STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 18, 2019
[redacted]
AGENCY: MAP
FH #: 7980346H

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 July 15, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

Centers Plan for Healthy Living

Debra Ferguson, Fair Hearing Representative

ISSUE

Was the determination of Centers Plan for Healthy Living to authorize Personal Care Services for the Appellant in the amount of 84 hours 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, who is 71 years old, receives Medical Assistance from Centers Plan for Healthy Living.

2. The Appellant had been in receipt of a Personal Care Services Authorization in the amount of 84 hours per week, at the rate of 12 hours a day, 7 days a week.

3. On October 15, 2018, Centers Plan for Healthy Living completed a Uniform Assessment System - UASNY Comprehensive Community Assessment Report as part of a routine reassessment for the Appellant.

4. The Appellant requested an increase of Personal Care Services to 24 hours Live in Personal Care Service.

5. On April 9, 2019, Centers Plan for Healthy Living completed a Uniform Assessment System - UASNY Comprehensive Community Assessment Report as part of a routine reassessment for the Appellant.

6. Centers Plan for Healthy Living denied the Appellant's application for 24 hours Live in Personal Care Services, because it was not medically necessary; that the personal care services hours currently received by the Appellant are appropriately and safely meeting the Appellant's personal care needs. Centers Plan for Healthy Living notified the Appellant that a review of the Appellant's current assessment showed no change in activities of daily living within the last 90 days and no change in overall self-sufficiency; there has been no change in social circumstances. The notice further informs the Appellant, that based on a thorough review of Appellant's recent assessment, clinical documentation presented and tasking tool; it was identified that that "there's no deterioration in Appellant's functional status; that Appellant is able to ambulate with a seated rollator, and uses pullups, pantyliners and under-pads for bladder and bowel incontinence, and is able to use the Personal Emergency Response System (PERS)". Therefore, your current Personal Care Aide (PCA) services of twelve (12) hours per day seven (7) days per week…are appropriately and safely meeting your personal care needs.

7. The Appellant requested an internal appeal of Centers Plan for Healthy Living decision, and by a Notice of Final Adverse Determination dated April 19, 2019, Centers Plan for Healthy Living upheld the prior denial and determined to deny the Appellant's internal appeal.

8. On June 18, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

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. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Social Services Law §365-a(2) provides that "Medical Assistance" 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 United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

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.

Pursuant to Social Services Law §365-a(2)(e) Medicaid provides personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Social Services Law §365-a(2)(e)(iv) provides 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.

18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.

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. 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.

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

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(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.

(b) Before continuous personal care services or live-in 24-hour personal care services may be authorized, additional requirements for the authorization of such services, as specified in clause (b)(4)(i)(c) of this section, must be met.

In Rodriguez v. City of New York, 197 F.3d 611 (2nd Cir. 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.

Section 505.14(c)(9) of the Regulations provides that each local social services department shall have a plan to monitor and audit the delivery of personal care services provided by arrangements or contracts.

New York City has received approval to deliver Personal Care Services through a Task Based Assessment methodology. Service delivery is task oriented, not time oriented, and the client continues to receive service in accordance with assessed needs.

Section 505.14(b)(5)(iv)(c) of the Regulations provides: The social services district's determination to deny, reduce or discontinue personal care services must be stated in the client notice, and,

(1) Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;

(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;

(iii) the client is not self-directing and has no one to assume those

responsibilities;

(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

(v) the client refused to cooperate in the required assessment;

(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

(2) Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

(iii) the client refused to cooperate in the required reassessment;

(iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and

(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides, in part, the intent of 18 NYCRR 505.14 is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping.

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be

performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

• The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;

• The specific task or tasks with which the person requires frequent assistance during the night;

• The frequency at which the person requires assistance with these tasks during the night;

• Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;

• The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;

• The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and

• Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

General Information System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

Districts were first advised of the Mayer case in May 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of

any personal care services recipient whom the district has determined needs 24-hour care, including continuous 24-hour services ("split-shift"), 24-hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.

This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split shift or live-in services.

When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Remember that the contribution of family members or friends 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.)

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

1.Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24-hour split shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24-hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this

recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24-hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The district should authorize services in an amount that is less than 24-hour live-in services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of live-in services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

Important Additional Information on TBA Plans:

Until notified otherwise by the Department, the following also apply to the use of TBA plans:

1. A district cannot use a TBA plan unless the TBA plan was already in use on March 14, 1996, or the district had the Department's approval as of that date to implement a TBA plan. This complies with the temporary restraining order in Dowd v. Bane, which the Department notified districts of in a previous GIS message, 96 MA/013, issued April 4, 1996.

2. Districts are not required to include safety monitoring as an independent task on their TBA forms. The Department recently obtained a stay of the August 21, 1997 federal court order that had required safety monitoring to be included as an independent TBA task. [See GIS 97 MA/26, issued November 6, 1997, informing districts of the stay of the order in Rodriguez v. DeBuono (S.D.N.Y., 1997).]

DISCUSSION

The Appellant applied for an increase of Personal Care Services, because she wants someone to help her change her diapers when they get soaked.

The Appellant has been in receipt of Personal Care Services Authorization in the amount of 84 hours per week, which according to Centers Plan for Healthy Living, are sufficient, safely, and appropriately meeting Appellant’s personal care needs. Her diagnoses include: Atherosclerotic heart disease of native coronary artery without angina pectoris, Constipation, unspecified, Essential primary hypertension, Gastro-esophageal reflux disease without

esophagitis, Type 2 diabetes mellitus with unspecified complications among others.

The record of the hearing reveals that the Appellant has been receiving Personal Care Services in the amount of 84 hours weekly. The Appellant requested an increase of Personal Care Services to 24 hours Live in Personal Care Service.

Centers Plan for Healthy Living evaluated the Appellant's application for additional hours, and determined that the request for 24 hours Live in Personal Care Service, was not medically necessary. Centers Plan for Healthy Living determined that based on a review of all available medical information on the Appellant; a review of the Appellant's prior and current assessments as well as the Appellant's current living arrangement, and family support information, the current hours provided are adequate to support Appellant's activities of daily living such as bathing, dressing, toileting, and housekeeping related services.

Centers Plan for Healthy Living denied the Appellant's application for 24 hours Live in Personal Care Service, because it was not medically necessary; that the personal care services hours currently received by the Appellant are sufficient and appropriate to meet Appellant's personal care needs. Centers Plan for Healthy Living notified the Appellant that a review of the Appellant's current assessment showed no change in activities of daily living within the last 90 days and no change in overall self-sufficiency; there has been no change in social circumstances. The notice further informs the Appellant, that based on a thorough review of Appellant's recent assessment, clinical documentation presented and tasking tool; it was identified that that "there's no deterioration in Appellant's functional status; that Appellant is able to ambulate with a seated rollator, and uses pullups, pantyliners and under-pads for bladder and bowel incontinence, and is able to use the Personal Emergency Response System (PERS)". Therefore, your current Personal Care Aide (PCA) services of twelve (12) hours per day seven (7) days per week…are appropriately and safely meeting your personal care needs.

The Appellant at the hearing, further testified that Appellant applied for an increase of Personal Care Service hours, for her safety; that Appellant needs someone around to help her, in case of an emergency like a fire outbreak.

At a hearing concerning the adequacy of services, the Appellant must establish that the Plan erred in its determination. The Appellant's testimony has been considered, but it was found not persuasive. The Appellant failed to draw any direct connection between the Appellant's medical condition and her need for additional time/hours. The record establishes that task time has already been allotted Appellant's personal care and activities of daily living tasks, and the Appellant did not establish that the allotted time was insufficient. The Appellant did not enumerate or specify any task for which additional hours were required. Requiring an aide to further perform these tasks already provided for, borders on companionship and safety supervision. The provider is not required to include companionship and or safety monitoring as a separate standalone task.

The record establishes that the Managed Care Plan's plan of care does allocate a reasonable number of daily hours for assisting Appellant with her daily needs. The record establishes that

the program is designed in such a way so as to ensure that the Appellant is receiving services in accordance with assessed needs. The Appellant failed to establish that the Appellant's need for assistance was not already being properly addressed by the Medicaid Managed Care Plan authorized plan of care.

The Appellant failed to establish the Appellant's alleged needs are anything other than an attempt to obtain safety monitoring or companionship. Also, the Appellant failed to establish a need for additional hours for tasks already being provided to the Appellant.

The record fails to establish a change in Appellant's medical condition such that an increase in hours beyond that already approved (to 24 hours Live in Personal Care Service), is medically necessary. The Appellant failed to meet her burden of proof and did not establish that her application for additional hours, beyond that which Centers Plan for Healthy Living now provides, of Personal Care Services was based on medical necessity.

DECISION

The determination of Centers Plan for Healthy Living to authorize Personal Care Services for the Appellant in the amount of 84 hours weekly is correct.

DATED: Albany, New York
08/16/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee