STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 20, 2018
[redacted]
AGENCY: MAP
FH #: 7742915L

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City 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 May 17, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the MLTC Plan ("Centers for Healthy Living")

Centers Plan for Healthy Living's appearance waived by the Office of Administrative Hearings

ISSUE

Was the April 18, 2018, determination of the Appellant's Managed Long Term Care Plan, Centers for Healthy Living, to deny the request for an increase in the Appellant's personal care services from 63 hours (nine hours per day, seven days per week) to live-in 24-hour personal care services, 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 88, has been enrolled in a Managed Long Term Care Program and has been receiving care and services, including personal care services, through a Medicaid Managed Long Term Care Health Plan operated by Centers for Healthy Living.

2. The Appellant requested that her personal care services be increased from 63 hours (nine hours per day, seven days per week) to live-in 24-hour personal care services.

3. On April 6, 2018, a nurse completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs.

4. By "Initial Adverse Determination" dated April 18, 2018, Centers for Healthy Living advised the Appellant of its determination to deny the Appellant's request for an increase to live-in 24-hour personal care services, stating the reason for the denial was that the Plan was unable to conduct a UAS-NY assessment.

5. On April 20, 2018, the Appellant requested the present hearing.

APPLICABLE LAW

Part 438 of 21 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 21 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 21 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 21 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 21 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.

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Section 505.14(a) of the Regulations provides in part 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 shall 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) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

8) feeding;

9) 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;

10) providing routine skin care;

11) using medical supplies and equipment such as walkers and wheelchairs, and;

12) changing of simple dressings.

General Information System message, GIS 97 MA/033, states in pertinent part that once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by authorizing 24-hour split-shift personal care services for a recipient who is medically eligible for split-shift services, and who otherwise meets the fiscal assessment requirements, but has no informal or formal supports.

18 NYCRR 358-5.9(a) provides that, at a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, or an exemption from work activity requirements, the Appellant must establish that the Agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 states, in pertinent part, that 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**.**

GIS 12 MA/026 provides in pertinent part that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1) adaptive for specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2) voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

GIS 15 MA/24 provides in pertinent part that:

1. 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 of daily on interrupted sleep during the aids eight of sleep.

2. Live-in 24 hour personal care services is a provision of care by a personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with transferring, walking, toileting, turning and positioning, or feeding, and whose needs 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 of period of sleep.

GIS 15 MA/24 further provides that the social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized.

DISCUSSION

The evidence establishes that on April 6, 2018, a nurse completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs.

By "Initial Adverse Determination" dated April 18, 2018, Centers for Healthy Living

advised the Appellant of its determination to deny the Appellant's request for an increase to live-in 24-hour personal care services, stating the reason for the denial was that the Plan was unable to conduct a UAS-NY assessment.

It is noted that the Appellant was admitted into [redacted] in or about late January/early February due to an edema (caused by fluid in legs due to a heart condition). The Appellant was later transferred to [redacted] on February 23, 2018 for physical therapy and rehabilitation consequent to her hospitalization. [redacted] planned to discharge the Appellant on April 13, 2018, but she was not discharged because the Appellant's representative and the Appellant's witness have requested that the Plan authorize live-in personal care services for the Appellant instead of 63 hours of personal care services weekly, which they contend is more appropriate for the Appellant due to her medical conditions.

It is also noted that Centers for Healthy Living conducted an assessment (Uniform Assessment System (UAS) report) of the Appellant on April 6, 2018 although the April 18, 2018 notice states that the Plan was unable to conduct a UAS-NY assessment.

At the hearing, the Appellant's representative contended that the Appellant has a stage 2 pressure ulcer in her sacral region, and that consequently she requires assistance with turning and positioning in her bed at night because she is unable to turn or position herself in her bed without assistance.

The Appellant's representative presented medical evidence dated May 15, 2018, from [redacted], which states that the Appellant has been diagnosed with post-polio syndrome, paroxysmal atrial fibrillation, chronic ischemic heart disease, osteoporosis, essential primary hypertension, age-related physical debility, rotator cuff atrophy, low back pain, status post cardioversion, status post PPM placement, hyperthyroidism, osteoarthritis, status post falls, and that she was admitted for STR from [redacted]. The letter further states that the Appellant requires assistance with ambulating, assistance with all household chores, and all her daily ADLs.

The Appellant's representative presented a letter from [redacted]., dated February 22, 2018 that states that the Appellant has a history of post-polio syndrome with worsening leg strength and very poor stamina. She is almost totally unable to manage her ADLs, as she can no longer shop for meals, prepare food, wash clothes, or bathe herself without extreme danger. She requires 24-hour, seven days home health aide assistance.

The Appellant's representative also presented physical therapy and discharge summary notes, dated April 13, 2018, that states that the Appellant requires assistance with ambulating with a 4-wheeled walker, demonstrates standing balance of F dynamic, and transitions safely from sitting to standing with stand-by assistance including verbal instruction/cues for safety.

The Plan submitted its April 6, 2018 UAS report that states that the Appellant is totally dependent on others for meal preparation, housework, managing medications and finances,

climbing and descending stairs, shopping, transportation, bathing, personal hygiene, dressing her upper and lower body, walking, locomotion, toileting, transferring to the toilet, and bed mobility. The Appellant's primary mode of locomotion indoors is by wheelchair and/or scooter. She is frequently incontinent of bladder, and infrequently incontinent of bowel; she uses diapers daily. The nurse noted that the Appellant requires assistance with ADLs and IADLS due to osteoarthritis, weakness, and foot problems. The Appellant is wheeled indoor and outdoor by others and she only uses a walker during physical therapy. The nurse further noted that the Appellant has polio deformity on her left foot which limits her walking. She wears a leg brace on her left leg in the daytime, and that she has a stage 2 pressure ulcer on her sacral region.

The Appellant's witness contended that the Appellant wears leg braces on both legs which cover her heels up to her upper calf/knee, contrary to the April 6, 2018 UAS report in which the nurse noted that she wears a leg brace only on her left leg. He stated that the leg braces must be placed on the Appellant's legs every morning and that the braces are removed at night before she sleeps. He stated that the Appellant's condition has worsened since she was hospitalized. He stated that the Appellant is unable to get into her bed or raise up from her bed without assistance, and she is unable to raise up from lying or sitting position to open her door for her aide.

The undisputed evidence establishes that the Appellant requires assistance during a calendar day with turning and positioning as well as other ADLs including transferring, walking/ambulating, and toileting because she is totally dependent on others to complete these activities. Thus, the Appellant's representative has established that the Appellant requires increased personal care services because the Appellant's nighttime needs cannot be met due to reasons stated above.

Accordingly, Centers for Healthy Living's April 18, 2018, determination to deny the Appellant's request for 24-hour personal care services cannot be sustained.

DECISION AND ORDER

Centers for Healthy Living's April 18, 2018, determination to deny the request for an increase in the Appellant's personal care services from 63 hours (nine hours per day, seven days per week) to live-in 24-hour personal care services, was not correct and is reversed.

1. Centers for Healthy Living is directed to authorize the Appellant to receive Personal Care Services in the amount of 24 hours daily, 7 days weekly, provided on a "Live-in" basis.

2. Centers for Healthy Living notify the Appellant and the Appellant's representative of its compliance with this Decision.

Should the Centers for Healthy Living 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 Centers for Healthy Living promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, Centers for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
06/05/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee