STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 9, 2018
[redacted]
AGENCY: MAP
FH #: 7787463J

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 August 1, 2018, 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 Plan

No Appearance

ISSUE

Was the determination of the Managed Long Term Care plan, Centers Plan for Healthy Living to deny appellant's request for 24-hour personal care 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, 78 years of age, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Long Term Care plan with Centers Plan for Healthy Living (hereafter, CHL).

2. The Appellant is currently authorized to receive 12 hours personal care services through AWNY Monday through Friday, and 24-hour personal care services Saturday and Sunday under the Consumer-Directed Personal Assistance (CDPAP) program.

3. The Appellant suffers from Alzheimer's disease, Parkinson's disease, anxiety, cognitive decline, dizziness and difficulty walking, incontinence of bowel and bladder, muscle weakness, shortness of breath, abnormalities of gait and tremors.

4. On or about June 1, 2018, appellant requested an increase in his personal care service to 24-hour service, 7 days per week, under the regular Medicaid plan, and not through CDPAP, as the family members participating in the CDPAP program were no longer able to care for appellant.

5. CHL conducted a Comprehensive Assessment on June 8, 2018.

6. Thereafter, by Notice of Initial Adverse Determination, dated March 21, 2018, CHL advised the appellant of its intention to deny the appellant's request for 24-hour personal care, 7 days per week, on the grounds that such care was not medically necessary.

7. Following an internal appeal by appellant, CHL issued a Final Adverse Determination, dated July 5, 2018, again denying appellant's request for 24-hour care, 7 days per week, for the same reason as noted above.

8. On July 9, 2018, 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 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) The reasons for the action...

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….".

(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.

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.

(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.

(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 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, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

18 NYCRR 505.14(a)(3)(iii)(b) provides, in part, that:

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers.

DISCUSSION

The appellant, 78 years of age, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Long Term Care plan with Centers Plan for Healthy Living (hereafter, CHL). The Appellant is currently authorized to receive 12 hours personal care services through AWNY Monday through Friday, and 24-hour personal care services Saturday and Sunday under the Consumer-Directed Personal Assistance (CDPAP) program. The Appellant suffers from Alzheimer's disease, Parkinson's disease, anxiety, cognitive decline, dizziness and difficulty walking, incontinence of bowel and bladder, muscle weakness, shortness of breath, abnormalities of gait and tremors, all as per the comprehensive evaluation conducted by CHL on June 8, 2018. On or about June 1, 2018, appellant requested an increase in his personal care service to 24-hour service, 7 days per week, under the regular Medicaid plan, and not through CDPAP, as the family members participating in the CDPAP program were no longer able to care for appellant. CHL conducted a Comprehensive Assessment on June 8, 2018. Thereafter, by Notice of Initial Adverse Determination, dated March 21, 2018, CHL advised the appellant of its intention to deny the appellant's request for 24-hour personal care, 7 days per week, on the grounds that such care was not medically necessary. Following an internal appeal by appellant, CHL issued a Final Adverse Determination, dated July 5, 2018, again denying appellant's request for 24-hour care, 7 days per week, for the same reason as noted above.

It is initially noted that no evidence was presented by the Managed Long Term Care Plan whatsoever, either by direct presentation at the hearing (the plan failed to attend the hearing) or by evidence by Waiver Packet (none was provided).

It is also noted that appellant, by his most recent assessment, has been found to be totally dependent in the areas of meal preparation, housework, shopping and managing medications, requiring maximal assistance in the areas of transportation, bathing and dressing, and requiring extensive assistance in the areas of locomotion, walking, toilet transfer, toilet use and bed mobility. Appellant had been receiving 24-hour care on the weekends to address his needs in the areas noted above, which include incontinence of both bowel and bladder; as no evidence was presented by CHL that appellant's condition has improved, appellant's needs are determined to have not changed. Thus, the consideration for this hearing is whether appellant's needs, acknowledged by CHL to be 24-hour in nature during the weekends, can continue to be addressed through the CDPAP program.

Appellant's care through CDPAP has been provided by his two sons, who are no longer able to provide such service to appellant. Through this program, appellant only required 12

hours per day, Monday through Friday, but continued to require the 24-hour personal care on the weekends, as acknowledged by CHL. Appellant's needs on the weekend are no different than his needs during the week. In the absence of the CDPAP individuals, and given appellant's continued need for personal care services which have not changed, the record supports the provision of 24-hour live in service 7 days per week.

While it is noted that appellant makes an additional request, in a letter submitted post-hearing, dated August 6, 2018, for 12-hour split shift care, the hearing record failed to establish that appellant's needs are frequent enough during the night that the aide would not be able to receive the requisite 5 hours of uninterrupted sleep which would justify 12-hour split shift care. The appellant may, however, request such service in the future if such care is sought.

DECISION AND ORDER

The determination of the Managed Long Term Care plan, Centers Plan for Healthy Living to deny appellant's request for 24-hour personal care is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to provide the appellant with 24-hour personal care services, 7 days per week, under authorization of Medicaid Long Term Care Plan (non-CDPAP).

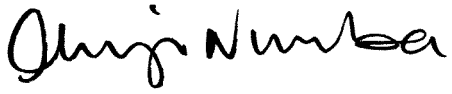
Should the Managed Long Term Care plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to AWNY promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, CHL must comply immediately with the directives set forth above.

DATED: Albany, New York
09/12/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee