STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 7, 2019
[redacted]
AGENCY: Suffolk
FH #: 8059387N

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County 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 27, 2019, in Suffolk 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 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[redacted], is in receipt of a Medicaid Consumer Directed Personal Care Services Authorization (CDPAP) through Centers Plan for Healthy Living (hereinafter Managed Care Plan) in the amount of 10 hours per day, 7 days a week based on a Uniform Assessment System (UAS) report dated March 26, 2019.

2. The UAS dated March 26, 2019 stated that the Appellant required maximal assistance with bathing, personal hygiene, dressing upper and lower body, transfer to toilet, toilet use, and bed mobility; extensive assistance with eating and is totally dependent with regard to walking/locomotion and is totally dependent with level I activities.

3. On September 18, 2019, the Managed Care Plan nurse conducted a new UAS evaluation. The UAS report stated the following diagnoses for the Appellant: cancer, congestive heart failure, constipation, hypertension, hypercholesterolemia, shortness of breath, cataract, kidney failure, osteoarthritis, urinary incontinence, and has incontinent bowel episodes. The UAS stated that the Appellant utilizes a CPAP machine and oxygen at bedtime.

4. The UAS dated September 18, 2019 stated that the Appellant has end stage renal failure, was hospitalized in September 2019 to receive a central venous catheter and receives hemodialysis three times a week.

5. The UAS stated that the Appellant resides alone and requires informal care from family members in addition to authorized CDPAP hours.

6. The UAS dated September 18, 2019 stated that the Appellant does not walk on her own, must be wheeled by others and is incontinent at night due to inability to get up and make it to the bathroom.

7. The UAS dated September 18, 2019 stated that the Appellant requires maximal assistance with bathing, personal hygiene, dressing upper and lower body, transferring to toilet, toilet use, and bed mobility, requires extensive assistance with eating, and is totally dependent in walking/locomotion and is totally dependent with level I activities. The UAS noted Appellant's dialysis-related fatigue, spinal stenosis-related limited range of motion, and joint swelling and stiffness, especially in the hands, creating the need for significant assistance with activities of daily living (ADLs). The UAS also noted that the Appellant has a central line in her right upper arm and is unable to raise her arms above her head, impeding her ability to perform ADLs.

8. By undated Initial Adverse Determination Notice, the Managed Care Plan advised Appellant of its determination to deny the request for increase in CDPAP services and to continue services to the Appellant in the amount of ten hours per day, seven days a week . The Notice stated that the increase was denied because there was no change in the Appellant's needs between the assessments dated March 26, 2019 and September 18, 2019 and that the Appellant's score improved. The notice stated that the Appellant can perform the following by herself with assistance: bathing, personal hygiene, dressing, turning and repositioning in bed, and eating.

9. By Final Adverse Determination Notice dated October 21, 2019, the Managed Care Plan upheld the denial upon appeal on the grounds that most of Appellant's abilities to perform physical functioning stayed the same between her prior assessment on March 26, 2019 and the September 18, 2019 assessment: dressing upper and lower body, personal hygiene, bed mobility, walking, bathing, transfer toilet, toilet use, and eating.

10. On November 7, 2019, this fair hearing was requested.

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-a(2)(e)(iv) provides 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.

505.28 Consumer directed personal assistance program.

(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

The Appellant's daughter and daughter in law appeared with signed authorization to represent from the Appellant. The Appellant's representatives stated that they are involved in Appellant's care, have personal knowledge of the Appellant's medical condition and needs, and that the Appellant, due to her medical condition and extreme fatigue from dialysis, would be

unable to provide any additional meaningful testimony at this hearing. The hearing therefore proceeded without the participation of the Appellant.

The Appellant's representatives maintained that the Appellant is becoming weaker, requiring increasing assistance. The representatives stated that the Appellant is unable to use her arms to lift, reach or pull due to a longstanding rotator cuff injury, the dialysis port in her arm, and bones weakened by cancer. The representatives further stated that the Appellant can't reach behind her or to the side, and therefore cannot reach and pull the toilet paper or clean herself. The representatives added that Appellant cannot utilize her arms to re-position herself in a chair or toilet, or to pull up and adjust her clothing. The representatives also stated that the Appellant is totally dependent to reach the bathroom and to be placed in a chair or bed afterward. The representatives noted that the Appellant is also dependent for frequent repositioning to avoid skin ulcers.

The Appellant's representatives submitted current medical documentation of Appellant's medical diagnoses, including multiple myeloma, spinal stenosis, and bilateral shoulder rotator cuff problems. The medical documentation correlated the Appellant's diagnoses with specific limitations to the performance of ADLs, including bed mobility and transfers and particularly noted the need for total assistance at bedtime with oxygen/CPAP mask.

A review of the Managed Care Plan's documents supports the position of the Appellant's representative regarding the Appellant's medical condition and needs for assistance with ADLs, including toileting, locomotion, bedtime assistance with oxygen/CPAP and nighttime ADLs including incontinence and bed mobility. The evidence from the Managed Care Plan demonstrated that Appellant's needs during non-authorized CDPAP hours are met through informal care from family.

The Appellant's representatives stated that family provides informal care for the Appellant during the hours when CDPAP services are not authorized. However, one family member, a grandson has now left the area to attend college and is no longer available to assist. The representatives added that they therefore requested one additional hour of services per day, for a total of eleven hours, seven days per week, to allow the remaining family members to attend to other needs before taking over for the nighttime hours.

Although the Managed Care Plan asserted that the Appellant's medical condition had not changed since the prior UAS assessment, the hearing record demonstrates that the request for additional hours was predicated on a change in social circumstances, with the change in availability of family caregivers. As the Managed Care Plan did not demonstrate that the adequacy of authorized hours was evaluated based on this change in availability of informal caregivers, the record does not establish that the Managed Care Plan followed the correct procedures were followed in determining the adequacy of CDPAP services and the Managed Care Plan's determination is reversed.

DECISION AND ORDER

The Managed Care Plan's determination as to the adequacy of CDPAP services for Appellant in the amount of ten hours per day, seven days a week is not correct and is reversed.

1. The Managed Care Plan is directed to immediately authorize CDPAP services for the Appellant in the amount of eleven hours per day, seven days per week.

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
01/09/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee