STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 25, 2019
[redacted]
AGENCY: MAP
FH #: 8034439N

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 October 23, 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

Centers Plan for Healthy Living, by: Debra Ferguson, Fair Hearing Representative

ISSUE

Was the Managed Long-Term Care Plan's determination to provide Appellant with 35 hours of Personal Care Services, provided 5 hours daily, 7 days weekly 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[redacted], resides alone, and has been in receipt of a Medical Assistance authorization for Personal Care Services in the amount of 35 hours weekly, provided 5 hours daily, 7 days weekly, through Centers Plan for Healthy Living, a partially capitated Managed Long-Term Care Plan, hereinafter, "MLTCP."

2. On May 30, 2019 Appellant requested a change in the allocation of Personal Care Services from 35 hours weekly, 5 hours daily, 7 days weekly to 35 hours weekly, provided 7 hours daily, 5 days weekly.

3. On June 10, 2019 the MLTCP obtained a "Uniform Assessment System – New York Community Assessment Comments Report," hereinafter, "UAS of June 10, 2019."

4. On June 19, 2019, the MLTCP obtained the Appellant's M11-Q from his physician signed on June 12, 2019.

5. On June 19, 2019, the MLTCP obtained medical records for the Appellant [redacted].

6. By "Initial Adverse Determination," hereinafter, the "Determination," dated June 11, 2019, the MLTCP informed the Appellant that his Personal Care Service hours increased from 28 hours weekly, 4 hours daily 7 days weekly to 35 hours weekly, 5 hours daily, seven days weekly.

7. On September 25, 2019, this fair hearing was requested on the adequacy of Appellant's Personal Care Services.

APPLICABLE LAW

Social Services Law section 365-a states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

> 2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

The Medicaid Managed Care Model Contract delineates the terms by which Medicaid Managed Care Plans agree to cover specified healthcare services in accordance with New York State Medicaid Guidelines. Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

GIS 11 MA/009 provides that effective August 1, 2011, personal care services for non-dual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract.

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 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. 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.

Section 505.14(a)(3)(iii)(a) 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:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

(3) 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.

General Information Service message 97 MA 033 includes a reminder concerning "statements of understanding". The GIS Message advises that the contribution of family members or friends to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.) In New York City, the form statement of understanding is entitled "Agreement of Friend or Relative."

12 OHIP/ADM-1 states, in part:

> With regard to informal caregivers, such support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

> arranging for the delivery of personal care services according to subdivision (c) of this section….
> monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

A GIS message 99/MA/036 dated December 16, 1999, advises that on October 6, 1999, the U.S. Court of Appeals for the second circuit in Rodriguez et al v. City of New York et al (197 F.3d 611) reversed the lower court's April 19, 1999, decision in Rodriguez et al v. DeBuono et al (44 F. Supp.2d 601) that safety monitoring should be an included task in task based assessments. Therefore, safety monitoring is not an included task in task based assessments.

General Information Service Message GIS 03/MA/03, released on January 24, 2003 by the New York State Department of Health, reads as follows:

The purpose of this GIS is to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies.

Social services districts, including those using locally developed task based assessment (TBA) instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patients' appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 N.Y.C.R.R. 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patients day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

When the district, in accordance with 505.14 (a)(4), has determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patients scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physicians order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patients personal care needs.

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.

Completion of accurate and comprehensive assessments are essential to safe and adequate care plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of daily living functional potential;
- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);
- Urinary incontinence and indwelling catheter;
- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);
- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental Care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

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4480. PERSONAL CARE SERVICES

C. Scope of Services – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Section 358-5.9 of the Regulations provide in part:

(a) 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.

DISCUSSION

The record establishes that the Appellant [redacted], resides alone, and has been in receipt of a Medical Assistance authorization for Personal Care Services in the amount of 35 hours weekly, provided 5 hours daily, 7 days weekly, through the MLTCP.

The record establishes that on May 30, 2019 Appellant requested a change in the allocation of Personal Care Services to 35 hours weekly, 7 hours daily, 5 days weekly from 35 hours weekly, 5 hours daily, 7 days weekly.

The record establishes that on June 10, 2019 the MLTCP obtained the UAS of June 10, 2019.

The record establishes that on June 19, 2019, the MLTCP obtained the Appellant's M11-Q from his physician, signed on June 12, 2019.

The record establishes that on June 19, 2019, the MLTCP obtained medical records for the Appellant [redacted].

The record establishes that by the Determination, the MLTCP informed the Appellant that on June 10, 2019, his Personal Care Service hours increased from 28 hours weekly, 4 hours daily 7 days weekly to 35 hours weekly, 5 hours daily, seven days weekly. Appellant's purported request for services of 49 hours weekly, 7 hours daily, 7 days weekly was denied by the MLTCP, stating in pertinent part:

> "…You requested an increase in your Personal Care Assistance (PCA) services because you stated you need more assistance with your activities of daily living (ADL's) due to feeling of hopelessness after companion loss and due to chronic pain. A Registered Nurse from Centers Plan for Healthy Living visited you in your home on 06/10/2019 and completed a face-to-face assessment, using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs. Based on this assessment, it was identified that:
>
> You are able to walk with the assistance of cane.
> You can transfer on and off the toilet and take care of your toileting needs with some assistance.

> You can manage incontinence with the use of incontinence supplies such as underpads.
> You are able to feed yourself once your meals are prepared by your Personal Care Aide.
> You are able to direct your own care.
> You can activate a Personal Emergency Response if necessary…"

Appellant did not appeal this determination, requesting a hearing on the adequacy of his Personal Care Services instead.

At the hearing, the Appellant testified that he requested his Personal Care Services to be reallocated so that he would have 7 hours of services daily, Monday through Friday only, and that he was not asking for additional service hours for the weekends. Appellant testified that his son was now taking him to his home for the weekends so that he no longer needs services 7 days weekly. The request for reallocation of Appellant's service hours was not determined by the MLTCP.

The UAS of June 10, 2019, states Appellant's diagnoses to be as follows:

Age-related osteoporosis without
Current pathological fracture
Benign prostatic hyperplasia without lower
Urinary tract symptoms
Chest pain, unspecified
Dizziness and giddiness
Dry eye syndrome of bilateral lacrimal glands
Edema, unspecified
Essential (primary) hypertension
Gastro-esophageal reflux disease without esophagitis
Hyperlipidemia, unspecified
Insomnia, unspecified
Nicotine dependence, cigarettes, uncomplicated
Obesity, unspecified
Other abnormalities of gait and mobility
Other chronic pain
Other fatigue
Other seasonal allergic rhinitis
Primary generalized (osteo) arthritis
Shortness of breath
Unspecified asthma, uncomplicated
Unspecified hearing loss, bilateral
Unspecified urinary incontinence
Vitamin deficiency, unspecified
Weakness

(UAS of June 10, 2019, pg. 21.)

Although duly notified of the time, date and location of the hearing and the subject matter being reviewed, the MLTCP failed to present a task sheet to support their determination. The task sheet must be provided so that the tasks and allocation of task time may be evaluated. The MLTCP's failure to present a task sheet is improper.

Appellant and his home attendant testified at the hearing that since Appellant's companion of 50 years passed away in May 2019, Appellant's medical condition has deteriorated and he needs more assistance with walking, as his walking has decreased from a 12-block maximum to 3 blocks, bathing, because his movements are slower, dressing and with other ADLs. The UAS of June 10, 2019 reports that Appellant has edema, an abnormal gait and dizziness all of which impact upon his ability to take care of himself. (See UAS of June 10, 2019, p. 21.)

The Appellant has not asked for increase in weekly Personal Care Service hours, only a re-allocation of services hours. [redacted] Appellant's and his home attendant's persuasive testimony that Appellant's Personal Care Service needs have increased, and the MLTCP's failure to present a task sheet lead to a finding that Appellant is in need of 35 hours of Personal Care Services, provided 7 hours daily, 5 days weekly. It is noted that the Determination states that Appellant's care would be reviewed again in August 2019, but that no new assessment was presented at the hearing.

The credible evidence at this hearing is that the Appellant qualifies for 35 hours of Personal Care Services to be provided 7 hours daily, 5 days weekly, Monday through Friday, pursuant to a task-based plan. The MLTCP's determination is not sustained.

DECISION AND ORDER

The MLTCP's determination authorizing the Appellant to receive Personal Care Services of 35 hours weekly, provided 5 hours daily, 7 days weekly is not correct and is reversed.

1. The MLTCP is directed to re-allocate Appellant's 35 hours of Personal Care Services to be provided 7 hours daily, 5 days weekly, pursuant to a task-based plan.

Should the MLTCP 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 MLTCP promptly to facilitate such compliance.

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

DATED: Albany, New York
11/19/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By
H. Cooper Gregory

Commissioner's Designee