STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 10, 2019
[redacted]
AGENCY: MAP
FH #: 8025670L

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 4, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long-Term Care Plan

Deborah Ferguson , Fair Hearing Representative

ISSUE

Was the determination by the Managed Long-Term Care plan, Centers Plan for Healthy Living, to continue to provide the Appellant with an authorization of Personal Care Services in the amount of thirty-one and one/half (31.5) per week and not to provide the Appellant with an authorization for forty-nine (49) hours per week (7 hours per day x 7 days) correct with regard to the adequacy of Personal Care Services, 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 [redacted], has been in receipt of a Medical Assistance authorization, Medicaid benefits, and has been enrolled in a Medicaid Managed Long-Term Care plan with Centers Plan for Healthy Living.

2. The Appellant has been in receipt of a Personal Care Services authorization in the amount of thirty-one and one-half (31.5) hours per week.

3. The Plan completed a Uniform Assessment System report based upon an evaluation of the Appellant's Personal Care Service needs by a registered nurse assessor who met with the Appellant on said date.

4. The Plan completed a Client Task Sheet which is dated May 6, 2019, and which recommends 31.5 hours of weekly Personal Care Services.

5. The Appellant has made no request of the Plan for an authorization to increase her Personal Care Services.

6. On September 10, 2019, the Appellant requested a fair hearing in this matter.

7. On October 28, 2019, the Plan completed a Uniform Assessment System report and a Client Task Sheet, which reports are based upon an evaluation of the Appellant's Personal Care Service needs by a registered nurse assessor who met with the Appellant on said date.

APPLICABLE LAW

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.

The Department's Managed Care Personal Care Services (PCS) Guidelines dated May 2013 advises that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with Public Health Law (PHL) Article 49, 18 NYCRR 505.14 (a), the Medicaid Managed Care (MMC) Model Contract and these guidelines. As such, denial or reduction in services must clearly set forth a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care (published May 31, 2013), Section III (Authorization and Notice Requirements for Personal Care Services) subsection d (Level and Hours of Service), requires that 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.

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.

18 NYCRR 505.14(a)(5) provides that:

Personal care services include, but are not necessarily limited to, the following:

(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.

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 in combination with any informal support contributions, 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.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. 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.

Completing accurate and comprehensive assessments is essential to safe and adequate care plan development and appropriate service authorization. Adhering to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

GIS 15 MA/24, published on December 31, 2015, advises of the revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR section 505.14 and 18 NYCRR section 505.28, and notes the following changes:

The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

Appellant right to fair hearing and appeal rights: 42 CFR section 438.402 (c)(1)(i) and 438 (f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld. 42 CFR section 438.402 (c)(1)(i)(A), 438.408 (c)(3) and 438.408 (f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applied when: an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan; an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State – specified timeframes; or a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR section 438.408. 42 CFR section 438.408 (f) (2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing. Pursuant to 42 CFR section 438.424 (a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

DISCUSSION

The record in this matter establishes that the Appellant is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living and has been in receipt of an authorization of Personal Care Services in the amount of thirty-one and one-half (31.5) hours per week. The Appellant requested a fair hearing for the purpose of seeking an authorization from the Plan to increase her Personal Care Services to seven (7) hours per day, seven (7) days per week for a total of forty-nine (49) weeks hours of services.

At the hearing it was established that the Appellant has made no request of the Plan for an authorization increasing the number of weekly Personal Care Service hours. The Appellant

testified at the hearing that she has spoken to the provider of services about wanting more hours and acknowledged that she has not contacted the Plan about her need for more hours of services.

The record therefore establishes that the Appellant's fair hearing request in this matter is premature.

The Appellant is advised that she may make a request of the Plan for an authorization to increase her Personal Care Services and that, if the Plan denies same, she may also request an internal appeal. The Appellant is also advised that, should the Plan make a final determination to deny an authorization for a requested increase of services, the Appellant may then request a fair hearing.

DECISION

There is no issue to resolve regarding the determination by Centers Plan for Healthy Living to continue to provide the Appellant with an authorization of Personal Care Services in the amount of thirty-one and one/half (31.5) per week, as the Appellant's fair hearing request is premature in this matter.

DATED: Albany, New York
11/08/2019

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee