STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 9, 2016
[redacted]
AGENCY: MAP
FH #: 7236751M

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 May 4, 2016, 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 Provider ("the MLTCP"),

Jillian Hinkson, Grievances & Appeals Manager

ISSUE

Was the determination of Appellant's Managed Long Term Care Plan not to provide increased hours 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, age 76, receives Medicare Parts A, B, and D, as well as Medicaid.

2. Appellant is enrolled in a partially capitated Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living. Appellant resides with her son, age 42.

3. The MLTCP had authorized Appellant to receive Personal Care Services Authorization in the amount of 25 hours per week; 5 hours a day, 5 days weekly, under a task-based plan of care.

4. Appellant had requested an increase in Personal Care Services to 50 hours a week, 10 hours a day, 5 days a week.

5. On September 17, 2015 and on December 5, 2015, the MLTCP prepared Uniform Assessment System-NY evaluations, using the standard forms, regarding the Appellant's personal care needs.

6. By notice dated January 12, 2016, the Appellant's request for increased hours was denied as " not medically necessary." The plan is "recommending you to adhere to your…vertigo treatment plan and also to accept …benefit available to you such as Adult Day Health Care service…."

7. On February 9, 2016, 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 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...".

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...

On October 6, 1999 the 2nd Circuit Court of Appeals held that the Agency is not required to authorize task-based Personal Care Services time for safety monitoring. Rodriguez v. DeBuono, 197 F. 3rd 611 (2nd Cir. 1999); cert. denied 531 U.S. 864.

GIS 03/MA/03, states as follows:

…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.

NYS DEPARTMENT OF HEALTH

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

I. Scope of the Personal Care Benefit

(a) vii. Personal care services includes some or total assistance with:

1. Level I functions as follows:
    a. Making and changing beds ;
    b. Dusting and vacuuming the rooms which the member uses;
    c. Light cleaning of the kitchen, bedroom and bathroom;
    d. Dishwashing;
    e. Listing needed supplies;
    f. Shopping for the member if no other arrangements are possible;
    g. Member's laundering, including necessary ironing and mending;
    h. Payment of bills and other essential errands; and
    i. Preparing meals, including simple modified diets.
2. Level II personal care services include Level I functions listed above and the following personal care functions:
    a. Bathing of the member in the bed, the tub or the shower;
    b. Dressing;
    c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
    d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
    e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
    f. Transferring from bed to chair or wheelchair;
    g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
    h. Feeding

i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
j. Providing routine skin care;
k. Using medical supplies and equipment such as walkers and wheelchairs; and
l. Changing of simple dressings….

III. Authorization and Notice Requirements for Personal Care Services

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

ii. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).
iii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.
iv. 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.

In Mayer v. Wing, 922 F. Supp 902 (S.D.N.Y. 1996), Plaintiffs challenged New York City's efforts to reduce their personal care services. The Court found that prior to issuing any reduction notice, the Agency must first identify some development that justifies altering a recipient's level of services. Specifically, the Agency was enjoined from reducing recipient's home care services unless the Agency's notice states that a reduction is justified because of a series of reasons as listed immediately above.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

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 record discloses that the Appellant, age 76, is currently receiving Medicaid and is enrolled in a partially capitated Managed Long Term Care Plan ("MLTCP") operated by Centers

Plan for Healthy Living. By notice dated January 12, 2016, the Appellant's request for increased hours to 50 hours a week, 10 hours a day, 5 days a week, was denied as " not medically necessary." The plan is "recommending you to adhere to your…vertigo treatment plan and also to accept …benefit available to you such as Adult Day Health Care service…."This hearing was requested to review the Plan's refusal to provide increased hours for Appellant.

According to the Plan's December evaluation, Appellant has been diagnosed with depression, anxiety, dizziness/vertigo, osteoarthritis, hypertension, insomnia, fatigue, and allergies. Appellant also produced medical documentation noting that Appellant suffers from obesity, diverticulosis, gastro-esophogeal reflux disease ("GERD"), hearing loss, and internal hemorrhoids. The Plan's December, 2015 evaluation noted that Appellant's ADL (activities of daily living) status had improved in the preceding 90 days and that her self-sufficiency have remained the same as before. Appellant's Nursing Facility Level of Care Score had actually dropped slightly from 18 in September, 2015, to 17 in December, 2015.

Appellant was found to have total dependence for meal preparation, housework, and shopping, need maximal assistance with bathing, and need extensive assistance with dressing upper and lower body, walking, locomotion, toilet use, stairs, and transferring to and from the toilet, and need limited assistance with medications and bed mobility.

Appellant's vertigo is listed as the main issue of concern. Appellant has suffered from recent falls. Unfortunately, regulations do not permit the use of Personal Care Services time for safety monitoring. The Plan did note that there are adult day care programs Appellant qualifies for—to provide a safe environment for additional hours. The home attendant's hours could then be set in coordination with the adult day care.

The Plan failed to provide its sheet showing how hours were to be allocated for specific tasks. Appellant's son meanwhile testified without controversion that Appellant would often have three doctor's appointments a week, for which she needed escort. Additionally, Appellant and her son were able to successfully establish that Appellant has unscheduled needs which should be factored into the time allotment. Regulations allow for unscheduled needs to be provided for, as opposed to safety monitoring. (See, e.g., GIS 03 MA/003.) For the Appellant, 120 minutes a week for unscheduled needs has been found to be reasonable here. Otherwise, Appellant should be allocated the same amount of time fee-for-service care provides for various services.

Based upon the record at this hearing and fee-for-service guidelines for home care, the following allotment of time has been found to be appropriate here:

Task		**minutes per week**
bathing	daily	140.00
dressing	daily	70.00
grooming	daily	90.00
shampooing	one day per week	30.00
routine skin care	seven days weekly	70.00

toileting	seven days weekly	210.00
transferring		70.00
unscheduled needs	seven days weekly	120.00
indoor mobility	seven days weekly	140.00
outdoor mobility	seven days weekly	120.00
escort to appointments	3x weekly	360.00
meal preparation	seven days weekly	420.00
assist w medications	3 x daily	105.00
chore services (housekeeping)		420.00
Total		2375.00

Divided by 60 minutes equals 40 hours weekly (rounded up).

As Appellant has established a need, for increased hours as set forth above, the determination of the MLTCP not to increase hours can not be upheld

DECISION AND ORDER

The Appellant's Managed Long Term Care Provider's determination to deny Appellant's request for an increase in the hours of Personal Care Services received was not correct and is reversed.

1. Centers Plan for Healthy Living is directed to authorize Personal Care Services to the Appellant in the amount of 40 hours weekly.

2. Centers Plan for Healthy Living is directed to notify Appellant, upon compliance with this fair hearing decision.

Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's representative must provide it promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
05/20/2016

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee