STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 26, 2018
[redacted]
AGENCY: MAP
FH #: 7883472K

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 January 23, 2019, 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

Deborah Ferguson, Centers Plan, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long-Term Care Program provider (hereinafter "Centers Plan" or "the Plan") to deny the request, on the Appellant's behalf, for an increase in CDPAP services from 51 hours weekly to 78 hours weekly, 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 91, has been enrolled in a Managed Long-Term Care Program and has received care and services, including Consumer Directed Personal Assistant Program (CDPAP) Services, through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

2. The Appellant has been authorized to receive CDPAP Services in the amount of 51 hours weekly (i.e. 8.5 hours daily, 6 days weekly.)

3. The Appellant requested an increase in the Appellant's CDPAP services hours to 78 hours weekly (i.e. 13 hours daily, 6 days weekly).

4. By Initial Adverse Determination, dated November 29, 2018, the Plan denied the Appellant's request.

5. By Final Adverse Determination, dated December 3, 2018, the Plan decided to not change its decision to deny the Appellant's request for an increase in the Appellant's CDPAP services hours from 51 hours weekly to 78 hours weekly.

6. On December 26, 2018, this fair hearing was requested.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, HEAP, SNAP benefits, Medical Assistance 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.

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...

GIS 15 MA/24, published on December 31, 2015, advises of the revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR section 505.14 and 18 NYCRR section 505.28, and notes the following changes:

The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

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.

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.

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions shall include some or total 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.

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.

Pursuant to GIS 03 MA/003, task based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

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**.**

Completion of accurate and comprehensive assessments are essential to safe and adequate care Medical Plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

Appellant right to fair hearing and appeal rights:

42 CFR section 438.402 (c)(1)(i) and 438 (f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld. 42 CFR section 438.402 (c)(1)(i)(A), 438.408 (c)(3) and 438.408 (f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed

exhaustion applied when: an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan; an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State – specified timeframes; or a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR section 438.408.

42 CFR section 438.408 (f) (2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing. Pursuant to 42 CFR section 438.424 (a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

DISCUSSION

The evidence establishes that the Appellant, age 91, has been authorized to receive CDPAP services in the amount of 51 hours weekly (i.e., 8.5 hours daily, 6 days weekly). The Appellant requested an increase in the Appellant's CDPAP services hours to 78 hours weekly. By Initial Adverse Determination, dated November 29, 2018, the Plan denied the Appellant's request. By Final Adverse Determination, dated December 3, 2018, the Plan decided to not change its decision to deny the Appellant's request for an increase in the Appellant's CDPAP services hours from 51 hours weekly to 78 hours weekly. According to the plan:

"She lives with you and your wife on the first floor of a multi-family home….She recently underwent a follow-up fact-to-face clinical assessment on November 23, 2018 utilizing the New York State Department of Health's Uniform Assessment System Tool that showed some of her abilities to perform physical functioning stayed the same and some improved since her prior assessment that was completed…on July 20, 2018. ..She showed that her abilities to perform physical function improved to perform dressing upper and lower body and personal hygiene (cleaning yourself)."

According to the November 23, 2018 Uniform Assessment System – New York Community Assessment Level of Care Report, Centers Plan reports that the Appellant suffers from [redacted]. The Appellant is totally dependent in walking, locomotion, eating, meal preparation, medication management and ordinary housework; the Appellant needs maximal assistance in dressing upper and lower body, personal hygiene, bed mobility, bathing, toilet transfer and toilet use. The UAS indicates that the Appellant is frequently bladder incontinent and bowel continent.

At the hearing, the Appellant's daughter-in-law/representative testified that the Appellant requires additional CDPAP service hours for all aspects of daily living. The Appellant is now fully bowel and bladder incontinent, has severe dementia and is suffering from malnutrition. The Appellant has developed a bed sore due to immobility. The Appellant was living in an upstairs apartment in the family house but could no longer do stairs and now resides with her son,

daughter-in-law and sixteen-year-old grandson. The son and daughter-in-law run a full-time business in the basement. The Appellant's representative testified that the caregiver is not a family or community member but the family was advised by Centers Plan to participate in the CDPAP program.

The Appellant's representative disputed that there has been any improvement in dressing upper body and lower body and personal hygiene and testified that the Appellant's abilities have declined.

The Appellant's representative submitted a letter from the Appellant's treating Neurologist who is recommending 24/7 care for the following reasons:

> "[The Appellant] has unscheduled toileting needs 24 hours a day that can only be met with assistance with a care giver. She is frequently incontinent of bowel and bladder …and wears pullups…She needs hands-on assistance with changing clothing, personal hygiene, and changing bedding. Severe dementia, as evidenced on neurological evaluation…impairment in all areas of cognitive functioning…It is unsafe for her to be left unattended because she will attempt to wander outside the home or complete tasks that she isn't physically or cognitively able to do safely. She does not have the cognitive ability to safely care for herself…She is at risk for falls despite the use of a walker. She needs hands-on or standby assistance with all mobility related activities, due to complete lack of appetite and no interest in food, she will not eat without being spoon fed…Placement in a nursing home has been recommended by [the Plan]. Such placement is not medically necessary and would likely be detrimental for [the Appellant]. It is imperative that she continue to live in familiar surroundings with family nearby. Around the clock PCA assistance allows her to remain safely and comfortably at home."

The Appellant's representative's testimony was plausible and persuasive and substantiated by medical documentation

Regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. In this case, the Appellant's representative has done so. While the regulations do not allow for CDPAP services for the stand-alone tasks of safety monitoring and fall prevention, the record in this case has been considered, and the credible evidence reflects the evaluation of the Appellant and reflects the Appellant is in need of additional assistance for meal preparation, dressing, toileting and personal hygiene, bed mobility, walking and locomotion. Although the notice at issue denied an increase in services to 78 hours weekly (i.e. 13 hours daily, 6 days weekly), credible evidence and testimony at the hearing establishes that the plan's determination not to increase the Appellant's CDPAP services is not correct.

The record has been considered. Pursuant to GIS 03 MA/003, the Plan must develop a care plan that meets the Appellant's scheduled and unscheduled nighttime needs during the span of time in which those needs arise. Further, the Regulations provide that the Plan may take into

consideration any informal support, but cannot require that the Appellant's family members to do so. Moreover, once the aide leaves, the Appellant needs assistance with toileting, hygiene, locomotion and dressing during the Appellant's awake hours; the aforementioned are the same tasks the Plan has determined the Appellant needs assistance for during the already approved CDPAP service hours.

Therefore, there was evidence provided to establish that the Appellant hours should be increased by 4.5 hours per day, six days per week (27 hours per week) to 13 hours per day, six days per week (78 hours per week).

DECISION AND ORDER

The determination of the Appellant's Managed Long-Term Care Plan to deny the request, on the Appellant's behalf, for an increase in CDPAP services is reversed.

1. The Plan is directed to provide the Appellant with a CDPAP Services Authorization in the amount of 78 hours weekly (i.e., 13 hours daily, 6 days weekly).

2. The Plan is directed to notify the Appellant, in writing, of the Plan's determination to increase the Appellant's CDPAP Services Authorization, from 51 hours weekly to 78 hours weekly.

Should Centers Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant's representative must provide it to Centers Plan promptly to facilitate such compliance.

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

FH# 7883472K

DATED: Albany, New York
02/15/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee