared home attendant would need to spend more time with the husband, neglecting Appellant's substantial needs.

The record reflects that Appellant needs a higher level of care than a home attendant can provide. The MLTCP's final adverse determination to deny an increase to 24 hour Personal Care Services, must be upheld.

It is noted that while a homebound Appellant could have the right to a home hearing, the record establishes that Appellant's mental condition from dementia is such that a home hearing would not be useful to her.

DECISION

The Appellant's Managed Long Term Care Plan's final adverse determination to deny Appellant's request for a further increase in the hours of Personal Care Services received is correct.

DATED: Albany, New York
03/12/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee