STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 31, 2019
[redacted]
AGENCY: MAP
FH #: 7904354Y

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 February 26, 2019, 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

No appearance by Plan

ISSUE

Was the Managed Long Term Care Plan's determination dated December 10, 2018 to deny the Appellant's request for an increase in personal care services hours 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, age 68 has been in receipt of a Personal Care Services authorization from a Managed Long Term Care Plan, Centers Plan for Healthy Living.

2. The Appellant resides with his wife and sister in an apartment.

3. The Appellant currently received Personal Care Services as follows: 7 days per week, 7.5 hours per day. The Appellant seeks a Personal Care Services authorization in the amount of 7 days per week, 24 hours per day/ spit shift.

4. On April 18, 2018 a nursing assessor completed a Uniform Assessment System evaluation of the Appellant's personal care needs.

5. On October 9, 2018 a nursing assessor completed a Uniform Assessment System evaluation of the Appellant's personal care needs.

6. By Initial Adverse Determination Notice dated December 5, 2018, the Managed Long Term Care Plan determined not to increase the Appellant's Personal Care Services authorization to 7 days per week, 24 hours per day/ split shift, but to continue to provide the Appellant with a Personal Care Services authorization in the amount of 7 days per week, 7.5 hours per day.

7. By Final Adverse Determination Notice dated December 10, 2018, the Managed Long Term Care Plan determined not to increase the Appellant's Personal Care Services authorization to 7 days per week, 24 hours per day/ spit shift, but to continue to provide the Appellant with a Personal Care Services authorization in the amount of 7 days per week, 7.5 hours per day.

8. By letter dated February 15, 2019, Yong Yan Cui, MD, states that the Appellant" has had multiple falls" and is "totally dependent on others for his care".

9. By letter dated February 5, 2019, Nora Vanegas-Arroyave, MD, states that the Appellant has had a decline in mobility, visions and progressive Parkinson's disease".

10. By letter dated February 25, 2019, Konstantin Zarkadas, MD, states that the Appellant's wife, needs to be "relieved of the assigned duties of caring" for her husband", "to avoid castastrophes" as she is pending a request for the same due to her declining condition.

11. On January 31, 2019, the Appellant requested this fair hearing.

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; 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.

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.

18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.

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. Such services must be essential to the maintenance of the patient's health and safety in his or her own home…."

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(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.

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

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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 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 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.

DISCUSSION

The Appellant, age 68, is in receipt of authorization for Medical Assistance, and is enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living (MLTC).

The Appellant has been in receipt of a Personal Care Services authorization from a Managed Long Term Care Plan, Centers Plan for Healthy Living. The Appellant seeks an increase in hours. The Appellant currently receives personal care services 7 days per week, 7.5 hours per day. The Appellant seeks7 days per week, 24 hours per day/ split shift.

The evidence establishes that on April 18, 2018 and again on October 9, 2018 a nursing assessor completed a Uniform Assessment System evaluation of the Appellant's personal care needs.

The evidence further establishes that by notice dated December 10, 2018, the Managed Long Term Care Plan determined not to increase the Appellant's Personal Care Services authorization but to continue to provide the Appellant with a Personal Care Services authorization in the amount of 7 days per week, 7.5 hours per day.

By letter dated February 15, 2019, Yong Yan Cui, MD, states that the Appellant" has had multiple falls" and is "totally dependent on others for his care". By letter dated February 5, 2019, Nora Vanegas-Arroyave, MD, states that the Appellant has had a decline in mobility, visions and progressive Parkinson's disease". By letter dated February 25, 2019, Konstantin Zarkadas, MD, states that the Appellant's wife, needs to be "relieved of the assigned duties of caring" for her husband", "to avoid castastrophes" as she is pending a request for the same due to her declining condition.

The credible evidence supporting the Appellant's request for an increase in hours was unrefuted by the Plan's evidence. Therefore, the Plan's determination cannot be sustained

DECISION AND ORDER

The determination of the Appellant's managed long term care plan, to deny the Appellant's request for an increase in personal care services hours is not correct and is reversed.

1. The Managed Long Term Plan is directed to authorize the Appellant to receive 7 days per week, 24 hours per day/ split shift, of personal care services authorization effective immediately.

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

DATED: Albany, New York
03/28/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee