

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 19, 2019

AGENCY: MAP
FH #: 8065501L

In the Matter of the Appeal of	:
	: DECISION
	AFTER
	: FAIR
	HEARING
from a determination by the New York City	:
Department of Social Services	:

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 3, 2020, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



For the Managed Long Term Care Plan

B. Ferguson, Fair Hearing Representative

ISSUE

Was the determination by the Managed Long-Term Care plan, Center's Plan for Healthy Living to deny the Appellant's request for an authorization to increase the Appellant's Personal Care Services from 24.5 hours a week (3.5 hours per day x 7 days) to 45.5 hours a week (6.5 hours per day x 7 days) 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 seventy-six (76), resides her spouse (67), and has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living.

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2. The Appellant has been in receipt of an authorization of Personal Care Services in the amount of 24.5 hours per week (3.5 hours per day x 7days).

3. The Appellant requested that the Plan authorize an increase in Personal Care Services to 45.5 per week a (6.5 hours per day x 7 days).

4. On September 26, 2019, a registered nurse assessor completed a Uniform Assessment System-NY, Community Level of Care Report.

5. On October 12, 2019, a registered nurse assessor completed a Uniform Assessment System-NY, Community Level of Care Report.

6. The Appellant has a Medical diagnosis which includes the following: Alzheimer's disease and Asthma.

7. By written notice of Initial Adverse Determination which is dated October 17, 2019, stated that on or about October 14, 2019 there was a request for an increase in hours from 24.5 hours a week to 45.5 hours per week. That the request was denied because the Appellant was able to bathe with guidance; the Appellant had a cane and a shower grab bar to assist her with her needs; the Appellant requires safety minoring and supervision as a standalone takes and time has been allotted for light housekeeping.

8. The Appellant's Representative/Spouse requested an internal appeal.

9. By written notice of Final Adverse Determination, which is dated November 12, 2019, the Plan upheld its determination to deny the Appellant's request for an authorization increasing her Personal Care Services.

10. On November 19, 2019, the Appellant requested a fair hearing in this matter.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b).

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to

prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

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

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

42 CFR 438.402 provides, in part, that:

(a)The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F.

(b)Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c)Filing requirements -

(1) Authority to file.

(i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

(A)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

42 CFR 438.408 provides, in part, that:

(f) Requirements for State fair hearings -

(1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

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.

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, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides:

(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.

(3) 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 this section.

(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;

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- (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.

General Information Service message GIS 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.

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.

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits

DISCUSSION

At the hearing, it was established that the Appellant, age seventy-six (76), resides her spouse (67), and has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living. The Appellant has been in receipt of an authorization of Personal Care Services in the amount of 24.5 hours per week (3.5 hours per day x 7 days). The Appellant requested that the Plan authorize an increase in Personal Care Services to 45.5 per week a (6.5 hours per day x 7 days).

On September 26, 2019, a registered nurse assessor completed a Uniform Assessment System-NY, Community Level of Care Report. On October 12, 2019, a registered nurse assessor completed a Uniform Assessment System-NY, Community Level of Care Report. The Appellant has a Medical diagnosis which includes the following: Alzheimer's disease and Asthma. By written notice of Initial Adverse Determination which is dated October 17, 2019, stated that on or about October 14, 2019, there was a request for an increase in hours from 24.5 hours a week to 45.5 hours per week. That the request was denied because the Appellant was able to bathe with guidance; the Appellant had a cane and a shower grab bar to assist her with her needs; the Appellant requires safety minoring and supervision as a standalone takes and time has been allotted for light housekeeping. The Appellant's Representative/Spouse requested an internal

appeal. By written notice of Final Adverse Determination, which is dated November 12, 2019, the Plan upheld its determination to deny the Appellant's request for an authorization increasing her Personal Care Services.

As this hearing is concerning the denial or the adequacy of Medical Assistance benefits or services, the Appellant must establish that the determination at issue was made in error or otherwise not supported by the record. While the Appellant's Representative's testimony was slightly convoluted, that may have been attributed to the

In this case, the Appellant has done so. In that the Appellant was hospitalized in September 2019 and October 2019. The Appellant is in need of cuing for walking and eating. At the hearing the Appellant's spouse stated that in fact his wife/Appellant wears adult diapers, because of incontinence. The Appellant is in need of more assistance even when the Agency's own records state that the Appellant needs assistance with dressing because the Appellant at times dresses inappropriately for the weather such as wearing three layers of clothing. The Appellant is dependent on others for assisting her get dressed, grocery shopping, housekeeping, as well as dressing and bathing. Therefore, based upon the Appellant's credible testimony it would appear that the need for a Personal Care Aide for more hours is not for "security" reasons but rather a myriad of reasons, one of which is to ensure that the Appellant's needs are being met. There is also the Appellant's need for extensive ambulating and toileting assistance is reflected in the UAS.

DECISION AND ORDER

The determination by the Managed Long-Term Care plan, deny the Appellant's request for an authorization to increase the Appellant's Personal Care Services from 24.5 hours a week (3.5 hours per day x 7 days) to 45.5 hours a week (6.5 hours per day x 7 days):

1. Authorize personal care services to the Appellant in the amount of 45.5 hours a week (6.5 hours per day x 7 days)
2. Notify Appellant's representative, in writing, upon compliance with this fair hearing Decision.

As required by Section 358-6.4 of the Regulations, Center's Plan for Healthy Living must comply immediately with the directives set forth above.

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DATED: Albany, New York
01/16/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "Alvin Chorney". The signature is fluid and cursive, with a large loop at the end of the last name.

Commissioner's Designee