STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 3, 2019
[redacted]
AGENCY: MAP
FH #: 7989183L

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 July 30, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the June 21, 2019 Initial Adverse Determination and the June 26, 2019 Final Adverse Determination of the Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny appellant's request for an increase in personal care service hours from forty-nine (49) hours weekly (i.e., 7 hours daily, 7 days weekly) to eighty-four (84) hours weekly (i.e., 12 hours daily, 7 days weekly) 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 64 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.

2. The Appellant is currently authorized to receive 49 hours weekly of personal care services (i.e., 7 hours daily, 7 days weekly).

3. The Appellant's diagnosed health conditions include: [redacted].

4. The Appellant requested an increase in the personal care hours, claiming a need for eighty-four (84) hours weekly (i.e., 12 hours daily, 7 days weekly) of personal care assistance. At the time of the Appellant's request the Appellant had been receiving 49 hours of weekly personal care services times (i.e., 7 hours daily, 7 days weekly).

5. On April 23, 2019, the plan completed a Client Task Sheet which found that the Appellant requires personal care services in the amount of 49 hours weekly.

6. On April 23, 2019, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview the Appellant by a registered Nurse Assessor on April 23, 2019.

7. On June 18, 2019, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview the Appellant by a registered Nurse Assessor on June 17, 2019.

8. On June 18, 2019, the plan completed a Client Task Sheet which found that the Appellant requires personal care services in the amount of 49 hours weekly.

9. By Notice of Initial Adverse Determinations, dated June 21, 2019 and by Notice of Final Adverse Determination dated June 26, 2019 the plan advised the appellant that the request for an increase in personal care hours to eighty-four (84) hours weekly was denied on the grounds that "the health care service is not medically necessary."

10. On July 3, 2019, the Appellant requested this fair hearing.

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 Public Assistance, HEAP, SNAP benefits, 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 some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. 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:

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.

In Rodriguez v. City of New York, 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.

DISCUSSION

The record in this matter establishes that the Appellant's Managed Long-Term Care plan, Centers Plan for Healthy Living, has authorized Personal Care Services to the Appellant in the amount of forty-nine (49) hours weekly (i.e., 7 hours daily, 7 days weekly). The record also establishes that the Appellant requested an increase of Personal Care Service hours to eighty-four (84) weekly (12 hours daily, 7 days weekly). The Managed Long-Term Care Plan, by Initial Adverse Determination dated June 21, 2019 and by Final Adverse Determination dated June 26, 2019 denied the Appellant's request for an increase in personal care services. The Appellant requested this fair hearing.

At the hearing the Managed Long-Term Care Plan entered into evidence the Initial Adverse Determination dated June 21, 2019 which states:

"…On 06/21/2019, Centers Plan for Healthy Living decided to deny this service because the health care service is not medically necessary.

The request for Personal Care Aide Level 2, 12 Hours/Day – 7 day(s) per week – Total of 84 Hours per week was denied. This decision was based on:

You requested an increase in your Personal Care Aide (PCA) Services because you need more help throughout the day with eating, dressing, toileting, and walking. A Registered Nurse from Centers Plan for Healthy Living visited you in your home on 6/17/2019 and completed a face-to-face assessment using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs.

Based on this assessment, it was identified that:

You can transfer on and off the toilet with assistance.

You are able to verbalize an emergency plan.

You are able to direct your own care.

You have a tub chair and shower grab bars to assist with showering.

You use a walker to ambulate.

You currently receive Meals on Wheels.

To best meet your needs, your Care Management team has:

Recommended Personal Emergency Response System, which you accepted.

Recommended incontinence supplies (pull ups, diapers), however you declined.

Your requested increase in Personal Care Aide Services, along with your recent UAS-NY assessment, was thoroughly reviewed by Centers Plan for Healthy Living. Based on clinical documentation presented, your current Personal Care Aide Services of seven (7) hours per day, seven (7) days per week (totaling forty-nine (49) hours per week) are appropriately and safely meeting your personal care needs. Therefore, your Personal Care Aide Services will remain the same. Centers Plan for Healthy Living will continue to assess your health care needs. If you have any questions regarding your care, your Care Management team is available to assist at 1-855-270-1600 (toll free), seven (7) days a week, 8 AM-8PM."

See MLTC Plan Exhibit 1, Notice of Initial Adverse Determination dated June 21, 2019.

A review of the Managed Long-Term Care Plan's Uniform Assessment System New York Comprehensive Community Assessment Report dated June 17, 2019 indicates that the Appellant requires:

Total dependence with:
Meal preparation
Ordinary housework
Shopping
Eating

Maximal assistance with:
Managing medications
Bathing
Personal hygiene
Dressing upper body
Dressing lower body

Transportation
Bed mobility
Toilet use

Extensive assistance with:
Phone use
Walking
Locomotion
Transfer toilet

Bladder continence: Occasionally incontinent
Bowel continence: Continent

See MLTC Plan Exhibit 10, Uniform Assessment System-New York Comprehensive Community Assessment Report dated June 17, 2019.

At the hearing the Appellant's Representative, who is the Appellant's wife, credibly testified that the main reason for the need for an increase in Personal Care Service hours is due to the Appellant's [redacted]

The Appellant Representative who is the Appellant's wife further contended that the Appellant, who is 64 years old, resides with her, however she works full time, that the Appellant requires an increase in personal care services not merely for safety supervision, but rather to assist the Appellant in daily activities on the grounds of recently having a [redacted]. The Appellant's wife testified that the [redacted].

Lastly, the Appellant's wife stated that because of the Appellant's increased deterioration of [redacted] problems: [redacted].

The record shows that the Appellant has had an increase in weakness of the muscles due to his [redacted] diagnosis resulting in requiring an increase in all activities of daily living, including bathing, dressing, toileting, ambulating, personal hygiene, meal preparation, ordinary housework, transferring to toilet, and eating. In light of same, the Appellant's wife credibly testified that the Appellant requires an increase in assistance to perform tasks of daily living such as transfer to the toilet, bathing and personal hygiene. The Appellant Representative presented medical documentation in support of these claims. It is undisputed that the Appellant requires Personal Care Services on a daily basis.

It is noted that provision of "span of time" for the adequate and successful completion of all activities of daily living may be provided in order to ensure that the Appellant is receiving the requisite services. In this matter the record supports the request of the Appellant for an increase

in Personal Care Services authorization to twelve (12) hours daily, seven (7) days weekly, totaling eighty-four (84) hours per week. The June 21, 2019 Initial Adverse Determination and the June 26, 2019 Final Adverse Determination of the plan to deny the Appellant's request for an authorization for the aforesaid increase in Personal Care Services was correct when made, however, in light of the new evidence submitted at the fair hearing by the Appellant Representative, cannot, therefore, be sustained.

DECISION AND ORDER

The June 21, 2019, Initial Adverse Determination and the June 26, 2019 Final Adverse 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 to eighty-four (84) per week (i.e., 12 hours daily, 7 days weekly) was correct when made, however, the plan is directed to:

1. immediately provide the appellant with an authorization of Personal Care Services in the amount of eighty-four (84) hours weekly (i.e., 12 hours daily, 7 days weekly).

2. notify the Appellant in writing of the plan's authorization increasing Personal Care Services to eighty-four (84) hours weekly (i.e., 12 hours daily, 7 days weekly) in compliance with this decision.

   Should Centers Plan for Healthy Living 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 Centers Plan for Healthy Living promptly to facilitate such compliance.

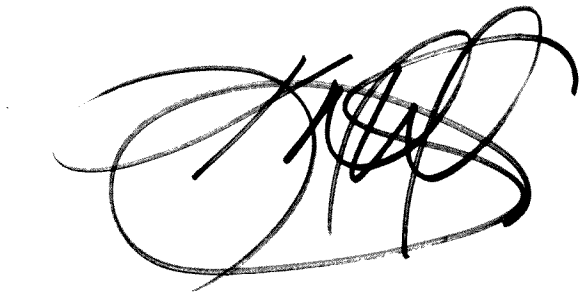
As required by 18 NYCRR 358-6.4, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

FH# 7989183L

DATED: Albany, New York
08/06/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee