STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 2, 2019
[redacted]
AGENCY: Nassau
FH #: 8039892K

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the Nassau County 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 December 4, 2019, in Nassau County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan

Managed Care Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Care Plan's determination as to the adequacy of CDPAS personal care services for Appellant 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 86, was in receipt of a Medicaid Consumer Directed Personal Assistant Services (CDPAS) authorization through Centers Plan for Healthy Living (hereinafter Managed Care Plan) in the amount of eight hours per day, seven days per week based on a November 20, 2018 Universal Assessment System (UAS) Report.

2. The UAS report dated November 20, 2018 stated the Appellant's diagnoses, including coronary heart disease, diabetes, osteoporosis, chronic pain, constipation, dizziness, hypertension, insomnia, low vision, nausea, degenerative diseases of nervous system, overactive bladder, cardia/vascular implants/grafts, sleep disorder, tremor, abnormalities of gait and mobility, macular degeneration, daily urinary incontinence and occasional bowel incontinence.
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3. The UAS report dated November 20, 2018 stated that the Appellant lives alone and is totally dependent in locomotion and requires maximal assistance with walking, bathing, hygiene, dressing upper and lower body, transfer and toilet use, extensive assistance with eating and was independent with regard to bed mobility.

4. On May 21, 2019, the Managed Care Plan nurse conducted a re-assessment and completed a UAS Report stating the Appellant's diagnoses, including coronary heart disease, diabetes, osteoporosis, chronic pain, constipation, dizziness, hypertension, insomnia, low vision, nausea, degenerative diseases of nervous system, overactive bladder, cardia/vascular implants/grafts, sleep disorder, tremor, abnormalities of gait and mobility, macular degeneration, daily urinary incontinence and occasional bowel incontinence.

5. The UAS report dated May 21, 2019 stated that the Appellant lives alone and is totally dependent in locomotion and requires extensive assistance with walking, bathing, hygiene, dressing upper and lower body, and transfer, and limited assistance with toilet use, bed mobility and eating. The UAS stated that Appellant's ability to walk was not tested during the visit as she does not walk on her own.

6. On May 23, 2019, the Managed Care Plan received a request for increase in CDPAS services for Appellant.

7. On May 30, 2019, the Managed Care Plan approved CDPAS services for the Appellant in the amount of eight hours per day, seven days per week.

8. By Final Adverse Determination notice dated June 6, 2019, the Managed Care Plan advised Appellant of its determination upon appeal to uphold the May 30, 2019 determination on the grounds that, pursuant to the May 21, 2019 UAS, most of the Appellant's abilities to perform daily activities improved since the last assessment and some stayed the same. The notice stated that the UAS did not support the need for nighttime hours. The notice also stated that a doctor's letter dated May 24, 2014 was reviewed in making the decision.

9. On October 2, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

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.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

GIS 11 MA/009 provides that effective August 1, 2011, personal care services for non-dual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract.

Pursuant to Social Services Law §365-a(2)(e) Medicaid provides personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Social Services Law 365-f provides, in pertinent part as follows:

1. Purpose and intent. The consumer directed personal assistance program is intended to permit chronically ill and/or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services. The department shall regularly monitor district participation in the program by reviewing the implementation plans submitted pursuant to this section. The department shall provide guidance to the districts to improve compliance with implementation plans and promote consistency among counties regarding approved

service levels based on the assessments required by this section. In addition, the department shall provide technical assistance and such other assistance as may be necessary to assist such districts in assuring access to the program.

2. Eligibility. All eligible individuals receiving home care shall be provided notice of the availability of the program, and no less frequently than annually thereafter, and shall have the opportunity to apply for participation in the program. Each social services district shall file an implementation plan with the commissioner of the department of health, which shall be updated annually. Such updates shall be submitted no later than November thirtieth of each year. Beginning on June thirtieth, two thousand nine, the plans and updates submitted by districts shall require the approval of the department. Implementation plans shall include district enrollment targets, describe methods for the provision of notice and assistance to interested individuals eligible for enrollment in the program, and shall contain such other information as shall be required by the department. An "eligible individual", for purposes of this section is a person who:

   (a) is eligible for long term care and services provided by a certified home health agency, long term home health care program or AIDS home care program authorized pursuant to article thirty-six of the public health law, or is eligible for personal care services provided pursuant to this article;

   (b) is eligible for medical assistance;

   (c) has been determined by the social services district, pursuant to an assessment of the person's appropriateness for the program, conducted with an appropriate long term home health care program, a certified home health agency, or an AIDS home care program or pursuant to the personal care program, as being in need of home care services or private duty nursing and is able and willing or has a legal guardian able and willing to make informed choices, or has designated a relative or other adult who is able and willing to assist in making informed choices, as to the type and quality of services, including but not limited to such services as nursing care, personal care, transportation and respite services; and

   (d) meets such other criteria, as may be established by the commissioner, which are necessary to effectively implement the objectives of this section.

3. Division of responsibilities. Eligible individuals who elect to participate in the program assume the responsibility for services under such program as mutually agreed to by the eligible individual and provider and as documented in the eligible individual's record. Such individuals shall be assisted as appropriate with service coverage, supervision, advocacy and management. Providers shall not be liable for fulfillment of responsibilities agreed to be undertaken by the eligible individual. This subdivision, however, shall not diminish the participating provider's liability for failure to exercise reasonable care in properly carrying out its responsibilities under this program, which shall include monitoring such individual's continuing ability to fulfill those

responsibilities documented in his or her records. Failure of the individual to carry out his or her agreed to responsibilities may be considered in determining such individual's continued appropriateness for the program.

4. Participating providers. All agencies or individuals who meet the qualifications to provide home health, personal care or nursing services and who elect to provide such services to persons receiving medical assistance may participate in the program. Any agency or individuals providing services under a patient managed home care program authorized under the former section thirty-six hundred twenty-two of the public health law or the former sections three hundred sixty-five-f of this chapter may continue to provide such services under this section.

Regulations at 18 NYRR 505.28 address the Consumer Directed Personal Assistance Program and provide, in pertinent part, as follows:

(b) Definitions. The following definitions apply to this section:

(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14(a)(6) of this Part.

18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.

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. Such services must be essential to the maintenance of the patient's health and safety in his or her own home….".

(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.

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(b) The authorization for Level I services shall not exceed eight hours per week.

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(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.

Section 505.14(a)(3)(iii) of the regulations provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, Managed Care Plan or program other than the medical assistance program; or

DISCUSSION

At the hearing, the Appellant and her two children stated that they requested an additional eight hours per day in CDPAS services, to increase Appellant's services to sixteen hours per day, seven days per week. The Appellant's daughter strongly disputed the Managed Care Plan's determination that the Appellant's physical functioning has improved, stating that the Managed Care nurse was advised at the time of the assessment of the Appellant's increasing difficulty in walking, toileting, and eating. The Appellant's children stated that the increase was requested due to the Appellant's decreased functioning and increasing nighttime needs.

The Appellants stated that the Appellant can no longer feed herself because her tremors are increasing. They also stated that the Appellant has unspecified nausea, with unpredictable vomiting during the day and at night and requires assistance with cleaning on these occasions. In addition, the Appellant maintained that she sleeps only two to three hours at a time and is then up for several hours. The Appellant stated that she must use the bathroom several times per night, requires assistance to get out of bed, and cannot walk to the bathroom alone. The Appellant also stated that due to pain in her legs and tremors in her hands, she cannot use the walker unassisted. The Appellant added that the walker does not fit through the doorways in her house, causing her to enter the bathroom without any device. The Appellant further stated that she has extreme dizziness, especially upon bending to lower her clothing. The Appellant also stated that her slowness increases her incontinence and that she then has difficulty cleaning and changing lower body clothing.

The Appellant's daughter asserted that the Appellant's difficulty in walking and utilizing the toilet have resulted in many nighttime falls since the June denial of increased services. Documentation was provided establishing that nighttime falls resulted in hospital visits with a vertebra compression fracture in July and a broken nose in August.

A review of the Managed Care Plan's evidence demonstrates that the 86 year old Appellant's chronic and degenerative diagnoses did not change between the November 2018 and May 2019 assessments. Although the Managed Care Plan asserted that the Appellant's ability to perform daily activities improved during this period, the May 2019 UAS stated that the Appellant was not observed walking and the Managed Care Plan did not provide any other evidence to explain how the Appellant's improvement was determined. Finally, although the notice asserted that a 2014 doctor's letter was utilized in making the determination, the letter was not provided and no explanation of the relevancy of a five-year old letter was provided. The Managed Care Plan therefore failed to provide sufficient evidence to support its determination of medical improvement.

Furthermore, the statements of the Appellant regarding tremors, dizziness, inability to walk alone, and need for assistance with toileting and incontinence care was supported by the May 2019 UAS. Finally, although the May 2019 UAS stated that the Appellant's nighttime needs now included assistance with regard to bed mobility, no time for this activity was provided in the May 2019 task sheet. For all of the foregoing reasons, the Managed Care Plan failed to provide sufficient evidence to support its determination as to the adequacy of authorized CDPAS services and that determination cannot be affirmed.

The Managed Care Plan should conduct a new evaluation of Appellant's medical need for Personal Care Services, including Appellant's need for nighttime assistance. The Managed Care Plan should also provide the Appellant with appropriate notice of the new determination.

DECISION AND ORDER

The Managed Care Plan's determination as to the adequacy of CDPAS personal care services for Appellant is not correct and is reversed.

1. The Managed Care Plan is directed to cancel its notices dated May 30, 2019, which approved the Managed Care Plan approved CDPAS services for the Appellant in the amount of eight hours per day, seven days per week and its final Adverse Determination notice dated June 6, 2019.

Should the Managed Care Plan 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, the Managed Care Plan must comply immediately with the directives set forth above.

DATED: Albany, New York
12/12/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee