STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 2, 2017
[redacted]
AGENCY: MAP
FH #: 7640214R

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 November 29, 2017, 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

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the September 19, 2017 determination of the Managed Long Term Care plan, Centers Plan for Healthy Living, to deny appellant's request for an increase in personal care hours, 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, aged 76, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Long Term Care plan with Centers Plan for Healthy Living (hereafter, CHL).

2. The Appellant was initially authorized to receive 84 hours per week of personal care services through CHL (12 hours per day, 7 days per week).

3. The Appellant suffers from dementia, osteoporosis, hypertension, full incontinence, insomnia, Parkinson's disease, abnormalities of gait and low levels of personal hygiene. Appellant is prescribed numerous medications to treat her various ailments.

4. On or about August 1, 2017, appellant requested an authorization for an increase in her personal care authorization from 12 hours per day to split-shift services.

5. On September 8, 2017, 2017, a Comprehensive Nursing Assessment was conducted by CHL to determine appellant's eligibility for increased personal care hours beyond the authorized 84 hours per week.

6. Thereafter, by Notice of Initial Adverse Determination, dated September 19, 2017, CHL advised the appellant that the request for an increase in personal care hours was denied on the grounds that there was no medical necessity for an increase; namely, that appellant's condition in most task areas either remained the same or improved.

7. Appellant filed an internal appeal to review the determination of CHL to deny the request for an increase in personal care hours.

8. Thereafter, Appellants' personal care service was increased to 12-hour split shift, which remained in effect for approximately 10 days. Thereafter, by notice dated October 9, 2017, CHL determined that the provision of 12 hour split shift was incorrect and, by such notice, was authorizing instead 24 hour live-in care.

9. On November 2, 2017, the Appellant requested this fair hearing, seeking the restoration of 12 hour split shift care.

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:

(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...

18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.

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. Such services must be essential to the maintenance of the patient's health and safety in his or her own home….".

(2) **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.

(4) **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.

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.

(5) 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.

(b) The authorization for Level I services shall not exceed eight hours per week.

(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.

Section 505.14(a)(3)(iii) of the regulations provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

18 NYCRR 505.14(a)(3)(iii)(b) provides, in part, that:

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers.

DISCUSSION

The appellant, aged 76, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Long Term Care plan with Centers Plan for Healthy Living (hereafter, CHL). The Appellant was initially authorized to receive 84 hours per week of personal care services through CHL (12 hours per day, 7 days per week). The Appellant suffers from dementia, osteoporosis, hypertension, full incontinence, insomnia, Parkinson's disease, abnormalities of gait and low levels of personal hygiene. Appellant is prescribed numerous medications to treat her various ailments. On or about August 1, 2017, appellant requested an increase in her personal care authorization to 12 hours per day. On September 8, 2017, 2017, a Comprehensive Nursing Assessment was conducted by CHL to determine appellant's eligibility for increased personal care hours beyond the authorized 84 hours per week. Thereafter, by Notice of Initial Adverse Determination, dated September 19, 2017, CHL advised the appellant that the request for an increase in personal care hours was denied on the grounds that there was no medical necessity for an increase; namely, that appellant's condition in most task areas either remained the same or improved. Appellant filed an internal appeal to review the determination of CHL to deny the request for an increase in personal care hours. Thereafter, Appellants' personal care service was increased to 12-hour split shift, which remained in effect for approximately 10 days. Thereafter, by notice dated October 9, 2017, CHL determined that the provision of 12 hour split shift was incorrect and, by such notice, was authorizing instead 24 hour live-in care.

There is no dispute as to appellants' nighttime needs, as the determination of CHL, in agreement with appellant, is that appellant is unable to care for herself throughout the day and night; hence, the authorization for 24 hour sleep-in service. The only issue for this hearing is whether appellant's nighttime needs are so extensive as to not allow a personal care aide to obtain the requisite 6 hours of uninterrupted sleep during the night, thereby qualifying appellant for 12 hour split shift care.

Pursuant to appellants' fair hearing request, Aid to Continue was authorized, so that appellant is currently receiving 12 hour split shift care. During the hearing, appellant's home care aide testified that she alternates with the other 12-hour aide between daily care (6 AM-6 PM) and nighttime care (6 PM – 6 AM). The aide testified that appellant has insomnia (verified by CHL's assessment) and that, once up, she remains up for most of the night. The aide further testified that when she is on duty during the nighttime shift, she rarely gets more than 3 hours of sleep, as appellant needs to use the bathroom and be cleaned (due to uncontested incontinence and inability to maintain personal hygiene) are extensive. No evidence was presented by CHL to establish that appellant's nighttime needs were not as extensive as credibly testified to.

The fair hearing record, therefore, credibly establishes appellant's need for 12 hour split shift care, as a 24 hour sleep in aide would not be able to achieve the necessary amount of uninterrupted sleep due to appellant's condition. The determination of CHL, therefore, to deny such service cannot be sustained.

DECISION AND ORDER

The determination of CHL to deny appellant's application for an increase in personal care hours is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to immediately provide the appellant an authorization of Personal Care Services in the amount of twenty-four (24) daily, "split-shift," services.
2. The Plan is directed to continue the authorization of "split-shift" services unchanged.

Should the Managed Long Term Care 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 CHL 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.

FH# 7640214R

DATED: Albany, New York
12/11/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee