STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 6, 2017
[redacted]
AGENCY: MAP
FH #: 7623933Q

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 17, 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 ("Centers Plan for Healthy Living")

A. Jacobs, Fair Hearing Representative

ISSUE

Was the August 15, 2017 determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the request for an increase in personal care service hours from 48 hours per week (eight hours per day, six days per week) to 60 hours per week (10 hours per day, six days per week) correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 71, has been enrolled in a Managed Long Term Care Program and has been receiving care and services, including Personal Care Services, through a Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

2. On July 31, 2017, a nurse from Centers Plan for Healthy Living completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs, and recommended that the Appellant receive personal care services in the amount of 48 hours weekly.

3. The Appellant requested that her personal care hours be increased to 60 hours per week (10 hours per day, six days per week).

4. On August 15, 2017, Centers Plan for Healthy Living issued its "Initial Adverse Determination" notice that stated that the Plan denied the Appellant's request for an increase in personal care services hours from 48 hours per week (eight hours per day, six days per week) to 60 hours per week (10 hours per day, six days per week) because the requested increase in health care service is not medically necessary.

5. On October 6, 2017, the Appellant requested the present hearing.

APPLICABLE LAW

Part 438 of 21 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 21 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. A. (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. i. (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 21 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 21 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 21 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 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.

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(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

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(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.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

Section 505.14(b)(5) of the Regulations provides in pertinent part that the social services district's determination to deny, reduce, or discontinue personal care services must be stated in the client notice. Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

> (i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;

(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;

(iii)the client is not self-directing and has no one to assume those responsibilities;

(iv)the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

(v) the client refused to cooperate in the required assessment;

(vi)a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(ix)the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

(x) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

(xi)the client refused to cooperate in the required reassessment;

(xii) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(xiii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services, and;

(xiv) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify.

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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a. II. Authorization and Notice Requirements for Personal Care Services

a. Standards for review. Requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate 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.

b. Timing of authorization review.

i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).

ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

c. Determination Notice. Notice of the determination is required whether adverse or

not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).

d. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;

ii. that were requested by the Enrollee or his/her designee, if so specified in the request;

iii. that are authorized for the new authorization period, and;

iv. the original authorization period and the new authorization period, as applicable.

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice**,** which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

i. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).

ii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.

iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social

circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

2. a mistake occurred in the previous personal care services authorization;

3. the member refused to cooperate with the required assessment of services;

4. a technological development renders certain services unnecessary or less time consuming;

5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;

6. the member's health and safety cannot be reasonably assured with the provision of personal care services;

7. the member's medical condition is not stable;

8. the member is not self-directing and has no one to assume those responsibilities;

9. the services the member needs exceed the personal care aide's scope of practice.

Section 438.210 of 21 CFR Subpart D states in pertinent part that services shall 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.

GIS 03/MA 03 states in pertinent part that 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. When the district, in accordance with 505.14 (a)(4), has 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.

DISCUSSION

The evidence establishes that on August 15, 2017, Centers Plan for Healthy Living issued its "Initial Adverse Determination" notice that stated that the Plan denied the Appellant's request for an increase in personal care services hours from 48 hours per week (eight hours per day, six days per week) to 60 hours per week (10 hours per day, six days per week) because the requested

increase in health care service is not medically necessary.

Centers Plan for Healthy Living's July 31, 2017 Uniform Assessment System (UAS) report states that the Appellant's diagnoses include coronary heart disease, chronic pain syndrome, essential hypertension, hyperlipidemia, hypothyroidism, lower back pain, overactive bladder, primary osteoarthritis, and unspecified abnormalities of gait and mobility. The report states that the Appellant is totally dependent on others to prepare meals, perform housework, manage finances, manage medications, shopping, and locomotion. She requires maximal assistance with climbing stairs, transportation, bathing, personal hygiene, dressing upper body, dressing lower body, walking, toileting, transferring to toilet, bed mobility, and eating. She is frequently incontinent of her bladder and bowel. The UAS report also states that the Appellant ambulates with rolling-seated walker indoors and with a wheelchair outdoors; she requires locomotion by wheelchair. The report states that the Appellant requires assistance with ADLs and IADLs due to right-side hemiparesis. The report further states the Appellant's son pre-pours the Appellant's medications weekly and the Appellant's partner administers medication daily.

The July 31, 2017 UAS report lists the Appellant's diagnoses as COPD, coronary heart disease, stroke, hemiplegia and hemiparesis, unspecified abnormalities of gait and mobility, unspecified urinary incontinence, fecal urgency, hyperlipidemia, and insomnia.

At the hearing, the Appellant's representative presented a letter dated October 25, 2017 from [redacted] that states that the Appellant has been diagnosed with cerebral infarction, epilepsy, gastro-esophageal reflux disease without esophagitis, essential primary hypertension, pure hypercholesterolemia. The letter states that the Appellant is unable to walk long distances and perform activities of daily living without assistance due to being bed confined. The Appellant has an increased risk of falling due to her medical condition.

At the hearing, the Appellant's witness (Appellant's son) stated that the Appellant's aide arrives at 9 am and leaves at 5pm. He stated that the Appellant cannot raise herself up from a sitting position to a standing position, and that she requires assistance of others to raise her body from a sitting position to a standing position. He stated that the Appellant uses a walker to ambulate. However, the Appellant's aide assists the Appellant while she walks because she is weak and she is unable to use her right arm due to hemiplegia; hence, the Appellant cannot maneuver the walker with only one arm. The Appellant's witness testified that the Appellant's aide bears the Appellant's weight while she is walking. The Appellant's witness stated that the Appellant takes water pills which causes the Appellant to urinate frequently and that she urinates approximately two to three times per hour. He testified that the Appellant's aide assists the Appellant with transferring to the toilet, and that her aide also assists the Appellant with cleaning herself after toileting including changing pads and adult diapers. Furthermore, the Appellant's witness stated that the Appellant had a stroke in her brain and that subsequently, she had seizure-like occurrence that caused her arm to become weaker; consequently, she cannot lift utensils to her mouth so she requires assistance with eating. He stated that the Appellant also requires assistance with showering because she cannot use her right hand due to hemiplegia.

Moreover, the Appellant's witness stated that the Appellant requires additional assistance

with toileting including incontinent care. The July 31, 2017 UAS report states that the Appellant requires maximal assistance with toileting and transferring. The report also indicates that the Appellant has hemiplegia. The Appellant's son credibly testified that the Appellant cannot use her right arm consequent to the hemiplegia. Due to reason, the Appellant requires assistance with transferring to the toilet because she needs both hands to ambulate with her walker and she requires assistance with toileting including cleaning herself after toileting and applying pads and adult diapers. The evidence establishes that additional personal care services are required to meet the Appellant's need for assistance with toileting. Therefore, an allotment of an additional 30 minutes for per week for toileting is appropriate to meet the Appellant's need.

The Appellant's witness stated that the Appellant requires additional assistance for ambulating. The July 31, 2017 UAS report states that the Appellant requires maximal assistance with walking and that she is totally dependent on others for locomotion. The Appellant's son credibly testified that the Appellant cannot use her walker because she cannot use her right arm consequent to the hemiplegia. Hence, the aide assists the Appellant while walking and the aide bears the Appellant's weight while assisting the Appellant. The evidence establishes that additional personal care services are required to meet the Appellant's need for assistance with ambulating. Therefore, an allotment of an additional 255 minutes for per week for toileting is appropriate to meet the Appellant's need.

The Appellant's witness stated that the Appellant requires additional assistance with tasks such as showering, eating, ambulating, and most activities that are performed by using an person's arms such as personal hygiene, skin care, and shampooing. Center Plan for Healthy Living's task-based assessment tool shows that the Plan allocated 10 minutes per day for personal hygiene; the Plan provided 26 minutes daily for showering, but it did not provide any time for shampooing or skin care. The evidence establishes that additional personal care services are required to meet the Appellant's need for assistance with personal hygiene, skin care, and shampooing. Therefore, an allotment of an additional 30 minutes per week for personal hygiene, an additional 30 minutes per week for shampooing, and an additional 60 minutes per week for skin care is appropriate to meet the Appellant's needs.

The Appellant's witness credibly testified that the Appellant requires additional assistance with eating because she is unable to lift utensils toward her mouth. Thus, the evidence in this case establishes that an allotment of an additional 60 minutes per week for eating is appropriate to meet the Appellant's need.

The July 31, 2017 UAS report states that the Appellant is frequently incontinent of bladder and bowel, and that she wears incontinent pads. Center Plan for Healthy Living's task-based assessment tool does not indicate that the Plan authorize personal care services for unscheduled/unpredictable needs. GIS 03/MA 03 provides that, in addition to scheduled needs, a patient's unpredictable needs (unscheduled) must be met. The evidence establishes that an additional allotment of 255 for unscheduled needs is appropriate to meet the Appellant's unpredictable needs.

Based on the evidence presented at the hearing, the record establishes that the Appellant

is entitled to an increase of 12 hours weekly, which results in personal care service hours of 60 hours weekly (10 hours per day, six days per week). Accordingly, Centers Plan for Healthy Living' determination cannot be sustained.

DECISION AND ORDER

The August 15, 2017 determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the request for an increase in personal care service hours was not correct and is reversed. Centers Plan for Healthy Living is directed to:

1. Authorize the Appellant for personal care services of 60 hours weekly (10 hours per day, six days per week).

2. Notify the Appellant and Appellant's representative of its compliance with this Decision.

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

DATED: Albany, New York
12/27/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee