STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 24, 2019
[redacted]
AGENCY: MAP
FH #: 7983400Y

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 August 13, 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)

D. Ferguson, Plan Representative

ISSUE

Was the determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Personal Care Services from 66 hours per week to 84 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 [redacted], has been enrolled in a Managed Long Term Care Program and has received care and services, including Personal Care Services, through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living (a/k/a "Centers Plan or "The Plan").

2. The Appellant has been authorized to receive Personal Care Services in the amount of 66 hours per week (10 hours x 5 days, Monday – Friday, and 8 hours x 2 days per week, Saturday and Sunday).

3. On May 14, 2019, the Appellant, or their representative, requested an increase in Personal Care Aide hours from 66 hours per week to 84 hours per week.

4. On November 19, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs along with a "Client Task Sheet".

5. On May 12, 2019, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs along with a "Client Task Sheet".

6. By a Notice of Initial Adverse Determination dated May 17, 2019, the Plan advised Appellant of its determination to deny the Appellant's request for an increase in services.

7. On May 24, 2019, the Appellant's Representative asked for a Plan Appeal concerning the Plan's May 17, 2019 Initial Adverse Determination.

8. By Final Adverse Determination dated May 28, 2019, the Plan upheld its May 17, 2019 determination.

9. On June 24, 2019, 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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who

have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--
(i) The enrollee and his or her representative;

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.

The Partial Capitation Managed Long-Term Care Model Contract provides, in part:

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section

363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the Choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.
Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

Pursuant to the New York State Department of Health Office of Health Insurance Programs MLTC Policy 15.03, 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 without first requesting an internal appeal of the determination.

The model contract for partially capitated MLTC plans advises that Social and environmental supports are services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Pursuant to Appendix G, Social and environmental supports may be provided through care management. Care management is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

Person Centered Service Plan (or plan of care) is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the Enrollee, as well as the person's functional level and support systems.

Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person centered service plan or elsewhere in the care management record.

MLTC policy memo 13.09(a) reminds Plans of MLTC Policy 13.09: *Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York* which indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM).

As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013;** the SAAM assessment must **not** be used for these new enrollees. Additionally, the UAS-NY must be used for *all* reassessments beginning **October 1, 2013**.

All SAAM assessments conducted from June 16, 2013 through September 30, 2013 must be submitted to the Department of Health by October 31, 2013 via the regular SAAM submission process.

MLTC policy memo 13.09(b) advises in part:

1. Is it permissible for an MLTC Plan to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.

No. All MLTC Plans (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC Plans to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

Section 505.14(a)(3)(iii)(a) of the regulations provides that 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.

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 patient's 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.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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II. Accessing the benefit

a. Request for Service: A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request…

b. Nursing and Social Assessment:
    i. Initial assessment
    Once the request is received the MCO is responsible for arranging an

assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.

ii. Social Assessment
In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated , whether the member's home has adequate sleeping accommodations for a personal care aide.

This nursing assessment and the social assessment can be completed at the same time. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139…

c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period the MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.

d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN and the personal care services worker to develop the plan of care based on the MCO's authorization.

III. Authorization and Notice Requirements for Personal Care Services

e. Standards for review. Requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

f. Timing of authorization review.
   i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
   ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

g. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).

h. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):
   i. that were previously authorized, if any;
   ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
   iii. that are authorized for the new authorization period; and
   iv. the original authorization period and the new authorization period, as applicable.

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.

Pursuant to GIS Message 13 MA/015, at a fair hearing to review the district's denial of a Medicaid application, the Medicaid applicant has the burden of proving that the district's denial was incorrect. When the applicant prevails, the fair hearing decision will reverse the denial. The district cannot deny the application based on the reason that was set forth in the agency's denial that was reversed. If no remaining eligibility factors need to be considered, the district must find the applicant eligible for Medicaid.

DISCUSSION

The record at the hearing established that the Appellant [redacted], has been enrolled in a Managed Long Term Care Program and has received care and services, including Personal Care Services, through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living (a/k/a "Centers Plan or "The Plan"). The Appellant has been authorized to receive Personal Care Services in the amount of 66 hours per week (10 hours x 5 days, Monday – Friday, and 8 hours x 2 days per week, Saturday and Sunday). On May 14, 2019, the Appellant's representative requested an increase in Personal Care Aide hours from 66 hours per week to 84 hours per week. On November 19, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs along with a "Client Task Sheet", and on May 12, 2019, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs along with a "Client Task Sheet". By a Notice of Initial Adverse Determination dated May 17, 2019, the Plan advised Appellant of its determination to deny the Appellant's request for an increase in services. On May 24, 2019, the Appellant's Representative asked for a Plan Appeal concerning the Plan's May 17, 2019 Initial Adverse Determination, and by a Final Adverse Determination dated May 28, 2019, the Plan upheld its May 17, 2019 determination.

The Plan's Medical Review Form lists the Appellant's medical issues as Diabetes, Atherosclerotic heart disease, Heart failure, hypertension, the presence of a cardiac pacemaker, Tremor in arms, urine incontinence, osteoarthritis, cognitive decline. Additionally, the most recent UAS of May 12, 2019 states "Member has a dx of OA, Parkinson's, and cognitive decline that causes pain, tremors and confusion. Thus, the member requires significant weight bearing assistance with dressing upper and lower body, and bathing…Member requires significant assistance with toilet transfer…"

At the hearing, the Appellant's daughter stated that the Appellant needed the additional hours because his health conditions have declined/deteriorated. His issues from Parkinson's have gotten worse, and she, due to her own health challenges, can no longer be there every weekend at the end of the day until her father goes to bed at 8:00pm. The Appellant's representative did not provide any updated medical reports to the hearing, and there has been inconclusive evidence to increase the Appellant's hours to the requested 12 hours per day, 7 days per week

The Plan denied the request for increased hours stating "In summary, many of your abilities to perform physical functioning (daily activities) stayed the same and some improved; therefore, your hours stay the same at 10 hours per day 5 days per week, and 8 hours per day, 2 days per week, for a total of 66 hours per week." A review of the documents submitted at the hearing do not show there has been any improvement of the Appellant's condition.

Additionally, the daughter's credible testimony that due to her own health challenges she would not be able to help her father many weekends brings credence to the need to bring the weekend hours up to the same as the hours needed every weekday, and therefore the Appellant's personal care hours should be increased to 10 hours per day x 7 days per week for a total of 70 hours per week.

DECISION AND ORDER

The determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Personal Care Services from 66 hours per week was not correct and is reversed.

1. Centers Plan for Healthy Living is directed to authorize Personal Care Services to the Appellant in the amount of 10 hours per day, 7 days a week.

Should Centers Plan for Healthy Living 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 Centers Plan for Healthy Living promptly to facilitate such compliance.

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
01/07/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee