STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 19, 2018
[redacted]
AGENCY: MAP
FH #: 7880869Y

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

For the Appellant

[redacted]

For the Social Services Agency

No appearance by Agency

ISSUE

Was Centers Plan for Healthy Living's determination to deny the Appellant's request for an increase in the number of hours of personal care services from 56 hours a week to 24 hours a day, 7 days a week "live-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 85, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living.

2. The Appellant requested that Centers Plan for Healthy Living increase the

Appellant's number of hours of personal care services from 56 hours a week to 24 hours a day, 7 days a week "live-in" services.

3. By written notice dated November 30, 2018, Centers Plan for Healthy Living determined to deny the Appellant's request for an increase in the number of hours of personal care services from 56 hours a week to 24 hours a day, 7 days a week "live-in" services.

4. On December 19, 2018, 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 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.

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, 2014, 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.

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of personal care services in Medicaid Managed Care

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i. Personal care services include some or total assistance with:
    1. Level I functions as follows:
        a. Making and changing beds;
        b. Dusting and vacuuming the rooms which the member uses;
        c. Light cleaning of the kitchen, bedroom and bathroom;
        d. Dishwashing;
        e. Listing needed supplies;
        f. Shopping for the member if no other arrangements are possible;
        g. Member’s laundering, including necessary ironing and mending;

h. Payment of bills and other essential errands; and
i. Preparing meals, including simple modified diets.

2. Level II personal care services include Level I functions listed above and the following personal care functions:
   a. Bathing of the member in the bed, the tub or the shower;
   b. Dressing;
   c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
   d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
   e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
   f. Transferring from bed to chair or wheelchair;
   g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
   h. Feeding
   i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
   j. Providing routine skin care;
   k. Using medical supplies and equipment such as walkers and wheelchairs; and
   l. Changing of simple dressings.

MLTC Policy 16.07, issued on November 17, 2016, provides as follows:

"This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.
If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring, supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates.

NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have

frequent or recurring needs for assistance during the day or night (emphasis in original). A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link: http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at mltcworkgroup@health.ny.gov."

DISCUSSION

The record establishes that the Appellant, age 85, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living.

The record establishes that the Appellant requested that Centers Plan for Healthy Living ("the Agency") increase the Appellant's number of hours of personal care services from 56 hours a week to 24 hours a day, 7 days a week "live-in" services. By written notice dated November 30, 2018, the Agency determined to deny the Appellant's request for an increase in the number of hours of personal care services from 56 hours a week to 24 hours a day, 7 days a week "live-in" services.

The Agency did not appear at the hearing and did not submit a waiver request.

The Appellant's daughter, age 56, represented her mother at the hearing. She testified that her mother lives with her 55-year-old brother in an apartment about 3 blocks from her own residence. She submitted a copy of the Agency's Final Adverse Determination dated November 30, 2018. That notice states that the "reason" for the denial is as follows:

> "You were in the Emergency Room on September 18, 2018 for a fall. You tasked for 52 hours per week in August and re-tasked for 42 hours per week in November. You have a PCA for 56 hours per week and requested live-in, 7 days per week. Denial is upheld. You receive considerably more hours than you task for and there are no demonstrated night needs. PCA hours remain at 8 hours per day, 7 days per week.
>
> This decision is based on the NYS Department of Health Uniform Assessment System (Uniform Assessment System-NY) and the plan's client tasking tool."

The Appellant's daughter submitted medical documentation indicating that her mother suffers from [redacted]. The Appellant's daughter testified that her brother is [redacted] and works as a supermarket packer for minimum wage. While he is limited in his abilities to assist his mother, he stays with her until the aide arrives at 9 am and gives limited assistance to his mother after work. He helps her change her clothes after she has soiled them, but does not bathe her. The Appellant's daughter generally visits her mother three times a day, in the morning, at dinner time and again at bedtime. Her mother has been [redacted] for several years and [redacted], and her [redacted] started several months ago and is increasing and unpredictable. In addition to the fall referred to by the Agency in the Final Adverse Determination, the Appellant fell again on the morning of January 11, 2019 before the aide arrived while she was going into the kitchen to get a drink of water. As a result of that fall, the Appellant was hospitalized with a [redacted]. The Appellant's daughter testified that because of her mother's [redacted] and her overall condition, it is not a healthy situation for her brother to continue to live with her, but that he has persisted because his mother needs the help. She testified that he will move from his mother's apartment to her apartment when an overnight aide is in place.

All the evidence has been considered. The Agency's notice is totally conclusory and does not state a conceivable basis for the denial other than its reference to a Uniform Assessment System report and a client tasking tool, but no such reports are in the record. Accordingly, the

Agency has failed to indicate that it did an individualized assessment of the Appellant's need for assistance, including assessments of the actual time and frequency of needs for this particular Appellant, taking into account her specific conditions and the resultant increase in her needs. Similarly, there is no individualized assessment of needs for safety monitoring, general supervision or prompting. The Agency has failed to address the Appellant's apparent needs for assistance before 9 am and after 5 pm. Finally, the Agency has not demonstrated that it first conducted the necessary inquiry preliminary to using a task based assessment, i.e., whether the Appellant needs 24-hour services. The evidence presented at the hearings indicates that the Appellant needs 24-hour live-in personal care services for 7 days a week. Centers Plan for Healthy Living' determination to deny the Appellant's request for an increase to that level of services is thus incorrect.

DECISION AND ORDER

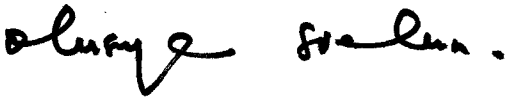
Centers Plan for Healthy Living's determination to deny the Appellant's request for an increase in the weekly number of hours of personal care services from 56 hours to 24 hours a day, 7 days a week "live-in" services was not correct and is reversed.

1. The Agency is directed to authorize increased personal care services to the Appellant in the amount of 24 hours a day, 7 days a week "live-in" services.

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

DATED: Albany, New York
01/28/2019

NEW YORK STATE
DEPARTMENT OF HEALTH
By



Commissioner's Designee