STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 27, 2018
[redacted]
AGENCY: MAP
FH #: 7782002P

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 2, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Medicaid Managed Long Term Care plan

Debora Ferguson, Fair Hearing Specialist

ISSUE

Was the determination by the Medicaid Managed Long-Term Care plan's to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization from 84 hours per week (12 hours per day x 7 days per week) to 24 hour, continuous ("split-shift") care (168 hours per week), and to partially approve an increase in Personal Care Services authorization to provide for twenty-four (24) hour daily care via "sleep-in" services 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 eighty-nine (89), has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter "Plan").

2. The Appellant is currently authorized to receive Personal Care Services in the amount of 24-hour daily care via a "live-in" services ("live in") care (91 hours per week).

3. The Appellant's diagnosed health conditions include Alzheimer's disease, age-related osteoporosis, anorexia, depression, diabetes, GERD, hyperglycemia, hyperosmolality and hypernatremia, hypercholesterolemia, restlessness and agitation, shortness of breath, abnormalities of gait and mobility, glaucoma, and wandering. The Appellant also has an overactive bladder, and is fully incontinent of the bowel and bladder.

4. On November 1, 2017, a registered nursing assessor conducted a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

5. On June 5, 2018, a registered nursing assessor conducted a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

6. On or about June 7, 2018, the Appellant's daughter requested an increase in the Appellant's Personal Care Services Authorization, from 84 hours per week (12 hours per day x 7 days per week) to 24 hour, continuous ("split-shift") care (168 hours per week).

7. By Initial Adverse Determination, dated June 21, 2018, the Plan determined to partially deny the Appellant's daughter's June 7, 2018 request for an increase in the Appellant's Personal Care Services Authorization. The Plan approved Personal Care Services in the amount of 24 hour, live-in ("live in") care (91 hours per week), not 24 hour, continuous ("split-shift") care (168 hours per week).

8. The Appellant's daughter requested an internal review.

9. On June 27, 2018, the Appellant's Attorney requested this fair hearing to appeal the Plan's determination.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, HEAP, SNAP benefits, Medical Assistance 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.

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 438.404(b) of 42 CFR Subpart F provides in part:

(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 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 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

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

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's 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. 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 patient's 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.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

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**.**

Pursuant to GIS 03 MA/003, task based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of Personal Care Services. This GIS was promulgated 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. 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.

Completion of accurate and comprehensive assessments are essential to safe and adequate care Medical 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.

Section 505.14(a)(4) of the Regulations provides that **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.

Section 505.14(a)(2) of the Regulations provides that **24 hour continuous personal care services ("split shift") 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**.

State of New York, Department of Social Services, Memorandum DSS-524EL, dated May 1, 1991, Russell J. Hanks, Policy Clarifications, states, in part: In some cases, an Appellant will provide evidence for the first time during a hearing[,] which was not provided to the social services district at the time the original determination was made. Where the evidence demonstrates that a determination in the Appellant's favor is now appropriate, the decision should indicate that the determination of the district was correct when it was made but that new evidence now requires a different result.

Appellant right to fair hearing and appeal rights: 42 CFR section 438.402 (c)(1)(i) and 438 (f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution

(Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld. 42 CFR section 438.402 (c)(1)(i)(A), 438.408 (c)(3) and 438.408 (f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applied when: an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan; an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State – specified timeframes; or a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR section 438.408. 42 CFR section 438.408 (f) (2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing. Pursuant to 42 CFR section 438.424 (a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

DISCUSSION

The uncontroverted evidence in this case establishes that the Appellant, age 89, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan and is currently authorized to receive Personal Care Services (hereinafter "PCS") in the amount of 24 hour, live-in ("live in") care (91 hours per week) (hereinafter "24 hour, live-in"). Medical evidence submitted at the hearing provides that the Appellant's diagnosed health conditions include Alzheimer's disease, age-related osteoporosis, anorexia, depression, diabetes, GERD, hyperglycemia, hyperosmolality and hypernatremia, hypercholesterolemia, restlessness, agitation, shortness of breath, abnormalities of gait and mobility, glaucoma, and wandering. The Appellant also has an overactive bladder, and is fully incontinent of the bowel and bladder.

The record further establishes that on or about June 7, 2018, the Appellant's daughter requested an increase in the Appellant's PCS Authorization, from 84 hours per week (12 hours per day x 7 days per week) to 24 hour, continuous ("split-shift") care (168 hours per week) (hereinafter "24 hour, split-shift"). By Initial Adverse Determination, dated June 21, 2018, the Plan determined to partially deny the Appellant's daughter's June 7, 2018 request for an increase in the Appellant's PCS Authorization. The Plan approved PCS in the amount of 24 hour, live-in, not 24 hour, split-shift. On June 27, 2018, the Appellant's daughter filed for this fair hearing after, as the Appellant's daughter contends, filing for an internal appeal with the Plan, where the Plan upheld it's June 21, 2018 determination. It is noted that the Plan did not present evidence of a Final Adverse determination having been issued. The Plan's representative acknowledged at the hearing that the lack of presentation of a Final Adverse Determination does not mean that an appeal was not filed. The record, in this matter, establishes that the pre-requisite internal appeal process has been exhausted by virtue of the amount of time which has elapsed from the date of the initial adverse action, the request for internal appeal and the date of this fair hearing.

With regard to the Appellant's need for assistance with Activities of Daily Living

(hereinafter "ADLs"), the Plan's June 21, 2018 determination establishes the Appellant's need for 24 hour, live-in PCS.

With regard to the provision of 24 hour, split-shift PCS, the Regulations provide that "continuous personal care services (split-shift) 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. Since the Plan established the Appellant's need for a 24-hour, live-in care PCS Authorization in its June 21, 2018 determination, the issue to be determined herein is whether or not the frequency of the Appellant's nighttime PCS needs would prevent a 24 hour, live-in Personal Care Aide ("PCA") from obtaining 5 hours of uninterrupted sleep in an 8-hour sleep period.

With respect to the frequency of the Appellant's nighttime needs for assistance with ADLs, the Appellant's daughter submitted into evidence, the results of a May 13, 2018 and an August 14 – 15, 2018 nighttime Sleep Study, which the Appellant's daughter contends she conducted. The results of this Sleep Studies provide that the Appellant requires assistance multiple times between the hours of 12:00 AM and 6:00 AM, with diaper changes (urine and stool) as well as turning and repositioning. It is noted that the Appellant's Daughter did not log assistance the Appellant received between the hours of 8:00 PM and 12:00 AM. It is further noted that the Plan did not present evidence which might rebut the findings of this sleep study. The Appellant's Daughter also submitted into evidence, a doctor's letter from the Appellant's doctor, Dr. [redacted], which advises that the Appellant "has frequent incontinence, and needs to have diaper changed frequently…needs extensive assist[ance] in toileting as mentioned, but also walking, transferring to and from the bed or chair, effective turning [and] positioning, and feeding."

The Appellant's June 5, 2018 UAS assessment, submitted into evidence by the Plan, provides support for the Appellant's daughter's and doctor's contentions. The assessment provides that the Appellant requires assistance with toileting (use and transfer), bathing, personal hygiene, dressing (upper and lower body), walking, locomotion, transferring, bed mobility, meal preparation, eating, and managing medications. The June 5, 2018 UAS also provides that the Appellant is frequently incontinent of the bladder and bowel; has abnormalities of gait and mobility; and suffers from dizziness and poor balance. Collectively, this evidence establishes that a 24 hour, live-in PCS Authorization would be inappropriate as a 24 hour, live-in PCA would be unable to receive 5 hours of uninterrupted sleep in an 8 hour sleep period due, in large part, to the Appellant's excessive toileting needs.

The record has been considered. Based on the Appellant's daughter's testimony and credible contentions, which are supported by the evidence adduced at this hearing, the record establishes that the Appellant has care needs sufficient to warrant the provision of a 24 hour, split-shift PCS Authorization. Accordingly, the Plan's determination cannot be sustained.

DECISION AND ORDER

The Plan's determination to deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from 84 hours per week (12 hours per day x 7 days per week) to 24-hour, continuous ("split-shift") care (168 hours per week), is not correct and is reversed.

The Plan is directed to:

1. Immediately provide the Appellant with a Personal Care Services Authorization in the amount of 24-hour, continuous ("split-shift") care (168 hours per week).

2. Continue to provide the Appellant with a Personal Care Services Authorization in the amount of 24-hour, continuous ("split-shift") care (168 hours per week) unchanged.

Should Center's 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 the Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, Center's Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
11/01/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee