STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 17, 2018
[redacted]
AGENCY: MAP
FH #: 7826552P

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 October 10, 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 ("Centers Plan for Healthy Living")

No appearance by Centers Plan for Healthy Living

ISSUE

Was the September 11, 2018 determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in personal care service hours from 32.5 hours per week (six and one-half (6.5) hours per day, five days per week) to 40 hours per week (eight hours per day, five 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 88, 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. The Appellant was in receipt of personal care services in the amount of 30 hours per

week (six hours per day, five days per week).

3. On or about July 2, 2018, the Appellant requested that her personal care hours be increased to 40 hours per week (eight hours per day, five days per week).

4. On July 27, 2018, Centers Plan for Healthy Living issued an "Initial Adverse Determination" notice that stated that the Appellant's request for an increase in personal care services has been partially approved for an additional half hour each day, five days per week. The Appellant's personal care hours increased to six and one-half hours per day, five days per week (32.5 hours per week) from six hours per day, five days per week (30 hours per week).

5. Since July 27, 2018, the Appellant has been in receipt of personal care services in the amount of 32.5 hours per week (six and one-half (6.5) hours per day, five days per week).

6. On August 21, 2018, 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.

7. On or about September 7, 2018, the Appellant appealed the Plan's July 27, 2018 determination to partially deny the Appellant's request for an increase in personal care hours to 40 hours per week.

8. On September 11, 2018, Centers Plan for Healthy Living issued a "Final Adverse Determination" notice that stated that the Appellant's request for an increase in personal care services (from 32.5 hours per week to 40 hours per week) had been denied.

9. On September 17, 2018, 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 System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

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.

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR 358-3.3(a). An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain the specific reasons for the action. 18 NYCRR 358-2.2.

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.

GIS 97 MA/033 provides that, when the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth [in the GIS message].

1.Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24 hour split shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24 hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24 hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The district should authorize services in an amount that is less than 24 hour live-in services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of live-in services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

DISCUSSION

The uncontroverted evidence establishes that On September 11, 2018, Centers Plan for Healthy Living issued an “Final Adverse Determination” notice that stated that the Appellant’s request for an increase in personal care services (from 32.5 hours per week to 40 hours per week) had been denied.

Centers Plan for Healthy Living’s August 21, 2018 Uniform Assessment System (UAS) report states that the Appellant is totally dependent on others for meal preparation, ordinary housework, and shopping. The Appellant requires maximal assistance with climbing and descending stairs and transportation; extensive assistance with managing finances and medication, bathing, personal hygiene, dressing upper and lower body, walking, locomotion,

toileting, and transferring to the toilet; and limited assistance with phone use, bed mobility, and eating. The Appellant is occasionally incontinent of bladder and bowel, and he uses pull-ups and underpads.

The UAS report states that the Appellant's overall self-sufficiency has deteriorated as compared to her status 90 days ago. The report states that the Appellant requires assistance with ADLs and IADLS due to diagnoses of osteoarthritis, unsteady gait, history of falling, and cognitive impairment. The Appellant requires weight-bearing assistance from aide when ambulating. The Appellant's aide assists him with toileting, setup help, and daily reminders to ensure medication compliance. The Appellant ambulates with a cane indoors and seat walker outdoors; however, the Appellant's representative contended that the Appellant utilizes a walker rather than a cane when ambulating indoors.

Moreover, the August 21, 2018 UAS report states that the Appellant report that he fell to the ground in his home on June 28, 2018 while trying to access his walker to ambulate. The Appellant's wife was present and she called EMS. EMS personnel cleaned the Appellant's scrape; the Appellant refused to go to the hospital for further treatment.

At the hearing, the Appellant's representative stated that the Appellant's wife was the Appellant's primary caretaker. However, due to the Appellant's wife's medical conditions, she is unable to care for the Appellant. The Appellant's representative presented a letter dated October 4, 2018 from [redacted], from [redacted] that states that the Appellant's wife is a patient of [redacted]. The letter states that the Appellant's wife has chronic health conditions including severe osteoarthritis in multiple joints, gait and balance disorder that puts her at risk of falls, and degenerative arthritis of the spine that limits her ability to bend. [redacted] states that the Appellant has significant care needs that will not improve over time; such needs include assistance with toileting, cleaning after toileting, bathing, and dressing. [redacted] states that the Appellant's wife's impairments and limitations make it difficult for her to assist his husband with his care needs on a daily basis. He further states that the Appellant's wife's caregiving responsibilities compromise the Appellant's own health and well-being. [redacted] concludes that in his medical opinion, increasing the Appellant's personal care hours is medically appropriate given the Appellant's wife's functional and health limitations that are not expected to improve.

The Appellant's representative presented a letter dated August 31, 2018 from [redacted] from [redacted]. [redacted] indicates that the Appellant is receiving care at his office. [redacted] states in pertinent part that the Appellant's medical conditions have worsened in the past few months and he has become increasingly frail. The Appellant is not able to perform ADLs and IADLs and he is dependent on home care to assist him with these activities. The Appellant's wife is also becoming increasing frail and she cannot participate in his care especially with changing him whenever h has urinary or fecal incontinence.

Policy directives (see GIS MA/033) establishes that contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. Therefore, the

Appellant's wife's prior assistance was voluntary and it cannot be coerced now whether or not she is physically capable of providing assistance to the Appellant.

The Appellant's representative contended that the Appellant requires additional assistance with ambulating, transferring, and toileting. She stated that, due to the Appellant's unsteady gait, he requires weight bearing assistance while ambulating and his medical conditions have deteriorated as stated in the UAS report. In addition, the Appellant's wife is no longer able to assist the Appellant with performing these tasks. In light of the Appellant's representative's testimony and the documentary evidence presented, the evidence establishes that an additional 90 minutes each day would be appropriate to meet the Appellant's needs. Therefore, Centers Plan for Healthy Living's September 11, 2018 determination to deny the Appellant's request for 40 hours weekly of personal care services cannot be sustained.

DECISION AND ORDER

The September 11, 2018 determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's 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 40 hours weekly.

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

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

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

FH# 7826552P

DATED: Albany, New York
10/29/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee