

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

REQUEST: November 28, 2018

AGENCY: MAP  
FH #: 7868382M

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In the Matter of the Appeal of	:
	: <b>DECISION</b>
	<b>AFTER</b>
	: <b>FAIR</b>
	<b>HEARING</b>
from a determination by the New York City	:
Department of Social Services	:

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**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 21, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



For the Managed Long Term Care Plan

Debora Ferguson, Fair Hearing Representative

**ISSUE**

Was the determination of the Appellant's Managed Long-Term Care Program provider (hereinafter "Centers Plan" or "the Plan") to deny the request, on the Appellant's behalf, for an increase in personal care services from 28 hours weekly to 84 hours 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 78, has been enrolled in a Managed Long-Term Care Program and has received care and services, including Personal Care Services, through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

2. The Appellant has been authorized to receive Personal Care Services in the amount of

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28 hours weekly (i.e. 4 hours daily, 7 days weekly.)

3. The Appellant requested an increase in the Appellant's personal care services hours to 84 hours weekly (i.e., 12 hours daily, 7 days weekly).

4. By Initial Adverse Determination, dated August 9, 2018, the Plan denied the Appellant's request.

5. By Final Adverse Determination, dated August 10, 2018, the Plan decided to not change its decision to deny the Appellant's request for an increase in the Appellant's personal care services hours from 28 hours weekly to 84 hours weekly.

6. On November 28, 2018, this fair hearing was requested.

### **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...

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.

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.

#### 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 evidence establishes that the Appellant, age 78, has been authorized to receive personal care services in the amount of 28 hours weekly (i.e., 4 hours daily, 7 days weekly). The Appellant requested an increase in the Appellant’s personal care services hours to 84 hours weekly. By Initial Adverse Determination, dated August 9, 2018, the Plan denied the Appellant’s request. By Final Adverse Determination, dated August 10, 2018, the Plan decided to not change its decision to deny the Appellant’s request for an increase in the Appellant’s personal care services hours from 28 hours weekly to 84 hours weekly. According to the plan:

*“... additional hours of [Personal Care Worker] service is not medically necessary...”* The Plan further indicated: *“[The Appellant] showed no changes in ability to perform meal preparation, ordinary housework, and personal hygiene...[The Appellant] showed improvement in ability to perform dressing upper and lower body, bed mobility (moving around in bed), walking bathing and transfer toilet...”*

Conversely, the plan concluded: *“In summary, [the Appellant] showed no changes or improvements with most of his abilities to perform physical functions: therefore, his hours remain the same...”*

According to the August 2, 2018 Uniform Assessment System – New York Community Assessment Level of Care Report, Centers Plan reports that the Appellant suffers from

[REDACTED]. The Appellant is totally dependent in meal preparation and housework and needs limited assistance for eating, dressing lower and upper body, personal hygiene, walking, locomotion, bathing, transferring to toilet, and toilet use and requires supervision for medication management. The Appellant further requires extensive assistance for transportation (including getting out of the house and using public transportation.)

According to the Client Task Sheet, the Appellant requires Total Dependence on meal preparation and ordinary housework.

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Centers Plan for Healthy Living presented a Client Task Sheet dated August 2, 2018; with the following task based plan of care is found totaling 224 minutes (4 hours per day) 28 weekly:

Dressing Upper Body	7 days weekly	5 minutes daily	(35 minutes weekly)
Dressing Lower Body	7 days weekly	5 minutes daily	(35 minutes weekly)
Personal Hygiene	7 days weekly	5 minutes daily	(35 minutes weekly)
Walking	7 days weekly	12 minutes daily	(84 minutes weekly)
Locomotion	7 days weekly	10 minutes daily	(70 minutes weekly)
Bathing	7 days weekly	20 minutes daily	(140 minutes weekly)
Transfer Toilet	7 days weekly	21 minutes daily	(147 minutes weekly)
Toilet Use	7 days weekly	35 minutes daily	(245 minutes weekly)
Eating	7 days weekly	17 minutes daily	(204 minutes weekly)
Meal preparation	7 days weekly	60 minutes daily	(420 minutes weekly)
Ordinary Housework	7 days weekly	29 minutes daily	(203 minutes weekly)
Medication Management	7 day weekly	5 minutes daily	(35 minutes weekly)

At the hearing, the Appellant's representative testified that the Appellant requires additional personal care service hours including time for preparation of meals because, as noted in the tasking tool, the Appellant is unable to prepare his own meals. The Appellant's representative further testified that Appellant requires additional hours to leave the house including attending medical appointments. The Appellant's wife is unable to assist the Appellant because she is totally disabled and receives full time care. The Appellant's daughter lives in Virginia and is unable to provide day to day assistance.

The Appellant's PCA testified that that she arrives at 9 am every day and makes breakfast for the Appellant. The PCA helps the Appellant dress and then prepares lunch for the Appellant. After 1 pm the Appellant is alone and on several occasions, has left the gas on or a pot on the stove when trying to prepare dinner.

The Appellant's representative's testimony was plausible and persuasive. Given that the Appellant requires total assistance for meal preparation, an additional 120 minutes daily and an allotment of additional 17 minutes daily for eating is reasonable.

Moreover, given that the Appellant requires some assistance with dressing and personal hygiene (totaling 15 minutes daily), an allotment of an additional 15 minutes daily is reasonable.



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In addition, given that the Appellant requires some assistance with toileting and toilet transfer (totaling 56 minutes daily), an allotment of an additional 56 minutes daily is reasonable.

Given that the Appellant requires some assistance with locomotion, an allotment of an additional 20 minutes daily for locomotion and an allotment of an additional 12 minutes daily for walking is reasonable.

Regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. In this case, the Appellant's representative has done so. While the regulations do not allow for personal care services for the stand-alone tasks of safety monitoring and fall prevention, the record in this case has been considered, and the credible evidence reflects the evaluation of the Appellant and reflects the Appellant is in need of additional assistance for meal preparation, dressing, toileting and accompanying to appointments. Although the notice at issue denied an increase in services to 84 hours weekly (i.e., 12 hours daily, 7 days weekly), credible evidence and testimony at the hearing establishes that the plan's determination not to increase the Appellant's personal care services is not correct.

The record has been considered. Pursuant to GIS 03 MA/003, the Plan must develop a care plan that meets the Appellant's scheduled and unscheduled day and nighttime needs during the span of time in which those needs arise. Further, the Regulations provide that the Plan may take into consideration any informal support, but cannot require that the Appellant's daughter or the Appellant's wife's PCAs to do so. Moreover, once the aide leaves, the Appellant needs assistance with preparing meals, toileting, hygiene, locomotion and dressing during the Appellant's awake hours; the aforementioned are the same tasks the Plan has determined the Appellant needs assistance for during the already approved personal care service hours.

Therefore, there was evidence provided to establish that the Appellant hours should be increased by 240 minutes (4 hours) daily to equate an extra 28 hours weekly of care increasing the Appellant's personal care from 4 hours per day, seven days per week (28 hours per week) to eight hours per day, seven days per week (56 hours per week).

### **DECISION AND ORDER**

The determination of the Appellant's Managed Long-Term Care Plan to deny the request, on the Appellant's behalf, for an increase in personal care services is reversed.

1. The Plan is directed to provide the Appellant with a Personal Care Services Authorization in the amount of 56 hours weekly (i.e., 8 hours daily, 7 days weekly).
2. The Plan is directed to notify the Appellant, in writing, of the Plan's determination to increase the Appellant's Personal Care Services Authorization, from 28 hours weekly to 56 hours weekly.

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

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As required by Section 358-6.4 of the Regulations, VNSC must comply immediately with the directives set forth above.

DATED: Albany, New York  
01/09/2019

NEW YORK STATE  
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, consisting of several overlapping loops and strokes, positioned below the word "By".

Commissioner's Designee