STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 4, 2018
[redacted]
AGENCY: MAP
FH #: 7752242K

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 June 22, 2018, 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

Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of Centers Plan for Healthy Living to authorize Personal Care Services for Appellant in the amount of 42 hours per 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 86, who suffers from arthritis, constipation, urinary incontinence depression and unsteady gait was in receipt of Consumer Directed Personal Assistant Program (CDPAP) Authorization in the amount of 42 hours weekly (6 hours, 7 days a week) being provided by Centers Plan For Healthy Living (hereinafter referred to as the Managed Care Plan).

2. The Appellant through her Representative on April 6, 2018 requested that her Consumer Directed Personal Assistant Program (CDPAP) Authorization of 42 hours weekly be increased to 84 hours weekly (12 hours, 7 days a week).

3. On February 2, 2018, a nurse from Centers Plan For Healthy Living Plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs.

4. On August 9, 2017, a nurse from Centers Plan For Healthy Living Plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs.

5. On April 26, 2018, Centers Plan for Healthy Living denied the Appellant's request for an increase in Consumer Directed Personal Assistant Program (CDPAP) Authorization Services from 42 hours weekly to 84 hours weekly because the current Consumer Directed Personal Assistant Program (CDPAP) Authorization of 42 hours adequately meets the Appellant's needs. The Plan stated "Based on routine comprehensive NYS Department of Health Assessment System (UAS-NY that was conducted on 2/27/2018, compared to the previous UAS NY Assessment completed on 8/9/2017 , showed you have demonstrated some changes in your abilities to perform your Activities of Daily Living (ADLs) and one change in performing your Instrumental Activities of Daily Living (IADLs). The UAS-NY assessment produces a Nursing Facility Level of Care(NFLOC) score. Your NFLOC score changed from 21 on 8/9/2017 to 19 on 2/27/2018.

6. On May 4, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 358-3.1 of the Regulations provides, in part:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a right to a fair hearing if:

(3) your public assistance, medical assistance, SNAP benefits or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP or services are inadequate...

Section 358-2.21 of the Regulations provides:

Social services agency means the State, county, city, town official or town agency, social services district or HEAP certifying agency responsible for making the determination or for the failure to act, which is the subject of review at the fair hearing.

Section 4403 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.

The MLTC Contract for HomeFirst Plan, Article III.E, titled "Enrollee Protections," states, in part that the Contractor agrees to comply with federal Medicaid law and State Social Services Law as it related to due process, Articles 44 and 49 of Public Health Law and implementing regulations governing coverage determinations, grievances, and appeals. The Contractor agrees to establish a complaint and grievance resolution process and a utilization review plan and utilization review appeal process consistent with Articles 44 and 49 and 42 CFR Part 456.

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.

Federal Medicaid Managed Care Regulations at 42 CFR Section 438.400 provides in part that:

(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:

Action means--

In the case of an MCO or PIHP--

(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...

Federal Medicaid Managed Care Regulations at 42 CFR Section 438.402 provides in part that:

> (a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system...

Federal Medicaid Managed Care Regulations at 42 CFR Section 438.404 provides in part that:

Notice of action.

(a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.
(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...

Section 438.210 of 42 CFR Subpart D provides in part:

Section 438.210 Coverage and authorization of services.

(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 part:

Section 438.236 Practice guidelines.

(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.

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. The NYS Department of Health has entered into a contract (hereinafter “Contract’) with HomeFirst.

Appendix G of the Contract provides in part that personal care services are included in services which, if provided, would be covered for by the capitation rate. Appendix G of the Contract refers to Appendix J, “Definitions” for definitions and scope of services identified in

Appendix G.

Appendix J is titled “Definitions” and, provides in part:

Definitions of covered services are intended to provide general information about the level of care available through the Medical Assistance Program. The full description and scope of services specified herein are established by the Medical Assistance Program as set forth in the applicable eMedNY Provider Manual. Managed care organizations may not define covered services more restrictively than the Medicaid Program. Contractors are expected to provide services for individual Enrollees as described in each Enrollee's plan of care. Services may be provided either directly or through a sub-contract.

Personal care means some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by the Enrollee's physician and provided by a qualified person as defined in Section 700.2(b)(14) 10 NYCRR, in accordance with a plan of care.

The eMedNY Provider Manual for Personal Care Services states in part that:

> Prior to the authorization of personal care services, the local social services district, or its designee, must:
>
> • obtain an order from the patient’s physician that describes the patient’s medical condition, the personal care services required by the patient, the medication regimen, and whether or not the patient can be safely cared for in the home;
>
> • complete a social assessment to evaluate the potential contribution of informal caregivers, such as family and friends, to the patient’s care;
>
> • complete or arrange for completion of a nursing assessment that includes:
>
> ► a review and interpretation of the physician’s order,
> ► an evaluation of the functions and tasks required by the patient and the degree of assistance required for each function and task, and
> ► the development of a plan of care and a recommendation for service authorization.
> The plan of care must be a working document designed by the nurse assessor and maintained by the case manager and the provider of services. This plan must include a regimen to be followed in supervising the care provided to the patient and in the delivery of other health services.
>
> In the event that there is a disagreement between the physician's orders and/or the nursing and social assessments, or where there is disagreement over the appropriateness of the amount or level of care to be provided to the patient, the case

will be referred to the Local Professional Director or a physician designated by the Local Professional Director for review and final determination.

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) **Some or total assistance** shall be defined as follows:

(i) **Some assistance** shall mean that a specific function or task is performed and completed by the patient with help from another individual.

(ii) **Total assistance** shall mean that a specific function or task is performed and completed for the patient.

(3) **Continuous personal care services** means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

***

(5) **Live-in 24-hour personal care services** means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.

***

(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.

***

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.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

DISCUSSION

The Appellant, age 84, who suffers from heart failure, diabetes, and general body pain was in receipt of a Consumer Directed Personal Assistant Program (CDPAP) Authorization for personal care services in the amount of 42 hours weekly (6 hours, 7 days a week) being provided by Centers Plan For Healthy Living (hereinafter referred to as the Managed Care Plan).

The Appellant through her Representative on April 6, 2018 requested that her Consumer Directed Personal Assistant Program (CDPAP) Authorization of 42 hours weekly be increased to 84 hours weekly (12 hours, 7 days a week).

On February 2, 2018, a nurse from Centers Plan For Healthy Living Plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs.

On August 9, 2017, a nurse from Centers Plan For Healthy Living Plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's personal care needs.

On April 26, 2018, Centers Plan For Healthy Living advised the Appellant of its notice of initial adverse determination wherein it denied the Appellant's request for an increase in Personal Care Services from 42 hours weekly to 84 hours weekly because the current Consumer Directed Personal Assistant Program (CDPAP) Authorization of 42 hours adequately meets the Appellant's needs..

On April 26, 2018, Centers Plan For Healthy Living denied the Appellant's request for an increase in Personal Care Services from 42 hours weekly to 84 hours weekly because the current Consumer Directed Personal Assistant Program (CDPAP) Authorization of 42 hours adequately meets the Appellant's needs. The Plan stated "Based on routine comprehensive NYS Department of Health Assessment System (UAS-NY that was conducted on 2/27/2018, compared to the previous UAS NY Assessment completed on 8/9/2017, showed you have demonstrated some changes in your abilities to perform your Activities of Daily Living (ADLs) and one change in performing your Instrumental Activities of Daily Living (IADLs). The UAS-NY assessment produces a Nursing Facility Level of Care(NFLOC) score. Your NFLOC score changed from 21 on 8/9/2017 to 19 on 2/27/2018".

Personal care services are provided on a task oriented basis. The Appellant had been receiving personal care services in the amount of 42 hours weekly (6 hours a day, 7 days a week). The Appellant Representative stated that the Appellant was totally dependent for dressing, medication management, totally bladder incontinent and must have her diapers changed

every few hours and has difficulty walking. The Appellant Representative further stated that the Plan's report is factually incorrect and did not accurately report the Appellant's condition. The Appellant representative stated that the UAS and task sheet showed that the Appellant was occasionally bladder incontinent and stated that she was incontinent all the time. The Appellant Representative stated that the Appellant who is unable to with toilet, transfer and ambulate without extensive assistance also did suffer a fall recently. The Appellant's representative also presented supportive documentation from [redacted] Primary care physician recommending additional personal care hours.

At the hearing, the Managed Care Plan submitted evidence to support its decision, including a UAS return assessment reports, dated February 2, 2018 and August 9, 2017, finding the Appellant to be generally continent, oriented, and to require assistance for daily tasks. Specifically, the UAS assessment found that the Appellant was independent regarding toileting, ambulating and transferring and was being provided with assistance with bathing, cleaning, dressing, grooming, meal preparation and shopping and contended that the Appellant did not establish a need for additional personal care hours.

The record has been carefully considered. The Appellant's testimony regarding the Appellant's need for additional hours is found persuasive. According to the UASNY assessment, "Change in Appellant's ADL status as compared to 90 days ago or since last assessment if less than 90 days ago" indicates "No change." "Overall self-sufficiency of Appellant as compared to 90 days ago or since last assessment if less than 90 days ago," also indicates "No change." Furthermore a review of the assessment shows that the Appellant required additional time for ambulating and toileting. For example with bladder continence , the task sheet provided the Appellant with 20 minutes a day and was based on a 7 day period, 140 minutes a week which is were found not only to be grossly inadequate but also unreasonable based on the appellant's bladder incontinence.

Based on the particular facts and circumstances of this case, the weight of the credible evidence establishes that Centers Plan For Healthy Living should authorize Appellant to receive personal care services in the amount of 8 hours daily, 7 days a week (56 hours weekly).

DECISION AND ORDER

The determination of Centers Plan For Healthy Living not to authorize Personal Care Services for Appellant in the amount of 84 hours weekly (12 hours, 7 days a week) is not correct and is reversed.

1. Centers Plan For Healthy Living is directed to authorize Personal Care Services to the Appellant in the amount 84 hours weekly (12 hours, 7 days a week) and notify Appellant, upon compliance with this fair hearing decision.

Should the Agency 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 Agency promptly to facilitate such compliance.

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

DATED: Albany, New York
07/30/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee