STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 23, 2019
[redacted]
AGENCY: MAP
FH #: 7899623N

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 15, 2019, 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

[On Papers -- Appearance waived for the Centers Plan for Healthy Living]

ISSUE

Was the determination of Centers Plan for Healthy Living (the MLTCP) to deny the Appellant's application for an increase in the number of hours of the Appellant's Personal Care Services to 32 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 63 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 6 hours per day, 4 days per week.

3. On January 3, 2019, Centers Plan for Healthy Living completed a Uniform Assessment System - UASNY Assessment Report as part of a routine reassessment for the Appellant.

4. On January 4, 2019, the Appellant made an application to the MLTCP to increase the Appellant's authorization for Personal Care Services to 32 hours weekly, at a rate of 8 hours per day, four days per week.

5. On January 8, 2019, Centers Plan for Healthy Living approved Personal Care Services of 6 hours per day, 4 days a week, a total of 24 hours per week.

6. On January 15, 2019, the Appellant requested an internal appeal.

7. On January 16, 2019, Centers Plan for Healthy Living upheld its January 8, 2019, decision.

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

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.

Completion of accurate and comprehensive assessments are essential to safe and adequate care plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

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 24 hours per week, at the rate of six hours a day, four days a week. The Appellant applied for an increase in her Personal Care Services to 32 hours per week, at the rate of eight hours a day, four days a week.

On January 8, 2019, Centers Plan for Healthy Living determined that the Appellant's request for a Personal Care Services authorization of 8 hours a day, 4 days a week, was not approved. On January 15, 2019, the Appellant requested an internal appeal. On January 16, 2019, Centers Plan for Healthy Living upheld the January 8, 2019 determination. The Medical Director on behalf of Centers Plan for Healthy Living decided to deny the Appellant's request for an increase in Personal; Care Services hours because the service is not medically necessary.

> The request for an increase in PCA services was denied because you do not meet the criteria. This decision was based on:
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> Ms. [redacted], you receive PCA services 6 hours per day, 4 days per week, a total of 24 hours per week. You task for 20 hours per week, 4 days per week, as of January 3, 2019. You requested 8 hours per day, 4 days per week, a total of 32 hours per week, as you are afraid to be alone. There is no indication that you cannot be alone. You have a PCA for more than you task for. The denial is upheld.

The Appellant stated that the aide provides her with personal care services on Thursdays, Fridays, Saturdays, and Sundays, between the hours of 9:00 a.m. and 3:00 p.m. The Appellant stated that her husband is with her on the other days. The Appellant claimed that she needs two additional hours of personal care services, from 3:00 p.m. to 5:00 p.m. because her husband gets

home at 5:00 pm., and she cannot be alone for the two hours until her husband gets home. The Appellant claimed that when she is alone she falls, and that she fell as recently as a couple days before the hearing. The Appellant also claimed that between 3:00 p.m. and 5:00 p.m., she needs assistance with taking [redacted] for headaches or [redacted] or [redacted] for nervousness. However, the Appellant admitted that is unable to predict when or how often she would need to take such medications.

In an attempt to support her claims, the Appellant presented a letter from her psychiatrist, dated January 22, 2019, which stated that the Appellant suffers from "Major Depressive Disorder with Panic Attacks. Her symptoms include depression, severe anxiety, irritability, chronic worry, panic attacks, fearfulness, impaired functioning, difficulty concentrating, insomnia, feelings of hopelessness, as well as other clinical symptoms." The Appellant also presented a letter from her medical doctor, dated December 26, 2018, which stated that the Appellant suffers from "multiple medical problems. She was recently diagnosed with breast cancer, she underwent mastectomy, chemotherapy and radiation tx. Pt's functional status continues to deteriorate, she has poor endurance due to multiple joint and muscle pains, generalized weakness, decrease ability to ambulate."

Centers Plan for Healthy Living evaluated the Appellant's application for increased additional hours, and determined that the increase was not medically necessary. Centers Plan for Healthy Living completed a UASNY on January 3, 2019, which indicated no change in ADL status as compared to 90 days ago, no change in overall self-sufficiency as compared to 90 days. The UASNY also noted no falls within the last 30 days, but fell 31-90 days ago.

With regard to the Appellant's contention that the Appellant needs additional hours and assistance, the Appellant's contention was considered but found not persuasive. Personal Care Services are task based, and requiring an aide for safety monitoring as a standalone task, and for companionship, is outside the scope of Personal Care Services which must be provided under the Regulations. Centers Plan for Healthy Living is not required to provide safety monitoring or companionship as independent Personal Care Services tasks.

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 32 hours weekly is correct.

DATED: Albany, New York
02/21/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee