STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 15, 2019
[redacted]
AGENCY: MAP
FH #: 8063376J

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 December 17, 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, Fair Hearing Representative

ISSUE

Was the determination by the Managed Long-Term Care plan, Center's Plan for Healthy Living, to deny the Appellant's request for an authorization to increase the Appellant's Personal Care Services from twenty-four and one-half (24.5) hours per week (3.5 hours per day x 7 days) to forty-two (42) hours per week (6 hours per day x 7 days) correct?

Was the determination by Center's Plan for Healthy Living to continue the authorization of Personal Care Services in the amount of twenty-four and one-half (24.5) hours per week (3.5 hours per day x 7 days) correct with regard to the adequacy of Medical Assistance and services

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 sixty-five (65) has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long-Term Care plan with Center's Plan for Healthy Living.

2. The Appellant resides with his nephew.

3. The Appellant had been in receipt of an authorization of Personal Care Services in the amount of twenty-four and one-half (24.5) hours per week (3.5 hours per day x 7 days).

4. The Appellant requested that the Plan provide him with an authorization to increase Personal Care Services to forty-two (42) hours per week (6 hours per day x 7 days).

5. On August 8, 2019, the Plan completed a Uniform Assessment System evaluation of the Appellant's personal care needs, and also a Person Centered Care Plan and a client task sheet, all of which are based upon an evaluation conducted by a registered nurse of the Appellant during a visit with the Appellant on said date. The task sheet recommends twenty-eight (28) hours of services per week.

6. The nurse assessor reported that the Appellant requires the following degree of need with the following activities of daily living: maximal assistance with meal preparation, ordinary housework and shopping; extensive assistance with managing medications, transportation, bathing and dressing lower body; limited assistance with personal hygiene, dressing upper body, walking, locomotion and toilet transfer.

7. The nurse assessor reported that the Appellant's status with regard to his activities of daily living has not declined as compared with 90 days prior or since the last assessment, and that the Appellant's over-all self-sufficiency has not deteriorated significantly as compared to his status 90 days prior or since the last assessment.

8. The Appellant has a medical diagnosis which includes the following: difficulty walking, dizziness and giddiness, essential (primary) hypertension, history of falling, hyperlipidemia, long term (current) use of insulin, fatigue, insomnia, pain, type 2 diabetes mellitus without complications, abnormalities of gait and mobility, osteoarthritis, and occasional urinary incontinence.

9. The Plan, by written Initial Adverse Determination Denial Notice which is dated August 12, 2019, advised the Appellant of the Plan's determination to deny the request to authorize an increase in Personal Care Services to forty-two (42) hours per week and to continue the authorization of twenty-four and one-half (24.5) hours per week unchanged as the request for an increase in services was determined to be not medically necessary.

10. The Appellant requested an internal appeal from the Plan.

11. By written denial notice, Final Adverse Determination, which is dated September 26, 2019, the Plan advised the Appellant of the Plan's determination to uphold the Plan's determination to deny the request to authorize an increase in Personal Care Services.

12. On November 15, 2109, the Appellant and his representative requested a fair hearing in this matter.

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:
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> (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
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> (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.

The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care provides, in part, that:

The assessment process should evaluate and document when and to what degree the member 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. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

The Department's Managed Care Personal Care Services (PCS) Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with Public Health Law (PHL) Article 49, 18 NYCRR 505.14 (a), the Medicaid Managed Care (MMC) Model Contract and these guidelines. As such, denial or reduction in services must clearly set forth a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically

necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

18 NYCRR 505.14(a)(5) provides 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.

(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…

(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.

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.

Pursuant to Office of Health Insurance Programs MLTC Policy 16.07, "Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services," issued on November 17, 2016, the New York State Department of Health has not approved the use of any particular task-based assessment tool. Managed Long-Term Care plans, however, are allowed to choose to use such tools as guidelines for determining an enrollee's plan

of care. In any event, if the plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.
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- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring,
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- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.
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- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight-hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

The federal Center for Medicare and Medicaid Services State Medicaid Manual states, in part, at section 4480 regarding Personal Care Services (speaking of activities of daily living, or "ADL's"):

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.

DISCUSSION

The record in this matter establishes that the Appellant requested an authorization to increase his Personal Care Services from three and one-half (3.5) hours per day, for a current total of twenty-four and one-half (24.5) hours per week to six (6) hours per day for a total of forty-two (42) hours per week. The Plan has denied the Appellant's request on the grounds that there is no medical necessity established for the requested increase.

At the hearing the Appellant contended that he needs two and one-half (2.5) additional hours per day so that his home attendant can accompany him to medical appointments at the hospital and other locations. The Appellant also testified that he has approximately three (3) medical appointments per month, on average.

At the hearing the Plan presented documentation which establishes that a registered nurse evaluator had met with the Appellant and reviewed with him his various needs for assistance with his activities of daily living and that the nurse recommended twenty-eight hours per week (4 hours per day x 7 days) of Personal Care Services. The Plan, though, did not present evidence which might explain why the Plan is only providing an authorization for three and one-half (3.5) hours per day and not the recommended four (4) hours per day.

The evidence as presented by both parties in this matter has been carefully reviewed and the contentions of the respective parties have been duly considered. The Appellant's claim of a need for an increase of Personal Care Services in the amount of two and one-half (2.5) hours per day so that he may attend approximately three (3) medical appointments per month is neither persuasive, plausible nor meritorious. It is noted that the Appellant may ask the Plan ahead of medical appointment dates of the need for a temporary increase of service hours for any particular appointment. The record, however, also fails to establish that the Plan's determination to provide an authorization for only three and one-half (3.5) hours of Personal Care Services when the Plan's registered nurse assessor recommended four (4) hours of services is correct.

In this matter, the record establishes that the Plan's determination to deny the Appellant's request for an authorization to increase Personal Care Services to forty-two (42) hours per week (6 hours per day x 7 days) is correct and must be sustained. However, the determination by Center's Plan for Healthy Living to continue the authorization of Personal Care Services in the amount of twenty-four and one-half (24.5) hours per week (3.5 hours per day x 7 days) is not correct and cannot be sustained.

DECISION AND ORDER

The determination by Center's Plan for Healthy Living to deny the Appellant's request for an authorization to increase the Appellant's Personal Care Services from twenty-four and one-half (24.5) hours per week (3.5 hours per day x 7 days) to forty-two (42) hours per week (6 hours per day x 7 days) is correct.

The determination by Center's Plan for Healthy Living to continue the authorization of Personal Care Services in the amount of twenty-four and one-half (24.5) hours per week (3.5 hours per day x 7 days) is not correct and is reversed.

Center's Plan for Healthy Living is directed to:

1. Immediately provide to the Appellant an authorization to increase the Appellant's Personal Care Services to twenty-eight (28) hours per week (4 hours per day x 7 days).

2. Continue the authorization of Personal Care Services in the amount of twenty-eight (28) hours per week (4 hours per day x 7 days) unchanged.

Should Center's 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 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 to the Managed Long-Term Care plan promptly to facilitate such compliance.

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

DATED: Albany, New York
12/23/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee