STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 12, 2017
[redacted]
AGENCY: MAP
FH #: 7664480R

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 February 8, 2018, 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, Grievance & Appeals Supervisor

ISSUES

Was the Managed Long Term Care Plan determination not to immediately continue Appellant's participation in the CDPAP program with the home aide of her choice correct?

Was the Managed Long Term Care Plan's determination as to the amount of hours of Personal Care Services authorized for Appellant upon transfer to the Managed Long Term Care Plan correct?

FACT FINDINGS

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 65, has been receiving Medical Assistance (Medicaid).

2. From December, 2016 through October 31, 2017, Appellant had been enrolled in a partial capitation Managed Long Term Care Plan operated by Fidelis Care.

3. While with Fidelis, Appellant was enrolled for Personal Care Services with participation in the CDPAP program.

4. Effective as of November 1, 2017, Appellant has been enrolled in a partial capitation Managed Long Term Care Plan operated by Centers Plan for Healthy Living.

5. Appellant was initially approved by Centers Plan for Healthy Living for Personal Care Services in the amount of 12 hours a week.

6. Appellant's niece and home attendant under CDPAP was only authorized by Centers Plan for Healthy Living, effective November 29, 2017.

7. By notice dated January 28, 2018, Appellant was approved for Personal Care Services in the amount of 20 hours a week from November 29, 2017 through April 30, 2018.

8. On December 12, 2017, the Appellant requested this fair hearing. The issues were amended on the initial hearing date to reflect the Appellant's actual concerns.

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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department’s satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor’s network for as long as the Contractor is unable to provide them within the network.

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 clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. 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:

(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.

(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.

(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.

(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 specified in clause (i)(a) of this paragraph 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 of 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)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) 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.

Subsection (b) of the just-cited section of Regulations provides, in part:

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, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

18 NYCRR 505.28 (b) includes the following definitions:

…

(2) "consumer directed personal assistance" means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated directive.

…

(5) "designated representative" means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assist and to perform the consumer's responsibilities specified in subdivision (g) of this section who is willing and able to perform these responsibilities. With respect to a non-self-directing consumer, a "designated representative' means the consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

…

(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14 (a)(6) of this Part.

(d) Assessment process. When the social services district receives a request to participate in the consumer directed personal assistance program, the social service district must assess whether the individual is eligible for the program. The assessment process includes a physician's order, a social assessment and a nursing assessment and, when required under paragraph (5) of this subdivision, a referral to the local professional director or designee.

General Information system message GIS02MA/024, dated September 3, 2004, describes the scope of services under the Consumer Directed Personal Assistance Program (CDPAP) and advises that such program authorized by Social Services Law Section 465-f, enables Medicaid recipients who are eligible for home care services to have greater flexibility and freedom of choice in obtaining needed services. CDPAP participants may hire, train, supervise and discharge their aides and, in particular, my exercise greater control regarding the manner in which their aides complete the various personal task and other services for which the CDPAP participant has agreed to accept responsibility under the program.

Medicaid recipients eligible to participate in the CDPAP may need assistance with personal care services and/or other home care services. The CDPAP aide may perform home health aide and skilled nursing services when a registered professional nurse has determined that the individual who will instruct the CDPAP aide is self-directing and capable of providing such instruction. [Education Law Section 6908 (i)(a)(iii)]. The scope of services that a CDPAP aide may provide thus includes all services provided by a personal care services aide as well as all services provided by a home health aide, registered nurse, licensed practical nurse, physical therapist, occupational therapist or speech pathologist.

Accordingly, social services district's CDPAP assessments and authorizations should include the full scope of home care services that the Medicaid recipient may require and for which he or she, or his self-directing representative, agrees to be responsible under CDPAP program. When issuing an authorization, districts must include not only the personal care or home health aide services tasks with which the recipient needs assistance but also any skilled therapy or speech pathology services. The social services district should determine the amount of time required to complete a task by evaluating the task to be performed and discussing with the Medicaid recipient, or representative, the steps needed to complete the tasks. Tasks that are needed, but for which the Medicaid recipient or his or her representative is unwilling or unable to assume responsibility under CDPAP may be provided through another source.

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."

The Department's MLTC Policy 13.03:

The Partnership Plan terms and conditions (28 (d)) require:

Each enrollee who is receiving community-based long-term services and supports, as specified below, that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later.

Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R . § 438.404, mailed at least ten days before the proposed effective date of the change (as required by 42 C.F.R. § 431.211), that clearly articulates the enrollee's right to file an internal appeal (either expedited, if warranted, or standard), the right to have authorized services continue pending the resolution of the internal appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the internal appeal.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits 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.

DISCUSSION

The record discloses that from December, 2016 through October 31, 2017, Appellant had been enrolled in a partial capitation Managed Long Term Care Plan operated by Fidelis Care. While with Fidelis, Appellant was enrolled for Personal Care Services with participation in the CDPAP program. Effective as of November 1, 2017, Appellant has been enrolled in a partial capitation Managed Long Term Care Plan operated by Centers Plan for Healthy Living. Appellant's niece and home attendant under CDPAP was only authorized by Centers Plan for Healthy Living, effective November 29, 2017. This hearing was requested in part to review the delay in approving Appellant's niece.

The record also discloses that Appellant was initially approved by Centers Plan for Healthy Living for Personal Care Services in the amount of 12 hours a week. Appellant's niece stated this was not the amount approved by the prior Managed Long Term Care Plan under Medicaid immediately before the switch to Centers Plan. This hearing was requested in part for review of that allegation.

Regulations and policy are clear that a new MLTCP is supposed to maintain the prior hours of Personal Care Services until it can make its own determination, in which case a proper notice as to the change should be issued. It is uncontested that immediately prior to enrollment with Centers Plan, Appellant was receiving Personal Care Services with participation in the CDPAP program, and with her niece as the designated hired and paid caregiver. It is also uncontested that Appellant's niece was only authorized by Centers Plan, effective as of November 29, 2017. The 28 day gap was not proper.

With Appellant's niece's testimony that she did provide care for Appellant from November 1 through 28, there remains an active issue for the Commissioner to review. Centers Plan for Healthy Living can not be upheld here.

The record also discloses that Appellant was initially approved by Centers Plan for Healthy Living for Personal Care Services in the amount of 12 hours a week. Appellant's niece stated this was not the amount approved by the prior Managed Long Term Care Plan under Medicaid immediately before the switch to Centers Plan.

Centers Plan's records, provided at the hearing, state Appellant was receiving 12 hours a week, 6 hours a day, 2 days a week, through Fidelis immediately prior to the transfer. Appellant's niece presented a letter from her home care agency, but not Fidelis, stating she was working 25 hours a week. However, the letter said nothing about how many hours were actually authorized and paid for as well as who was paying for what. The niece could have been working without pay or be paid by someone else during some of those hours. The Appellant's niece also showed a tendency to exaggerate in her testimony. On the initial hearing date, the niece was insistent she was working and getting paid for **30** hours a week, immediately prior to the transfer. Without clear proof Appellant was authorized by Fidelis for more than 12 hours a week immediately prior to the transfer, Centers Plan's initial determination as to hours must be upheld.

DECISION AND ORDER

The Managed Long Term Care Plan's determination initially approving Personal Care Services in the amount of 12 hours weekly for Appellant is correct.

The Managed Long Term Care Plan's determination not to approve Appellant's niece as Appellant's home attendant under the CDPAP program until November 29, 2017 is not correct and reversed.

1. The Managed Long Term Care Plan shall process time sheets for November 1 through November 28, 2017 for time worked by Appellant's niece and issue (or arrange for the issuance of) appropriate payment.

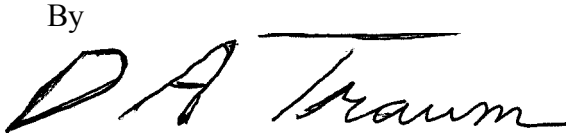
Should the Managed Long Term Care Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and Appellant's provider promptly in writing as to what documentation is needed. If such information is required, the Appellant must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

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
02/23/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee