STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 13, 2018
[redacted]
AGENCY: OHC
FH #: 7740252K

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 May 31, 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 ("the MLTCP")

Appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan to reduce the Appellant's authorization for Personal Care Services from 84 hours a week, 12 hours a day, 7 days a week, to 52.5 hours a week, 7.5 hours a day, 7 days a week, under a task based plan of care 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 92, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living . Appellant lives with her daughter, age 63, her son-in-law, age 66, and her

grandson, age 38.

2. Appellant had been in receipt of a Personal Care Services authorization in the amount of 84 hours weekly, 12 hours a day, 7 days a week, authorized under a task-based plan of care.

3. On February 12, 2018, the MLTCP completed Uniform Assessment System-NY evaluations, using the standard forms, for the Appellant's personal care needs.

4. By Initial Adverse Determination Notice dated March 21, 2018, effective April 1, 2018, the MLTCP determined to reduce the Appellant's personal care services from 84 hours a week, 12 hours a day, 7 days a week, to 52.5 hours a week, 7.5 hours a day, 7 days a week, under a task based plan of care.

5. On April 13, 2018, the Appellant requested this fair hearing.

6. On or about April 17, 2018, an internal appeal was requested on behalf of Appellant.

7. On May 15, 2018, by Final Adverse Determination Notice, Centers Plan upheld its prior determination to reduce Personal Care Services.

APPLICABLE LAW

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 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.

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:

(2) 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.

(4) 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.

(5) 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.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

Subsection (b) of the just-cited section of Regulations provides, in part:

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

I. Scope of the Personal Care Benefit

(a) vii. Personal care services includes some or total assistance with:

1. Level I functions as follows:
    a. Making and changing beds ;
    b. Dusting and vacuuming the rooms which the member uses;
    c. Light cleaning of the kitchen, bedroom and bathroom;
    d. Dishwashing;
    e. Listing needed supplies;
    f. Shopping for the member if no other arrangements are possible;
    g. Member's laundering, including necessary ironing and mending;
    h. Payment of bills and other essential errands; and
    i. Preparing meals, including simple modified diets.
2. Level II personal care services include Level I functions listed above and the following personal care functions:
    a. Bathing of the member in the bed, the tub or the shower;
    b. Dressing;
    c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
    d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
    e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
    f. Transferring from bed to chair or wheelchair;
    g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
    h. Feeding
    i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
    j. Providing routine skin care;
    k. Using medical supplies and equipment such as walkers and wheelchairs; and
    l. Changing of simple dressings….

III. Authorization and Notice Requirements for Personal Care Services

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.

ii. 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).

iii. 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.

iv. 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.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

In fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The record discloses that the Appellant, age 92, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living . By Initial Adverse Determination Notice dated March 21, 2018, effective April 1, 2018, the MLTCP determined to reduce the Appellant's personal care services from 84 hours a week, 12 hours a day, 7 days a week, to 52.5 hours a week, 7.5 hours a day, 7 days a week, under a task based plan of care. On or about April 17, 2018, an internal appeal was requested on behalf of Appellant. On May 15, 2018, by Final Adverse Determination Notice, Centers Plan upheld its prior determination to reduce Personal Care Services.
The Appellant's representatives requested this hearing to challenge Centers Plan's determination to reduce hours.

NYS Department of Health Guidelines lists nine appropriate reasons for reducing Personal Care Services authorized under Mainstream Managed Care or Managed Long-Term Care. Centers Plan did not cite any of the listed reasons in either its initial or final determination. This constituted a serious violation of State policy and would, on its own, require reversal of the MLTCP's determination.

The record otherwise does not give conclusive support to Centers Plan's determination that Appellant needs fewer hours of care. The February, 2018 nurse assessment found Appellant's self-sufficiency and ADL (activities of daily living) level remain the same as before. The Appellant is only alert and oriented x 2, with a memory problem. Appellant has been diagnosed with Alzheimer's Disease, CVA, coronary heart disease, congestive heart failure, depression, allergic rhinitis, angina pectoris, cerebral infarction, hearing loss, vision loss, dizziness & giddiness, constipation, edema, hypertension, GERD, hypokalemia, muscle weakness, pain, shortness of breath. These diagnoses include serious, chronic conditions likely to continue to limit Appellant, particularly at her advanced age. In the February, 2018 nurse assessment, Appellant was found to need total assistance with housework, meal preparation, finances, and

shopping, and maximal assistance with medications, phone use, stairs, transportation, bathing, hygiene, dress upper and lower body, locomotion, transfer toilet, toilet use, bed mobility, and eating.

The burden of proof was on Centers Plan to show that its reduction was justified. Centers Plan however failed to meet its burden. The MLTCP can not be upheld here.

DECISION AND ORDER

The Appellant's Managed Long Term Care Plan's determination to reduce the Appellant's Personal Care Services authorization from 84 hours a week, authorized over 7 days weekly, to 52.5 hours a week, authorized over 7 days weekly, is not correct and is reversed.

1. The MLTCP is directed to withdraw its determination and to restore Appellant's Personal Care Services to the amount of 84 hours weekly, 12 hours a day, 7 days a week, authorized under a task-based plan of care.

2. The MLTCP is further directed to continue to authorize Personal Care Services to the Appellant in the amount of 84 hours weekly, 12 hours a day, 7 days a week, authorized under a task-based plan of care over 6 days weekly, and to notify Appellant upon compliance with this fair hearing decision.

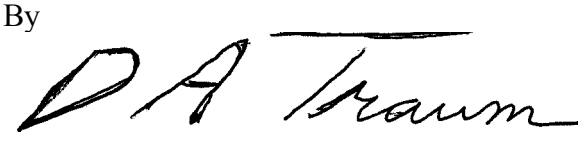
Should Centers Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it promptly to facilitate such compliance.

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

DATED: Albany, New York
06/13/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee