**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** November 20, 2018
[redacted]
**AGENCY:** MAP
**FH #:** 7865576L

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| In the Matter of the Appeal of<br>[redacted] | : | **DECISION AFTER FAIR HEARING** |
| from a determination by the New York City Department of Social Services | : | |

## JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 29, 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

Deborah Fegusson, Fair Hearing Representative

## ISSUE

Was the Appellant's Managed Long Term Care Plan's determination not to provide the Appellant with an increase in Personal Care Assistant hours from 33 hours per week to 38 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 94, resides alone, has been in receipt of Medical Assistance benefits, and is enrolled in a partially capitated Managed Long Term Care Plan through Centers Plan for Healthy Living (the Plan).

2. The Appellant is in receipt of a Personal Care Assistant (PCA) authorization in the amount of 63 hours per week.

3. On October 18, 2018, the Appellant requested that her Medicaid Managed Long Term Care Plan increase her authorized Personal Care Assistance (PCA) Services from 63 hours per week to the amount of 84 hours per week.

4. On November 1, 2018, the Plan issued to the Appellant a written Initial Adverse Determination which advises the Appellant of its determination not to increase the number of PCA service hours to 84 hours per week.

5. On November 6, 2018, the Plan issued to the Appellant a written Final Adverse Determination which advises the Appellant of its determination not to increase the number of PCA service hours to 84 hours per week but to provide a partial increase to 66.5 hours per week.

6. On August 2, 2018, a registered nurse performed an in-home assessment of the Appellant's needs and issued a Uniform Assessment System (UAS) – New York Comprehensive Community Assessment Report, finalized on August 2, 2018.

7. On August 2, 2018, a registered nurse prepared a Tasking Tool for the Appellant following the August 2, 2018 assessment.

8. On October 19, 2018, a registered nurse performed another in-home assessment of the Appellant's needs and issued a Uniform Assessment System (UAS) – New York Comprehensive Community Assessment Report, finalized on October 19, 2018.

9. On October 19, 2018, a registered nurse prepared a Tasking Tool for the Appellant following the October 19, 2018, assessment.

10. On November 2, 2018, the Appellant requested appealed the partial denial of the Appellant's request for increase of the PCA services. On November 4, 2018, the Managed Long Term Care Plan determined not to change their decision to partially deny the Appellant's authorized Personal Care Assistance (PCA) Services from 63 hours per week to the amount of 84 hours per week.

11. On November 20, 2018, the Appellant requested this fair hearing.

## APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an Appellant has the right to examine the contents of the case record at the fair hearing. The Agency must provide complete copies of its documentary evidence to the hearing officer at the hearing and also to the Appellant or representative where such documents were not otherwise provided in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). Unless a waiver of appearance is approved by the Office of Administrative Hearings, a representative of the Agency must appear at the hearing

along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. If a waiver has been approved, the hearing officer may require the Agency's appearance if necessary to protect the appellant's due process rights. 18 NYCRR 358-4.3(b) and (c). In fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or
(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Section 505.14(a) of the Regulations provides in part that:

(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…

(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions…

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions shall include some or total assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(8) feeding;

(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(10) providing routine skin care;

(11) using medical supplies and equipment such as walkers and wheelchairs; and

(12) changing of simple dressings.

The United States Court of Appeals for the Second Circuit has reversed the lower court decision in Rodriguez et al v. DeBuono and Wing (S.D.N.Y.) that safety monitoring should be an included task in task based assessments. This means that social services districts that use TBA plans in their Personal Care Services Programs are NOT required to include safety monitoring as a separate task on their TBA forms, assess the need for safety monitoring as a separate task or calculate any minutes allotted for safety monitoring as part of the total personal care services hours authorized for Personal Care Services applicants and recipients.

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."

18 NYCRR 358-5.9. Fair hearing procedures.

(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; or an exemption from work activity requirements 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 or is exempt from work requirements pursuant to Part 385 of this Title.

**DISCUSSION**

The Appellant, age 94, resides alone, has been in receipt of Medical Assistance benefits, and is enrolled in a partially capitated Managed Long Term Care Plan through Centers Plan for Healthy Living (the Plan). The Appellant is in receipt of a Personal Care Assistant (PCA) authorization in the amount of 63 hours per week. On October 18, 2018, the Appellant requested that her Medicaid Managed Long Term Care Plan increase her authorized Personal Care Assistance (PCA) Services from 63 hours per week (9 hours per day, 7 days per week) to the amount of 84 hours per week (12 hours per day, 7 days per week).

On October 30, 2018, the Plan issued to the Appellant a written Initial Adverse Determination which advises the Appellant of its determination not to increase the number of PCA service hours to 84 hours per week but to provide a partial increase to 66.5 hours per week.

On November 2, 2018, the Appellant requested appealed the partial denial of the Appellant's request for increase of the PCA services. On November 4, 2018, the Managed Long Term Care Plan determined not to change their decision to partially deny the Appellant's authorized Personal Care Assistance (PCA) Services from 63 hours per week to the amount of 84 hours per week.

The August 2, 2018 UAS report states that the Appellant requires total dependence with meal preparation, housework and shopping; extensive assistance with transportation, bathing; managing medications, dressing, walking and locomotion; and supervision only with toilet use and transfer. It is noted that the August 2, 2018 Tasking Tool states that the weekly number of aide hours needed is 38.5.

The October 19, 2018, UAS report further states that the Appellant requires total dependence with meal preparation, housework and shopping; extensive assistance with transportation, bathing; managing medications, dressing, walking and locomotion; and supervision only with toilet use and transfer. It is noted that the August 2, 2018 Tasking Tool states that the weekly number of aide hours needed is 66.5.

At the hearing, the Appellant's representative disputed the findings in the August 2, 2018 and October 19, 2018, UAS and testified that the Appellant's condition is worsening rapidly, and has declined cognitively. The Appellant's representative tendered a letter from her doctor which enumerated the appellant's medical conditions. She testified that the Appellant suffers from Alzheimer dementia, osteoarthritis, anxiety, gait, instability, history of falls which requires total assistance with all her activities of daily living. The representative continued by stating that the Appellant needs help with bathing because she cannot take her clothes on or off and needs someone to clean her. She cannot clean herself after using the toilet because she is incontinent of both bladder and bowel and constantly remain in soiled diapers and lining until next morning when her aide arrives. The representative's testimony is found credible because it is detailed, sincere and corroborated, in part, by the Plan's own documents and records which predicated the partial denial. records.

While housework, shopping, and meal preparation can be scheduled for weekdays, assistance with transportation, bathing, toileting, stairs, dressing, medication management, and equipment management would be required over the weekend as well. **The Plan is reminded that contribution of family members or friends to the care of a PCA applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever**. The record establishes that the Appellant's personal care needs for tasks exist beyond the hours authorized by the Plan.

Federal regulations require that the State's contracts with Managed Long Term Care plans must provide, among other things, that the services the Managed Long Term Care plan offer be furnished in an "amount, duration and scope" that is no less than the "amount, duration and scope" for the same services furnished to Medicaid fee-for-service recipients and that the Managed Care plan may place appropriate limits on services on the basis of medical necessity, but the criteria for determining medical necessity may be no more restrictive than that applicable to fee-for-service recipients. In addition, Section 358-5.9 of the Social Services Law provides that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance benefits or services, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

For all of the foregoing reasons, the Appellant has established that the Plan's determination not to increase the number of personal service hours was not correct. Accordingly, The Plan's determination to deny an increase in personal care service hours cannot be sustained.

## DECISION AND ORDER

The Plan's determination of November 6, 2018 not to provide the Appellant with an increase in Personal Care Assistant hours from 66.5 hours per week to 84 hours per week (12 hours per day, 7 days per week) is not correct and is reversed.

1. The Plan is directed to authorize the Appellant for Personal Care services 12 hours per day 7 days per week for 84 hours per week.

2. The Plan is directed to notify the Appellant in writing of its compliance with this order.

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

FH# 7865576L

DATED: Albany, New York
02/21/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's

Designee