STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 31, 2018
[redacted]
AGENCY: MAP
FH #: 7886231Z

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 24, 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 (Centers Plan for Healthy Living)

Debra Fergurson, Fair Hearing Representative

ISSUE

Was the October 3, 2018 Final Adverse Determination Denial Notice of the Managed Long-Term Care Plan, Centers Plan for Healthy Living denying the Appellant's request for an increase in the Appellant's Consumer Directed Personal Care Program (CDPAP) hours from 42 hours per week (6 hours x 7 days per week) to 56 hours per week (8 hours per day x 7 days per week), 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, disabled, residing alone, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Care Plan with Centers Plan for Healthy Living.

2. The Appellant is currently authorized to receive forty-two (42) hours per week (6 hours per day x 7 days per week) of personal care services.

3. The Appellant receives personal care services through Centers Plan for Healthy Living in the Consumer Directed Personal Assistance Services Program (CDPAP).

4. The Appellant has a diagnosis of: [redacted]

5. The Appellant requested an increase in the personal care hours, claiming a need for 56 hours per week (8 hours per day x 7 days per week) of personal care assistance. At the time of the Appellant's request the Appellant had been receiving 42 hours per week (6 hours per day x 7 days per week) of personal care services.

6. On June 27, 2018, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview the Appellant by a registered Nurse Assessor on June 25, 2018.

7. By Notice of Final Adverse Determination Denial Notice, dated October 3, 2018 the plan advised the appellant that the request for an increase in personal care hours was denied and the plan approval stays at 6 hours per day x 7 days per week (42 hours per week).

8. On December 31, 2018, the Appellant Representatives requested this fair hearing.

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 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...

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. 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:

(6) 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 weekly 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.

Pursuant to the New York State Department of Health Guidelines for Consumer Directed Personal Assistance Services, published June 30, 2013, the scope of services regarding Consumer Directed Personal Assistance Services includes the following:

a. Purpose: Consumer Directed Personal Assistance Services is intended to permit chronically ill or physically disabled individuals receiving home care services greater flexibility and freedom of choice in obtaining such services.

b. An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative. Personal care services, home health aide services, and skilled nursing tasks shall have the same meaning as 18 NYCRR § 505.28 (b)(9), (7), & (11) respectively.

c. The terms consumer directed personal assistant and designated representative shall have the same meaning as 18 NYCRR § 505.28(b)(3) & (5).

e. Level of Service:

i. The assessment for home-based services identifies the tasks necessary to keep the enrollee safely in the home. The plan of care is developed by the enrollee with the assistance of the MCO, provider and any individuals the enrollee chooses to include.

ii. The plan of care is developed in conjunction with the enrollee based on the assessment and considers the number of hours authorized to accomplish the tasks. These tasks may include level 1 and level 2 PCS, home health aide services and/or skilled nursing tasks.
iii. The MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e).
iv. CDPAS services are managed by the enrollee in accordance with the enrollee's plan of care. The authorization should provide the number of hours authorized however, it is the enrollee who decides how those hours are arranged over the week. The MCO does maintain the right to determine whether the number of hours is appropriate to the plan of care. The FI is not responsible for assuring that the member is managing the plan of care.

18 NYCRR 505.28(b)(3) provides that "a consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer". However, a consumer directed personal assistant may include "any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary."

When the change in service needs results from a change in the consumer's medical condition, "including the consumer's loss of the ability to instruct, supervise or direct the consumer directed personal assistant", the district must obtain a new physician's order and nursing assessment. 18 NYCRR 505.28(f)(2)(ii).

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.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such

documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The record in this matter establishes that the Appellant's Managed Care Consumer Directed Personal Assistance Services (CDPAS) Plan, Centers Plan for Healthy Living, had authorized Personal Care Services in the amount of 42 hours weekly (6 hours per day x 7 days per week). The record also establishes that the Appellant requested an increase of Personal Care Service hours from 42 hours weekly (6 hours per day x 7 days per week) to an increase to 56 hours per week (8 hours per day x 7 days per week) of CDPAS Personal Care Service hours. By final adverse determination denial notice dated October 3, 2018, the Managed Long Term Care Plan determined to deny the Appellant's request for an increase from 42 hours per week (6 hours per day x 7 days per week) to an increase to 56 hours per week (8 hours per day x 7 days per week) of personal care services. The Appellant Representatives requested this fair hearing.

At the hearing the Managed Care Consumer Directed Personal Assistance Services (CDPAP) Plan, Centers Plan for Healthy Living submitted the final adverse determination denial notice dated October 3, 2018, marked as *MCP Exhibit 1*; Client Task Sheet dated June 25, 2018 marked as *MLTC Plan Exhibit 2,* Uniform Assessment System New York Assessment Comprehensive Report dated June 27, 2018 marked as *MCP Exhibit 3;* and Person Centered Service Plan dated November 26, 2018 marked as *MLTC Exhibit 4.*

The Managed Long-Term Care Plan Centers Plan for Healthy Living, Final Adverse Determination Denial Notice dated October 3, 2018 states in pertinent part:

"Why did we decide to deny the request?
The Medical Director on behalf of Centers Plan for Healthy Living decided to deny this service because the service is not medically necessary. The denial for an increase in CDPAP services at 8 hours per day, 7 days a week for a total of 56 hours per week is upheld. Your hours stay the same at 6 hours per day, 7 days a week for 42 hours per week.

The member lives alone in a one-bedroom apartment. You recently underwent a follow-up face-to face clinical assessment on 6/25/2018 utilizing the New York State Department of Health's Uniform Assessment System Tool) showed that most of your abilities to perform physical functioning stayed the same or improved when compared to a prior assessment that was completed by Centers Plan for Healthy Living on 1/14/2018. Your abilities to perform physical functions stayed the same for dressing lower body, bathing, meal preparation, medication

management and ordinary housework. You showed improvement in your ability to perform dressing upper body, personal hygiene (cleaning yourself), bed mobility (moving around in bed), walking, transfer toilet (getting on and off the toilet), toilet use and eating.

In summary, you showed that most of your abilities to perform physical functioning stayed the same or improved, therefore, your hours stayed the same at 6 hours per day, 7 days a week for 42 hours per week.

This decision is based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool."

See MLTC Plan Exhibit 1, Centers Plan for Healthy Living Final Adverse Determination Denial Notice dated October 3, 2018

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

The record establishes that the Managed Long-Term Care Plan for Healthy Living based its Final Adverse Determination to deny the Appellant's request for an increase in CDPAP Personal Care Services on the grounds that "when compared to a prior assessment that was completed by Centers Plan for Healthy Living on 1/14/2018. However, the Managed Long-Term Care Plan for Healthy Living did not submit into evidence a prior assessment that was completed by Centers Plan for Healthy Living on 1/14/2018.

A further review of the Managed Long- Term Care Plan's Final Adverse Determination Denial Notice states in pertinent part: "Your abilities to perform physical functions stayed the same for dressing lower body, bathing, meal preparation, medication management and ordinary housework. You showed improvement in your ability to perform dressing upper body, personal hygiene (cleaning yourself), bed mobility (moving around in bed), walking, transfer toilet (getting on and off the toilet), toilet use and eating."

The Managed Long-Term Care Plan Centers Plan for Healthy Living did not submit into evidence the Managed Long-Term Care Plan, Center's Plan for Healthy Living Initial Adverse Determination Denial Notice, nor did the Managed Long-Term Care Plan Centers Plan for Healthy Living submit the prior assessment of the Appellant that was completed by Centers Plan

for Healthy Living on 1/14/2018 and accordingly, The Managed Long-Term Care Plan Centers Plan for Healthy Living did not comply with Regulations at 18 NYCRR 358-3.7(a) as sited supra.

A review of MLTP UAS dated June 27, 2018, marked as *MLTC Plan Exhibit 3,* indicates that the Appellant requires:

Total Dependence:
Meal preparation
Ordinary housework
Shopping

Maximal Assistance:
Managing finances
Managing medications

Extensive Assistance:
Phone use
Stairs
Transportation
Bathing
Dressing Lower Body

Limited Assistance:
Personal hygiene
Dressing upper body
Walking
Locomotion
Transfer toilet
Bed mobility

Bladder continence:
Occasionally incontinent – Less than daily

Bowel continence:
Continent- Complete control; does not use any type of ostomy device

Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago:
No change

Overall self-sufficiency has changed significantly as compared to status 90 days ago, or since last assessment if less than 90 days:
No change

The Appellant Representatives contended that the MLTC Plan's UAS dated June 25, 2018 does not state "improvement" in Appellant's activities of daily living from prior UAS assessment of the Appellant, but on the contrary, indicates: "No change".

See MLTC Plan UAS dated June 25, 2018, marked as *MLTC Plan Exhibit 3.*

The Appellant Representatives contended that the Appellant requires an increase in Personal Care Services on the grounds that the Appellant's medical conditions have not improved but rather have deteriorated and accordingly, the Appellant needs additional personal care service hours to assist her in activities of daily living.

In support of the Appellant's claim, the Appellant Representatives submitted into evidence medical evidence from Appellant's doctor dated January 18, 2019, which stated:

"Ms. [redacted] is 91 years old woman with history of [redacted]. She has been living alone with 6 hours of home health aide a day. She is unfortunately getting medically worse. She has left stove fire on and forgot about it. She has also fallen more than once. She is at point needing 12-14 hours a day for her safety.

Sincerely

[redacted]

See Appellant Exhibit A, dated January 18, 2019, Dr. [redacted] MD.

The Appellant Representatives also submitted into evidence, and marked as *Appellant Exhibit B,* a letter dated January 21, 2019 from [redacted] which stated:

"I am writing this letter in regard to our tenant [redacted]. She is a sweet lady who is very isolated. She doesn't get moving on a daily basis. We have requested of her multiple times to participate in our programs. She stays in her apartment but we have found that when she is alone she tends to be irresponsible. Her hygiene is not up to par. She can't shower alone. She doesn't eat. Drinks lots of coffee leaves fire on. Sleep a lot.

The aide that she has is wonderful only the second half of the day she is alone. She needs more help.

[redacted].

See *Appellant Exhibit B*, dated January 21, 2019 from [redacted]

The Appellant Representatives argued that the Appellant is not requesting an increase in personal care services for safety monitoring as a stand-alone task, but rather are requesting an

increase in personal care services for safety monitoring while assisting the Appellant in activities of daily living, in particular, in personal hygiene, bathing, dressing, and meal preparation.

The evidence from both sides has been carefully reviewed (documents as well as the credible testimony] and the evidence establishes that the Managed Long Term Care Plan Centers Plan for Healthy Living Final Adverse Determination Denial Notice dated October 3, 2018 to deny the Appellant's request for an increase of personal care services (CDPAS) from 42 hours per week (6 hours per day x 7 days per week) to an increase to 56 hours per week (8 hours per day x 7 days per week) of personal care services was correct when made, however, in light of the new evidence presented by the Appellant Representatives at the fair hearing, the MLTC Plan Centers Plan for Healthy Living's Final Adverse Determination Denial Notice dated October 3, 2018 cannot be sustained.

DECISION AND ORDER

The October 3, 2018 Final Adverse Determination Denial Notice of the Managed Care Consumer Directed Personal Assistance Services (CDPAS) Centers Plan for Healthy Living, to deny appellant's request for an increase in personal care hours from 42 hours per week (6 hours per day x 7 days per week), to an increase to 56 hours per week (8 hours per day x 7 days per week) was correct when made, however, The Managed Care Plan Centers Plan for Healthy Living, Consumer Directed Personal Services (CDPAS), is directed to:

1. immediately provide the appellant with an authorization of CDPAS Personal Care Services in the amount of fifty-six (56) hours weekly (8 hours per day x 7 days per week).

2. notify the Appellant in writing of the plan's authorization increasing CDPAS Personal Care Services to (56) fifty-six hours per week (8 hours per day x 7 days per week) in compliance with this decision.

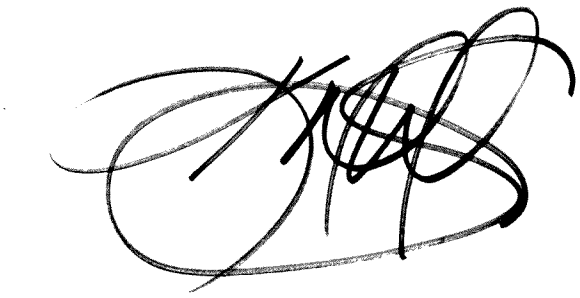
Should the Managed Care Plan Consumer Directed Personal Assistance Services (CDPAS) Centers Plan for Healthy Living, need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Managed Care Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
01/29/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee