STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 6, 2019
[redacted]
AGENCY: MAP
FH #: 8023649Y

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 October 7, 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)

Debra Fergerson, Fair Hearing Representative

ISSUE

Was the August 8, 2019 Final Adverse Determination of the Managed Long-Term Care Plan, Centers Plan for Healthy Living denying the Appellant's request for an increase in the Appellant's Consumer Directed Personal Care Program (CDPAP) hours from 38.5 hours per week (5.5 Hours/Day x 7 days per week) to 84 hours per week (12 hours per day x 7 days per week), and to partially approve the request by authorizing 45.5 hours per week (6.5 hours per day x 7 days per week) of personal care services, correct?

FINDINGS OF FACT

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

1. The appellant, [redacted], disabled, residing with her husband age 80, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Care Plan with Centers Plan for Healthy Living.

2. The Appellant is currently authorized to receive 45.5 hours per week (6.5 hours per day x 7 days per week) of Consumer Directed Personal Care Services (CDPAP).

3. The Appellant receives personal care services through Centers Plan for Healthy Living in the Consumer Directed Personal Assistance Services Program (CDPAP).

4. The Appellant has a diagnosis of: [redacted].

5. The Appellant requested an increase in the personal care hours, claiming a need for 84 hours per week (12 hours per day x 7 days per week) of personal care assistance. At the time of the Appellant's request the Appellant had been receiving 38.5 hours per week (5.5 hours per day x 7 days per week) of personal care services.

6. On July 2, 2019, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview the Appellant by a registered Nurse Assessor on July 2, 2019.

7. By Final Adverse Determination Denial, dated August 8, 2019 the plan advised the appellant that the request for an increase in personal care hours to 84 hours per week (12 hours per day x 7 days per week) was denied and the plan partially approved an increase in the amount of 45.5 hours per week (6.5 hours per day x 7 days per week).

8. On September 6, 2019, the Appellant Representative requested this fair hearing.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance 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.

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 438.404(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 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean 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:

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

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

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours weekly for individuals whose needs are limited to nutritional and environmental support functions.

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

(a) Personal care functions shall include some or total assistance with the following:

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

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

(8) feeding;

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

(10) providing routine skin care;

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

(12) changing of simple dressings.

Pursuant to the New York State Department of Health Guidelines for Consumer Directed Personal Assistance Services, published June 30, 2013, the scope of services regarding Consumer Directed Personal Assistance Services includes the following:

a. Purpose: Consumer Directed Personal Assistance Services is intended to permit chronically ill or physically disabled individuals receiving home care services greater flexibility and freedom of choice in obtaining such services.

b. An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative. Personal care services, home health aide services, and skilled nursing tasks shall have the same meaning as 18 NYCRR § 505.28 (b)(9), (7), & (11) respectively.

c. The terms consumer directed personal assistant and designated representative shall have the same meaning as 18 NYCRR § 505.28(b)(3) & (5).

e. Level of Service:

i. The assessment for home-based services identifies the tasks necessary to keep the enrollee safely in the home. The plan of care is developed by the enrollee with the assistance of the MCO, provider and any individuals the enrollee chooses to include.
ii. The plan of care is developed in conjunction with the enrollee based on the assessment and considers the number of hours authorized to accomplish the tasks. These tasks may include level 1 and level 2 PCS, home health aide services and/or skilled nursing tasks.
iii. The MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e).
iv. CDPAS services are managed by the enrollee in accordance with the enrollee's plan of care. The authorization should provide the number of hours authorized however, it is the enrollee who decides how those hours are arranged over the week. The MCO does maintain the right to determine whether the number of hours is appropriate to the plan of care. The FI is not responsible for assuring that the member is managing the plan of care.

18 NYCRR 505.28(b)(3) provides that "a consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer". However, a consumer directed personal assistant may include "any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary."

When the change in service needs results from a change in the consumer's medical condition, "including the consumer's loss of the ability to instruct, supervise or direct the consumer directed personal assistant", the district must obtain a new physician's order and nursing assessment. 18 NYCRR 505.28(f)(2)(ii).

Pursuant to GIS 03 MA/003, task based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated 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. The assessment process should evaluate and document when and to what degree the patient 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.

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.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The record in this matter establishes that the Appellant's Managed Care Consumer Directed Personal Assistance Services (CDPAS) Plan, Centers Plan for Healthy Living, had authorized Personal Care Services in the amount of 38.5 hours weekly (5.5 hours per day x 7 days per week). The record also establishes that the Appellant requested an increase of Personal Care Service hours from 38.5 hours weekly (5.5 hours per day x 7 days per week) to 84 hours per week (12 hours per day x 7 days per week) of CDPAS Personal Care Service hours. By final adverse determination dated August 6, 2019, the Managed Long Term Care Plan determined to deny the Appellant's request for an increase from 38.5 hours per week (5.5 hours per day x 7 days per week) to 84 hours per week (12 hours per day x 7 days per week) of personal care services and to partially approve the Appellant's request for an increase by authorizing personal care services in the amount of 45.5 hours per week (6.5 hours per day x 7 days per week). The Appellant Representatives requested this fair hearing.

At the hearing the Managed Care Consumer Directed Personal Assistance Services (CDPAP) Plan, Centers Plan for Healthy Living submitted the initial adverse determination dated August 6, 2019, marked as *MLTC Plan Exhibit 1*; Final Adverse Determination dated August 8, 2019 marked as *MLTC Plan Exhibit 2,* medical request marked as *MLTC Plan Exhibit* 3, Uniform Assessment System New York Assessment Comprehensive Report dated February 4, 2019 marked as *MLTC Plan Exhibit 4;* Tasking dated February 4, 2019 marked as *MLTC Exhibit 5;* Uniform Assessment System New York Assessment Comprehensive Report dated July 2, 2019 marked as *MLTC Plan Exhibit 6;* Tasking dated July 2, 2019 marked as *MLTC Plan Exhibit 7* and Service Plan dated July 2, 2019 marked as *MLTC Plan Exhibit 8.*.

The Managed Long-Term Care Plan Centers Plan for Healthy Living, Final Adverse Determination dated August 8, 2019 states in pertinent part:

"On 08/05/2019, Centers Plan for Healthy Living decided to partially approve this service because the health care service is not medically necessary.

The request for Consumer Directed Personal Assistance Services was partially approved. This decision was based on:

Your daughter requested an increase in your Consumer Directed Personal Assistance Service (CDPAS) because she feels that your cognitive and functional status has declined significantly and you need much more assistance than you did before.

A Registered Nurse from Centers Plan for Healthy Living (CPHL) visited your I your home on 7/2/2019 and completed a face-to-face assessment using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs.

Based on this assessment, it was identified that:
You are able to dress your upper and lower body with assistance
You are able to bathe with assistance
You are able to take care of your toileting needs with assistance
You are able to transfer on and off the toilet with assistant
You are able to walk with assistance
You have had no recent falls.
You are able to feed yourself once your meals are prepared by your Personal Assistant
You have grab bars and a shower chair in your home

To best meet your needs, your Care Management Team has

1.Contact your primary care physician, Dr. [redacted], to request clinical documentation and collaborate to meet your care needs.

2. Contacted your neurologist, Dr. [redacted] to request clinical documentation and collaborate to meet your care needs.

3. Made a recommendation for referral for Physical Therapy and Your Care Manager will continue to follow with your doctor, Dr. [redacted].

4. Made a referral for Home Delivered Meals and you have been approved to receive seven (7) dinners a week.

5. Made a recommendation for Social Day Care or Adult Day Health Care services, but your daughter declined.

6. Made a recommendation for you to receive incontinence supplies such as liners and/or protective underwear to manage your bladder incontinence, however your daughter declined.

Your daughter's requested increase in Consumer Directed Personal Assistance Services, along with your recent UAS-NY assessment, was thoroughly reviewed by Centers Plan for Healthy Living (CPHL). Based on clinical documentation presented, CPHL will increase your Consumer Directed Personal Assistance Services to six and a half (6.5) hours per day, seven (7) days per week (totaling forty-five and a half (45.5) hours per week). This increase will ensure that your personal care needs will continue to be met appropriately."

See MLTC Plan Exhibit 1, Centers Plan for Healthy Living Final Adverse Determination dated August 6, 2019.

A review of MLTP UAS dated February 4, 2019, marked as *MLTC Plan Exhibit 4,* indicates that the Appellant requires:

Total Dependence:
Meal preparation
Ordinary housework
Managing finances
Shopping

Maximal Assistance:
Managing medications
Phone use
transportation

Extensive Assistance:
Stairs
Bathing
Dressing Lower Body
Walking
Locomotion
Transfer toilet

Limited Assistance:
Personal hygiene
Dressing upper body
Toilet use
Bed mobility

Bladder continence:
Occasionally incontinent – occasionally incontinent

Bowel continence:
Continent- Complete control; does not use any type of ostomy device

See MLTC Plan UAS dated February 4, 2019, marked as *MLTC Plan Exhibit 4.*

A review of MLTP UAS dated July 2, 2019, marked as *MLTC Plan Exhibit 6,* indicates that the Appellant requires:

Total Dependence:
Managing medications

Maximal Assistance:
Phone use

Extensive Assistance:
Personal hygiene
Dressing upper body
Toilet use

Limited assistance:
Bed mobility

See MLTC Plan UAS dated July 2, 2019, marked as *MLTC Plan Exhibit 6.*

The Appellant Representatives contended that the Appellant requires an increase in Personal Care Services on the grounds that the Appellant's medical conditions have not improved but rather have deteriorated and accordingly, the Appellant needs additional personal care service hours to assist her in activities of daily living. She stated that the Appellant requires additional hours of personal care services to assist in personal hygiene, bathing, dressing upper and lower body, and toilet use.

In support of the Appellant's claim, the Appellant Representatives submitted into evidence medical evidence from Appellant's doctor dated July 1, 2019 from Dr. [redacted], which states in pertinent part:

"I am writing to you with regard to my patient, [redacted]. Mrs. [redacted] is an 84 year old woman with cognitive impairment. Due to her medical condition she is no longer able to attend to her daily activities and requires assistance with her basic needs and daily medication monitoring. A home health aide is needed for 12 hours a day, 7 days a week to assist Mrs. [redacted] with her daily activities. If you have any questions or need more information about Hedva Shagabaev, please feel free to call me at [redacted].

Sincerely,

[redacted], MD."

See *Appellant Exhibit A,* dated July 1, 2019 from Dr. [redacted].

The Appellant Representative also submitted into evidence a letter dated July 26, 2019, from the Appellant's Dr. [redacted], which stated in pertinent part:

"This is to certify that [redacted], has been under my care. The patient was seen on 3/26/219 for the neurological visit due to consultation.

Diagnosis:
[redacted]

Recommendations:
1. Due to patient condition she requires home health care
2. 12 hours a day 7 days a week for activities of daily living.
3. Next neurological follow up visit is scheduled on 4-6 weeks.

[redacted], M.D."

See *Appellant Exhibit B* dated July 26, 2019 from Dr. [redacted].

The Appellant Representatives argued that the Appellant is not requesting an increase in personal care services for safety monitoring as a stand-alone task, but rather are requesting an increase in personal care services for safety monitoring while assisting the Appellant in all activities of daily living, in particular, in personal hygiene, bathing, dressing, and toileting.

The evidence from both sides has been carefully reviewed (documents as well as the credible testimony]. The evidence establishes that the Appellant requires personal care services in the amount of 9 hours per day x 7 days per week (63) sixty-three hours per week. Therefore, the evidence establishes that the Managed Long Term Care Plan Centers Plan for Healthy Living Final Adverse Determination dated August 8, 2019 to deny the Appellant's request for an increase of personal care services (CDPAS) from 38.5 hours per week (5.5 hours per day x 7 days per week) to 84 hours per week (12 hours per day x 7 days per week) of personal care services and to partially approve the Appellant's request by approving personal care services in the amount of 45.5 hours per week (6.5 hours per day x 7 days) was correct when made, however, in light of the new evidence presented by the Appellant Representatives at the fair hearing, the MLTC Plan Centers Plan for Healthy Living's Final Adverse Determination dated August 8, 2019 cannot be sustained.

DECISION AND ORDER

The August 8, 2019 Final Adverse Determination of the Managed Care Consumer Directed Personal Assistance Services (CDPAS) Centers Plan for Healthy Living, to deny appellant's request for an increase in personal care hours from 38.5 hours per week (5.5 hours per day x 7 days per week) to (12 hours per day x 7 days per week) and to partially approve an increase in the amount of 45.5 hours per week (6.5 x 7 days per week) was correct when made, however, The Managed Care Plan Centers Plan for Healthy Living, Consumer Directed Personal Services (CDPAS), is directed to:

1. immediately provide the appellant with an authorization of CDPAS Personal Care Services in the amount of sixty-three (63) hours weekly (9 hours per day x 7 days per week).

2. notify the Appellant in writing of the plan's authorization increasing CDPAS Personal Care Services to (63) sixty hours per week (9 hours per day x 7 days per week) in compliance with this decision.

Should the Managed Care Plan Consumer Directed Personal Assistance Services (CDPAS) Centers Plan for Healthy Living, 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 Managed Care Plan promptly to facilitate such compliance.

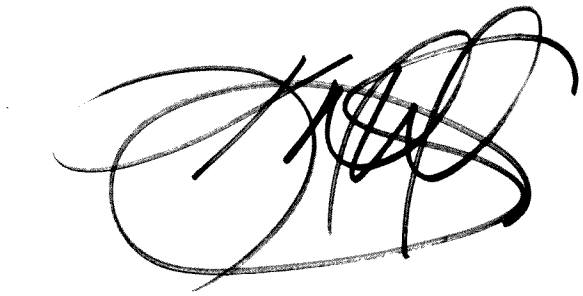
As required by 18 NYCRR 358-6.4, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

FH# 8023649Y

DATED: Albany, New York
10/18/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee