STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 29, 2019
[redacted]
AGENCY: MAP
FH #: 7952622Y

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 23, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan for Healthy Living

[No appearance by Centers Plan for Healthy Living]

ISSUE

Was the determination of Centers Plan for Healthy Living (hereinafter referred to as the Plan) to deny the Appellant's application for an increase in the number of Personal Care Services hours to 8 hours per day, 7 days per week, correct?

FACT FINDING

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, who is 85 years old, is in receipt of Medical Assistance from Centers Plan for Healthy Living, a Managed Long Term Care (MLTC) Partial Cap Plan.

2. The Appellant has been in receipt of Personal Care Services in the amount of 28 hours per week, at the rate of 4 hours per day, 7 days per week.

3. On March 21, 2019, the Plan completed a Uniform Assessment System - UASNY Assessment Report as part of a routine reassessment for the Appellant.

4. The Appellant applied for an increase of Personal Care Services to 56 hours weekly, at the rate of 8 hours per day, 7 days per week.

5. By notice dated April 5, 2019, Centers Plan for Healthy Living denied the request for an increase in the amount of the Appellant's Personal Care Services.

6. The Appellant requested an internal appeal, and on April 17, 2019, the Plan upheld the prior denial as per a "Final Adverse Determination Denial Notice" notice.

7. On April 29, 2019, this hearing was requested.

APPLICABLE LAW

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits 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. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

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.

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.

MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees dated July 2, 2015, provides:

For all MLTC partial capitation plan decisions made on or after July 1, 2015, that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately.
This change in policy has the following effects:

1) enrollees are no longer required to exhaust their plan's internal appeals processes before obtaining a State fair hearing;

2) aid-continuing is no longer available if the enrollee asks only for an internal appeal of a plan's proposed reduction or discontinuance of services and does not also timely request a State fair hearing;
3) to obtain aid-continuing, enrollees must request a State fair hearing within 10 days of the date of the Managed Long Term Care Action Taken notice;
4) enrollees do not need to specifically request aid-continuing to obtain it, but they may tell OTDA that they specifically decline it; and
5) the 60 day deadline to request a State fair hearing begins on the date of the Managed Long Term Care Action Taken notice.

Until further notice, this policy change applies only to enrollees in MLTC partial capitation plans. Enrollees in other MLTC products, such as MAP and PACE plans, must continue to exhaust their plan's internal appeals processes before obtaining a State fair hearing.

Personal care services means 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.

Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance. MLTC Policy 16.07.

DISCUSSION

On April 5, 2019, Centers Plan for Healthy Living denied the Appellant's application for an increase in Personal Care Services to 8 hours a day, 7 days a week.

The Appellant has been in receipt of Personal Care Services in the amount of 28 hours per week, at the rate of 4 hours per day, 7 days per week. Her diagnoses include [redacted].

On April 5, 2019, the Plan notified the Appellant that it had determined not to increase the amount of the Appellant's Personal Care Services and to continue to provide the Appellant with a Personal Care Services authorization in the amount of 28 hours weekly, on the grounds that the Appellant requested the increase in personal care services because she did not want to stay at

home alone while her daughter is at work. The Appellant appealed to the Plan, and by Final Adverse Determination, dated April 17, 2019, the Plan determined that the increase in services as not medically necessary. The Plan concluded that some of the Appellant's abilities to perform physical functioning stayed the same at limited assistance, and that there is no provision to give additional hours for companionship and safety supervision, when there are no tasks being done.

The evidence establishes that the Plan performed a nurse's assessment on September 28, 2018, and another March 22, 2019. A comparison of the two assessments establishes a decline in the Appellant's medical condition. For example, while the UASNY in September 2018 found that the Appellant was blind in one eye, by March 2019, the UASNY found that she had developed [redacted] difficulties in the other [redacted] as well. The assessments also establish that while the Appellant was independent in some ADLs in September 2018, by March 2019 she needed limited assistance for the same tasks, specifically walking, locomotion, bathing, grooming, personal hygiene, dressing upper and lower body. Although the nurse assessments indicate a decline in the Appellant's functional status between the assessments in September 2018 and March 2019, the Plan concluded that there was no change. The conclusions are inconsistent with the nurse's observations.

A review of the Agency's plan of care does not accord with the Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services, MLTC Policy 16.07. Rather than conducting an individualized assessment of the Appellant's need for assistance with IADLs and ADLs, the plan linked to the latest assessment in March 2019, simply lists services of four hours per day, Monday through Friday. Other task plans in the file relate to earlier assessments and therefore are factually irrelevant to current needs.

At the hearing, the Appellant's Representative presented medical evidence that establish a deterioration in the Appellant's medical condition and the need for more time expended for the rendering of in-home services. A letter from her treating physician dated May 9, 2019, contains the following remarks:

> [redacted] is under my medical care and was seen in my clinic on 5/8/2019. She needs her home care services increased from four hours a day to 8-10 hours per day.
> She has a h/o [redacted].
> She has severe [redacted]. As a result, her balance has gotten worse and she has fallen at least twice recently. She may also be dizzy.
> She now complains that everything has a smoky appearance. Opthomology diagnosed her with macular degeneration and it is progressing. She Needs additional supervision for vision and balance.
> ADLs needing assistance are: toileting, bathing, dressing, cooking, cleaning, and shopping.
> She can eat on her own, but needs food cut up for her. This has changed from her previous visit, when she was able to perform most ADLs on her own.
> Her [redacted] has gotten worse and the [redacted] has progressed. She curren[t]ly receives four hours per day, she needs 8 hrs a day minimum to enable her family to assist her in the evening.

In weighing the evidence, the record establishes that the Appellant is eligible for 8 hours a day, 7 days a week, Personal Care Services.

DECISION AND ORDER

The determination of Centers Plan for Healthy Living to deny the Appellant's application for an increase in the number of Personal Care Services hours to 56 hours weekly, is not correct and is reversed.

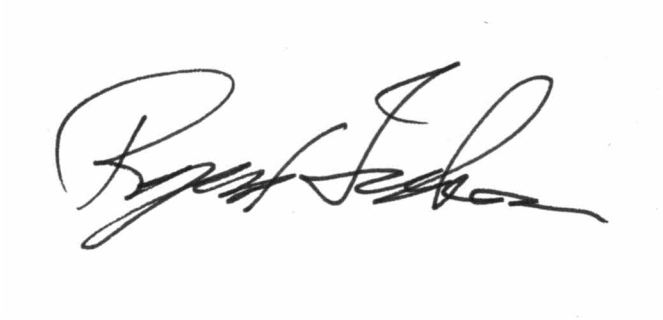
1. Centers Plan for Healthy Living is directed to provide the Appellant with 56 hours weekly Personal Care Services.

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

DATED: Albany, New York
06/14/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee