STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 8, 2018
[redacted]
AGENCY: MAP
FH #: 7858226J

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 December 4, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan for Healthy Living

Debra Ferguson, Representative

ISSUE

Was the determination of Centers Plan for Healthy Living to deny the Appellant's application for an increase in the number of hours of the Appellant's Personal Care Services to 84 hours per week correct?

FACT FINDINGS

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, who is 83 years old, is in receipt of Medical Assistance from Centers Plan for Healthy Living, a Managed Long Term Care Plan.

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

3. On August 1, 2018, Centers Plan for Healthy Living completed a Uniform Assessment System - UASNY Assessment Report as part of a routine reassessment for the Appellant.

4. On August 2, 2018, the Appellant made an application to Centers Plan for Healthy Living to increase the Appellant's authorization for Personal Care Services to 84 hours weekly, at a rate of 12 hours per day, seven days per week.

5. On August 14, 2018, by Notice of Initial Adverse Determination, Centers Plan for Healthy Living determined that the Appellant's request for Personal Care Services of 12 hours per day, 7 days a week, was not approved because the requested services were not medically necessary.

6. On August 28, 2018, the Appellant requested an internal appeal.

7. On August 30, 2018, Centers Plan for Healthy Living upheld the August 14, 2018, initial adverse determination.

8. On November 8, 2018, this hearing was requested.

APPLICABLE LAW

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

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

Section 438.210 of 42 CFR Subpart D provides, in 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...

18 NYCRR 505.14(a)(5) provides that:

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.

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

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

(9) feeding;

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

(11) providing routine skin care;

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

(13) changing of simple dressings.

18 NYCRR 505.14(a)(4) provides a new definition of "Live-in 24-Hour Personal Care Services" as follows: 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.

18 NYCRR 505.14(a)(2) provides a new definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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.

In Rodriguez v. City of New York, 197 F.3d 611 (2nd Cir. 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.

Section 505.14(c)(9) of the Regulations provides that each local social services department shall have a plan to monitor and audit the delivery of personal care services provided by arrangements or contracts.

New York City has received approval to deliver Personal Care Services through a Task Based Assessment methodology. Service delivery is task oriented, not time oriented, and the client continues to receive service in accordance with assessed needs.

DISCUSSION

The Appellant has been in receipt of a Personal Care Services Authorization in the amount of 49 hours per week, at the rate of seven hours a day, seven days a week. The Appellant applied for an increase in her Personal Care Services to 84 hours per week, at the rate of twelve hours a day, seven days a week.

On August 14, 2018, Centers Plan for Healthy Living determined that the Appellant's request for a Personal Care Services of 12 hours a day, 7 days a week, was not approved because the requested services were not medically necessary. On August 28, 2018, the Appellant requested an internal appeal. On August 30, 2018, Centers Plan for Healthy Living upheld the August 14,

2018 initial adverse determination, on the grounds that the requested services were not medically necessary.

At the hearing, the Appellant's Representative, who is also her daughter, stated that the Appellant is currently living with her because the Appellant's husband died on June 22, 2018. The Appellant's Representative claimed that since the death of the Appellant's husband, the Appellant's medical condition has worsened, to the extent that the Appellant needs more assistance to go to the bathroom, and is unable to prepare any meals. The Appellant's Representative claimed that the Appellant needs five additional hours daily because sometimes she has to stay by herself until someone comes home.

The Appellant testified that she goes to bed after the aide leaves at 4:00 p.m., that she needs additional assistance because she is unable to go to the bathroom, and she is unable to take her medications without meals. She claimed that she needs to take her medication between 5:30 and 6:00 p.m., and she is unable to take her medication because she is unable to eat without assistance. The Appellant did not present any evidence that she is required to take medication between the hours of 5:30 and 6:00 p.m., only, and that she may not take such medication at any other time, either when an aide is with her, or a family member. However, even if the Appellant's claims are accurate, the Appellant's daughter testified that someone comes home by 6:00 p.m. or 7:00 p.m, which, according to the Appellant, is close to the time that the Appellant is required to take her medication.

Centers Plan for Healthy Living evaluated the Appellant's application for increased additional hours, and determined that the increase was not medically necessary.

With regard to the Appellant's Representative's contention that the Appellant needs additional hours and assistance, the Appellant's Representative's contention was considered but found not persuasive. Requiring an aide for companionship is outside the scope of Personal Care Services which can be provided under the regulations. Centers Plan for Healthy Living is not required to provide companionship as an independent Personal Care Services task.

In weighing the evidence, the Appellant did not establish that Centers Plan for Healthy Living had erred in its findings. The Appellant did not meet her burden of proof, and failed to establish that the determination of Centers Plan for Healthy Living was not correct.

DECISION

The determination of Centers Plan for Healthy Living to deny the Appellant's application for an increase in the number of hours for the Appellant's Personal Care Services to 24 hours, 7 days weekly continuous care by more than one personal care aide is correct.

DATED: Albany, New York
12/20/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee