STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 26, 2019
[redacted]
AGENCY: MAP
FH #: 8036920Z

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 October 25, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was the determination of Appellant's Managed Long Term Care Plan not to provide Personal Care Services in the amount of 56 hours a week, 8 hours daily, 7 days a week 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 82, is in receipt of Medicaid and is enrolled in a Managed Long Term Care plan operated by Centers Plan for Healthy Living. Appellant resides with her husband, also age 82.

2. The MLTCP had authorized Appellant to receive Personal Care Services Authorization in the amount of 38.5 hours per week, 5.5 hours a day, 7 days weekly, under a task-based plan of care.

3. On or about August 19, 2019, Appellant's representative requested an increase to 56 hours a week, 8 hours a day, 7 days a week, from the MLTCP on Appellant's behalf.

4. On January 31, 2019 and on July 31, 2019, the MLTCP prepared a Uniform Assessment System-NY evaluation, using the standard forms, regarding the Appellant's personal care needs.

5. By initial adverse determination dated August 20, 2019, the Appellant's request for increased hours was denied

6. On August 20, 2019, an internal appeal was requested on behalf of Appellant.

7. By final adverse determination dated August 21, 2019, the MLTCP "decided we are not changing our decision to deny your request…."

8. On September 26, 2019, 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...

Subsection (b) of the just-cited section of Regulations provides, in part:

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….

Section 505.14(a)(4)(iii) of the regulations further provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

> (a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or
>
> (b) 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 section 505.14(b)(v)(d), meanwhile states:

> The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

General Information Services Message 96 MA/019 advised, in part:

> The Mayer preliminary injunction order prohibits social services districts from applying task-based assessment plans to reduce the hours of any recipient whom the district has determined needs 24 hour care, including continuous 24 hour services (split-shift); 24 hour live-in services; or the equivalent provided by formal or informal caregivers.

GIS 03 MA/03 states ""‘. . . a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs."

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

Section 505.14(b) of the Regulations provides that reauthorization for personal care services requires similar assessments as for the initial authorization; however a nursing assessment is not required for Level I services if the physician's order indicates that the patient's medical condition is unchanged. Reauthorization of Level II services must include an evaluation of the services provided during the previous authorization period and must include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

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….

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of daily living functional potential;
- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);
- Urinary incontinence and indwelling catheter;
- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);
- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental Care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

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4480. PERSONAL CARE SERVICES

C. Scope of Services – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

1. Cognitive Impairments.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

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:

> 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 Appellant, age 82, is enrolled in a Medicaid Managed Long Term Care plan operated by Centers Plan for Healthy Living. On or about August 19, 2019, Appellant's representative requested an increase to 56 hours a week, 8 hours a day, 7 days a week, from the MLTCP on Appellant's behalf. By initial adverse determination dated August 20, 2019, the Appellant's request for increased hours was denied. On August 20, 2019, an internal appeal was requested on behalf of Appellant. By final adverse determination dated August 21, 2019, the MLTCP "decided we are not changing our decision to deny your request…." This hearing was requested on behalf of Appellant for review.

Appellant's son testified that he is Appellant's only child. The son and his wife are available to help during evenings, but the son needs to work at his tailoring business during the day. According to the son, Appellant's husband is in no shape to help her. No one else is available on a regular basis.

The July, 2019 nurse evaluation reported that Appellant's ADL (activities of daily living) status had declined. Appellant was only alert and oriented x 2, with a reported short-term memory problem. Appellant scored 20 out of 30 on the Mini Mental State Exam that was administered to her, showing definite cognitive deficiencies. Furthermore, the report states that "foot problems limit walking" and Appellant needs a special diet because of esophageal issues.

The July nurse evaluation noted that Appellant suffered from several health conditions which can seriously impair her ability to function--- GERD, hyperlipidemia, fatigue, osteoarthritis, hearing loss, abnormalities of gait and mobility, Vitamin D deficiency, cognitive decline, osteoporosis, rhinitis, diarrhea, dizziness and giddiness, edema, hypertension, hypokaleria, insomnia, other allergy, cervical disk displacement, and esophageal disorder(s).. The report also found that the Appellant needed total assistance with housework, maximal assistance with meal preparation, stairs, shopping, and transportation, extensive assistance with finances, medications, bathing, hygiene, dressing upper body, dressing lower body, walking, locomotion, and transfer toilet, and limited assistance with toilet use, bed mobility, and eating.

As to the hours allocated to Appellant herself, her condition is such that she could qualify for 24 hour care. Appellant has been found by the Managed Long Term Care Plan to need extensive assistance with walking and locomotion, dressing lower body, transfer toilet, and limited assistance with bed mobility and toilet use. All of those are round the clock needs. Regulations specify that individuals with round the clock needs should not have hours calculated using a task-based assessment. {See 18 NYCRR 505.14(b)(v)(d) and GIS 96 MA/019.}

In light of the evidence and testimony presented at the hearing, Appellant's requested increase to 56 hours a week, 8 hours a day, 7 days a week, is found to be reasonable. Centers Plan can not be upheld here.

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 Managed Long Term Care Plan's adverse determination denying care 56 hours a week, 8 hours a day, 7 days a week, by a personal care aide is not correct and is reversed.

1. The MLTCP is directed to authorize Personal Care Services in the Appellant in the amount of 56 hours a week, 8 hours a day, 7 days a week.

2. The MLTCP is directed to notify Appellant in writing of its compliance with this decision.

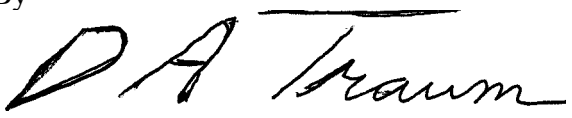
Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's 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
11/14/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee