STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 3, 2018
[redacted]
AGENCY: MAP
FH #: 7872583L

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 January 16, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

Centers Plan For Healthy Living

Deborah Ferguson, Representative, appeared for both appearances

ISSUE

Was Center Plan's determination to deny the Appellant's request for an increase in personal care services from 56 hours per week, 5 days a week, to 96 hours a week, 5 days a 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 in receipt of Medical Assistance benefits, is enrolled in a Managed Long-Term Care Plan MLTCP through Centers Plan for Healthy Living, and receives a Personal Care Services authorization for 5 days a week, 56 hours a week through CDPAS; wherein the Appellant's daughter provides hours from 6:00 am to 9:00 am, and then 6:00 pm to

11:00 pm, Monday through Friday. The daughter is asking for an attendant, not herself, to provide services from 9:30 am to 5:00 pm, Monday through Friday.

2. On or about October 17, 2018, the Appellant requested an increase in personal care services for the hours from 9:30 am to 5 pm, Monday through Friday, an additional 37.5 hours weekly.

3. On October 15, 2018, the plan conducted an assessment which indicates in most major areas of functional status that the Appellant requires maximal assistance-help throughout task, but performs less than 50% of task on own in the following categories: meal preparation, house work, shopping. The Appellant was assessed to require extensive assistance with managing finances; and total dependence for ordinary housework. ADL's such as bathing, personal hygiene, toilet use, locomotion, and dressing all activities required extensive assistance: Weight - bearing support by one helper where person still performs 50% or more of subtasks.

4. On October 31, 2018, the Plan partially denied the Appellant's request and provided an additional one hour and a half, daily, 5x a week, Monday through Friday, and determined that the additional service time was not deemed medically necessary.

5. On November 12, 2018, the plan, through an internal appeal, upheld the Agency's partial denial and provisions of the extra one hour and a half, daily, 5xs weekly, Monday through Friday.

6. On December 3, 2018, the Appellant requested this fair hearing.

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) of the Regulations provides in part that:

***

(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…

(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.

GIS 03 MA/003 provides in part:

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**.**

DISCUSSION

The Appellant, age 88, has been in receipt of Medical Assistance benefits, is enrolled in a Managed Long-Term Care Plan through Center Plan, and receives a Personal Care Services authorization for 5 days a week, 56 hours a week through CDPAP, daughter provides hours from 6:00 am to 9:00 am, and then 6:00 pm to 11:00 pm Monday through Friday. The daughter is asking for an attendant, other than herself to provide services from 9:30 am to 5:00 pm, Monday through Friday. On or about October 17, 2018, the Appellant requested an increase in personal care services for the hours from 9:30 am to 5 pm, Monday through Friday, an additional 37.5 hours weekly.

On October 15, 2018, the plan conducted an assessment which indicates in most major areas of functional status that the Appellant requires maximal assistance-help throughout task, but performs less than 50% of task on own in the following categories, meal preparation, house work, shopping. The Appellant was assessed to require extensive assistance with managing finances; and total dependence for ordinary housework. ADL's such as bathing, personal hygiene, toilet use, locomotion, and dressing all activities required extensive assistance, weight - bearing support by 1 helper where person still performs 50% or more of subtasks.

On October 31, 2018, the Plan partially denied the Appellant's request and provided an additional 1 hour and a half daily 5x a week, Monday through Friday, the services were not deemed medically necessary. On November 12, 2018, the plan through an internal appeal upheld the Agency's partial denial and provisions of the extra one hour and a half, daily 5 x weekly, Monday through Friday.

After careful review of all of the evidence presented at the hearing, it has been found that the Appellant needs substantial personal care assistance in all arears of activities and is dependent on a person for assistance concerning all mobility needs. The Appellant needs extensive assistance with feeding, cannot ambulate on her own or even shift positions while in bed without assistance. The Appellant's daughter cares for her mother 8 hours a day Monday through Friday as set forth herein, and goes to work from approximately 9:30 until 5:00 and is unable to attend to her mother's extensive needs during those hours. Furthermore, the daughter is assisting her mother throughout the night, and on the weekends. In consideration of the UAS assessment of October 15, 2018, the M11Q provided by the Appellant, doctors letter, and the nursing summary provided by the plan—these establish that the denial of the request for the additional hours was not supported by the credible evidence.

DECISION AND ORDER

The Plan's determination to deny the Appellant's request for an increase in personal care services from 37.5 hours weekly Monday through Friday from 9:30 a.m. until 5:00 p.m. is not correct and is reversed.

The MLTCP is directed to:

1. Provide the Appellant with a personal care services authorization beyond what is currently authorized to include 37.5 hours weekly Monday through Friday from 9:30 a.m. until 5:00 p.m.

Should the 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 requested, the Appellant must provide it to the plan promptly to facilitate such compliance.

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

DATED: Albany, New York
01/23/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee