STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 15, 2018
[redacted]
AGENCY: MAP
FH #: 7861878J

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 December 11, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Medicaid Managed Long Term Care Plan

Julia Rolffot, Manager of Appeals and Grievances

ISSUE

Was the determination by the Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from thirty-five (35) hours per week (7 hours per day x 5 days) to eighty-four (84) hours per week (12 hours per day x 7 days), and to partially approve the request to increase services by providing an authorization of fifty-six (56) hours per week (8 hours per day x 7 days) 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 79, has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living (hereinafter "Plan").

2. The Appellant had been in receipt of an authorization off Personal Care Services in the amount of thirty-five (35) hours per week (7 hours per day x 5 days).

3. On July 11, 2018, a registered nurse assessor conducted a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

4. On October 25, 2018, a registered nurse assessor conducted a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

5. The Appellant requested an authorization to increase her Personal Care Services from 35 hours per week (7 hours per day x 5 days) to 84 hours per week (12 hours per day x 7 days).

6. By Initial Adverse Determination, dated November 7, 2018, the Plan determined to deny the request to authorize an increase in Personal Care Services to 84 hours per week. The Plan, however, determined to authorize an increase to 56 hours per week (8 hours per day x 7 days).

7. The Appellant appealed the Plan's November 7, 2018 Initial Adverse Determination.

8. By written notice of Final Adverse Determination which is dated November 12, 2018, the Plan upheld the plan's determination to authorize 56 weekly hours of Personal Care Services and deny an authorization of 84 weekly Personal Care Services.

9. The Appellant is currently authorized to receive 56 hours per week (8 hours per day x 7 days) in Personal Care Services.

10. On November 15, 2018, the Appellant requested this fair hearing to appeal the Plan's determination.

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 assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

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.

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.

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.

Section 505.14(a)(4) of the Regulations provides that 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.

Section 505.14(a)(2) of the Regulations provides that 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.

MLTC Policy 16.07 provides, in pertinent part:

Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees

who are eligible for 24-hour care.

All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.

MLTC Policy 15.09 provides, in pertinent part:

Services shall not be authorized to the extent that the individual's need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

DISCUSSION

The uncontroverted evidence in this case establishes that the Appellant has been in receipt of Medicaid benefits provided through a Medicaid Managed Long-Term Care Plan. THe Appellant had, at the time of her request for an authorization to increase her Personal Care Services, been in receipt of an authorization thirty-five (35) hours per week (7 hours per day x 5 days). The Appellant, via her daughter, requested an authorization to increase her Personal Care Services to eighty-four (84) hours per week (12 hours per day x 7 days).

By Initial Adverse Determination, dated November 7, 2018, the Plan determined to deny the request for an authorization of 84 weekly hours of Personal Care Services. The Plan, however, determined to partially approve an increase of services to 56 hours per week (8 hours per day x 7 days per week). The Plan's notice stated, in pertinent part, that the determination was based on the October 25, 2018 UAS assessment and client tasking tool. On or about November 7, 2018, the Appellant's daughter appealed the Plan's November 7, 2018 Initial Adverse Determination, which the Plan upheld via Final Adverse Determination, dated November 12, 2018.

At the hearing, the Appellant's daughter/representative testified that the Appellant's Personal Care Aide (hereinafter "PCA") currently arrives at 10:00 AM and leaves at 6:00 PM, 7 days a week, based on the Plan's partial increase. The Appellant's daughter testified that she requested an increase in the Appellant's PCS hours to twelve (12) hours per day because the Appellant requires assistance until 10:00 PM each night, the time by which either she [the Appellant's daughter] or her son [the Appellant's grandson] arrives at the Appellant's home to provide overnight care. The Appellant's daughter further testified that the Appellant has been

hospitalized 3 times since the "initial request" for the increase [October 26, 2018 per the Plan's notice], the latest occurring "yesterday," meaning December 10, 2018. In support of her testimony, the Appellant's daughter submitted into evidence, a doctors letter, wherein the Appellant's physician reports, in pertinent part as follows:

> …The Appellant's [medical] condition has steadily deteriorated…[The Appellant] has advanced cancer, heart failure, and CVA [cerebrovascular accident]…mobility is seriously affected…[The Appellant] is total care, unable to turn and transfer, incontinent, unable to self-feed, has serious chronic medical conditions…[An increase] would provide prevention of unnecessary hospitalization and placement in nursing home.

With regard to the Appellant's need for assistance with Activities of Daily Living ("ADLs"), the Appellant's October 25, 2018 UAS assessment, submitted into evidence by the Plan, provides that the Appellant requires assistance with dressing upper and lower body, personal hygiene, bed mobility, walking, locomotion, bathing, toilet transfer, toilet use, meal preparation, eating, ordinary housework, and medication management. The UAS further provides that the Appellant is incontinent of the bladder, has abnormalities of gait and mobility, and suffers from dizziness and poor balance. The Plan's registered nursing assessor noted that the Appellant's decision-making capabilities have declined in the last 90 days (p. 2 of 23) and that the Appellant's overall self-sufficiency has deteriorated in the last 90 days (p. 5 of 23). In the Section F Comments (p. 5 of 23), the registered nursing assessor further noted:

> [The Appellant] has cellulitis, edema of extremities, cognitive impairment, limited rom [range of motion], lower back and leg pain, cancer and fatigue, and requires bed baths…cannot put on clothing or provide self personal hygiene…[Appellant] is wheeled by others and requires significant weight-bearing assist[ance] for transfers and bed mobility…[Appellant's] caregivers change [Appellant's] diapers [and] assist with pre-pouring medications…

With regard to 24-hour care, Section 505.14(a)(4) of the Regulations provides that live-in 24-hour PCS means the provision of care by one PCA for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, and/or feeding. In this case, the Appellant's documented care needs establish that the Appellant qualifies for 24-hour, live-in care. With regard to the provision of 24-hour care, MLTC Policy 16.07 provides that, when it is determined that an enrollee has a need for this level of care (as is the case here), the Plan must "evaluate and document when and to what extent the Appellant requires assistance with IADLs and ADLs, and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night, in order to "assure that the plan of care that is developed [for the Appellant] can meet any unscheduled or recurring daytime or nighttime needs that the [Appellant] may have for assistance."

With regard to the development of an appropriate care plan, the Plan may not use task-based assessment tools to authorize or reauthorize PCS and must, instead, determine whether, and the extent to which, the Appellant's need for assistance can be met by voluntary assistance

from informal caregivers. Here, the Appellant's daughter testified that the Appellant's PCS needs are met by voluntary assistance from the Appellant's daughter and grandson (informal caregivers) between the hours of 10:00 PM and 10:00 AM. Accordingly, since the evidence establishes that the Appellant's need for care is during the span of time from 10:00 AM through 10:00 PM each day, the Appellant's current care plan does not meet the requirements of MLTC Policy 16.07, as the Appellant is left without care between the hours of 6:00 PM and 10:00 PM.

Based on the foregoing, the Plan's determination cannot be sustained.

DECISION AND ORDER

The Plan's determination to partially deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from 35 hours per week (7 hours per day x 5 days per week) to 84 hours per week (12 hours per day x 7 days per week), is not correct and is reversed.

1. The Plan is directed to immediately provide the Appellant with a Personal Care Services Authorization in the amount of 84 hours per week (12 hours per day x 7 days) pursuant to Mayer III guidelines, such that although twenty-four (24) hour daily care is currently appropriate, the Appellant's family members have agreed to act as informal caregivers for the Appellant's overnight services/needs.

2. The Plan is directed to continue the authorization of Personal Care Services in the amount of 84 hours per week (12 hours per day x 7 days).

Should the Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Medicaid Managed Care Plan must comply immediately with the directives set forth above.

FH# 7861878J

DATED: Albany, New York
01/17/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee