STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 13, 2018
[redacted]
AGENCY: MAP
FH #: 7807644Q

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 October 2, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Medicaid Managed Long-Term Care Plan

Debora Ferguson, Fair Hearing Specialist

ISSUE

Was the Appellant's request for a fair hearing to review the Medicaid Managed Long Term Care Plan's April 17, 2018 determination to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from 56 hours per week (8 hours per day x 7 days per week) to 24-hour, live-in (91 hours per week), timely?

Assuming the request was timely, was the Medicaid Managed Long Term Care Plan's April 17, 2018 determination to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from 56 hours per week (8 hours per day x 7 days per week) to 24-hour, live-in (91 hours per week), correct?

Was the Medicaid Managed Long Term Care Plan's determination regarding the Appellant's eligibility for Durable Medical Equipment, 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 81, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter "Plan").

2. The Appellant is currently authorized to receive 56 hours per week (8 hours per day x 7 days per week) in Personal Care Services.

3. The Appellant's diagnosed health conditions include COPD, coronary heart disease, stroke, diabetes, age-related cognitive decline, edema, hypertension, hemiplegia, insomnia, obesity, hyperlipidemia, fatigue, pain, abnormalities of gait and mobility, dizziness and giddiness, chronic atrial fibrillation, hearing loss, osteoarthritis, urinary incontinence, and severe shortness of breath.

4. On March 30, 2018, a registered nursing assessor completed a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

5. On July 27, 2018, a registered nursing assessor completed a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

6. At an unspecified date, the Appellant's Representative requested an increase in the Appellant's Personal Care Services Authorization, from 56 hours per week (8 hours per day x 7 days per week) to 24-hour, live-in (91 hours per week).

7. By Initial Adverse Determination, dated April 17, 2018, the Plan determined to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization. The notice adequately advised the Appellant of the Appellant's appeal rights, and that a fair hearing must be requested within 60 days of the date of the notice.

8. On August 13, 2018, the Appellant's son requested this fair hearing to appeal the Plan's determinations.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

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 nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

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.

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. **In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours <u>in combination with any informal support contributions</u>, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs**. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

In <u>Rodriguez v. City of New York,</u> 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.

Section 505.14(a)(4) of the Regulations provides that **live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding** and whose need 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 period of sleep.

Section 505.14(a)(2) of the Regulations provides that 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 daily of uninterrupted sleep during the aide's eight hour period of sleep.

MLTC Policy 16.07 provides, in pertinent part:

Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care.

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**.

MLTC Policy 15.09 provides, in pertinent part:

Services shall not be authorized to the extent that the individual's need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

DISCUSSION

The uncontroverted evidence in this case establishes that the Appellant, age 81, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan and is currently authorized to receive 56 hours per week (8 hours per day x 7 days per week) in Personal Care Services (hereinafter "PCS"). The Appellant's diagnosed health conditions include COPD, coronary heart disease, stroke, diabetes, age-related cognitive decline, edema, hypertension, hemiplegia, insomnia, obesity, hyperlipidemia, fatigue, pain, abnormalities of gait and mobility, dizziness and giddiness, chronic atrial fibrillation, hearing loss, osteoarthritis, urinary incontinence, and severe shortness of breath.

At an unspecified date, the Appellant requested an increase in the Appellant's PCS Authorization, from 56 hours per week (8 hours per day x 7 days per week) to 24-hour, live-in

(91 hours per week). By Initial Adverse Determination, dated April 17, 2018, the Plan determined to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization. The notice adequately advised the Appellant of the Appellant's appeal rights, and that a fair hearing must be requested within 60 days of the date of the notice.

On August 13, 2018 the Appellant's son requested this fair hearing. However, the Appellant's son's request for this fair hearing was not timely, as it was made well in excess of the 60-day Statute of Limitations ("SOL") afforded to the Appellant, which began on April 17, 2018, the date of the Plan's notice. The Appellant's son contends that at the time of the request, the Appellant was living with her daughter, who was responsible for handling these affairs because the Appellant is incapable of doing same. The Appellant's son testified that in or around July 2018, the Appellant moved in with him so that he could direct the Appellant's care and handle the Appellant's affairs. The Appellant's son contends that once the Appellant moved in with him, he called the Appellant's Care Manager at the Plan, [redacted], to ask for an increase in the Appellant's PCS hours. The Appellant's son further contends that instead of submitting a new request, the Care Manager simply mailed the prior denial notice to him, which the Appellant's daughter failed to act on, and for which he filed for this fair hearing. The Plan's Representative agreed that this was "the most likely scenario." Based on these credible and plausible claims, that the Appellant relied on her daughter who failed to act on her behalf, the SOL is properly tolled based upon good cause.

With regard to the denial, the Plan's notice stated, in pertinent part, that the determination was based on the March 30, 2018 UAS assessment and client tasking tool, which recommend PCS in the amount of 8 hours a day, 7 days a week. However, the March 30, 2018 UAS, submitted into evidence by the Plan, provides that the Appellant requires assistance with dressing upper and lower body, personal hygiene, walking, locomotion, bathing, toilet transfer, toilet use, bed mobility, meal preparation, eating, ordinary housework, and medication management. The UAS also provides that the Appellant: is incontinent of the bladder; overall self-sufficiency compared to status 90 days ago or since last UAS has "deteriorated;" "fell three times when family member slept at night;" and has severe inability to start/complete normal daily activities due to diminished energy and shortness of breath.

With regard to 24-hour care, Section 505.14(a)(4) of the Regulations provides that live-in 24-hour PCS means the provision of care by one PCA for a patient who, because of the patient's medical condition, needs assistance during a **calendar day** with toileting, walking, transferring, turning and positioning, and/or feeding. In this case, the Appellant's documented care needs establish that the Appellant qualifies for 24-hour, live-in care. The Plan is reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II PCS task is being provided, and the appropriate monitoring of a patient who suffers from cognitive impairment, while providing assistance with the performance of Level II PCS tasks, such as transferring, toileting, or walking, to assure the task is being safely completed.

With regard to the provision of 24-hour care, MLTC Policy 16.07 provides that, when it is determined that an enrollee has a need for this level of care, the Plan must "evaluate and

document when and to what extent the Appellant requires assistance with IADLs and ADLs, and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night, in order to "assure that the plan of care that is developed [for the Appellant] can meet any unscheduled or recurring daytime or nighttime needs that the [Appellant] may have for assistance." If it is determined that an enrollee has a need for 24-hour care (as is the case here), the Plan may not use task-based assessment tools to authorize or reauthorize PCS and must, instead, determine whether, and the extent to which, the Appellant's need for assistance can be met by voluntary assistance from informal caregivers. Since the Appellant does not have voluntary, informal care, the Plan's determination cannot be sustained.

With regard to the issue of the provision, or rather lack thereof, of Durable Medical Equipment, the Appellant's son submitted into evidence prescriptions from the Appellant's doctor for a portable oxygen concentrator, cane, and wheelchair. However, the Appellant's son withdrew this issue from consideration at the hearing after testifying that he called for a fair hearing because he was unsure where he should appeal the denials for these three items, presumably denied under Medicare. The Plan's Representative confirmed that there were no such requests made to the Plan, nor did the Plan issue any denials regarding same.

DECISION AND ORDER

With regard to the Plan's determination regarding the Appellant's eligibility for Durable Medical Equipment, there is no issue for the Commissioner to decide as the Appellant has withdrawn said issue from consideration in this marter.

The Plan's April 17, 2018 determination to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from 56 hours per week (8 hours per day x 7 days per week) to 24-hour, live-in (91 hours per week), is not correct and is reversed.

The Plan is directed to:

1. Immediately provide the Appellant with a Personal Care Services Authorization in the amount of 24 hour, live-in (91 hours per week).

2. Continue said authorization unchanged.

Should the 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 Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Medicaid Managed Care Plan must comply immediately with the directives set forth above.

FH# 7807644Q

DATED: Albany, New York
11/07/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee