STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 14, 2018
[redacted]
AGENCY: MAP
FH #: 7756448Y

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on August 10, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan For Healthy Living)

Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination by the Appellant's Managed Long-Term Care Plan, Centers Plan For Healthy Living, to partially deny the Appellant's request for an increase in Personal Care Service from 10 hours per day, 7 days per week (70 hours weekly) to 24 hours live-in, 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 seventy-nine) has been in receipt of Medical Assistance benefits through a Managed Long-Term Care ("MLTC") Plan ("the Plan") operated by Centers Plan For Healthy Living.

2. The Appellant had been receiving Personal Care Service (PCS) 10 hours per day, 7 days per week (70 hours weekly).

3. The Appellant requested an increase in PCS from 10 hours per day, 7 days per week days per week (70 hours weekly) to 24 hours per day, 7 days per week live-in.

4. On April 9, 2018 the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on April 9, 2018. The UAS found that assistance was required for Independent Activities of Daily Living ("IADLs") such as chores and errands and for Activities of Daily Living ("ADLs") such as bathing, eating, medicating, locomotion and toileting and the UAS noted the Appellant was both bladder and bowel incontinent.

5. By Managed Long-Term Care Action Denial, Reduction or Termination of Benefits dated April 24, 2018 the Plan stated that the increase was partially approved. The Plan stated that effective April 25, 2018 the Plan approved twelve hours per day, 7 days per week (84 hours).

6. The April 24, 2018 Notice noted that the Plan is taking such action because:

"A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted on 4/09/2018. A comparison of the UAS-NY assessments completed on 11/17/2017 and 04/09/2018 showed that you have demonstrated SOME CHANGES in your abilities to perform your Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). The UAS-NY assessment produces a Nursing Facility Level of Care (NFLOC) Score. Your NFLOC Of24 on 11/17/27 to NFLOC 33 on 04/09/2018.

Dressing upper body, dressing lower body, walking, locomotion, transfer toilet, toilet use, personal hygiene, bathing, medication management showed no changes from Maximal assistance where you need physical help to complete most parts of this task, like someone to lean on or help you lift a body part, however you can complete some parts of this task by yourself.

Eating-declined from limited assistance where you need some physical touch and direction throughout the task, but you can complete the task without some to lean on or help you lift any body parts to extensive assistance where you need physical help to complete some parts of this task, like someone to lean on or help you lift a body part, however you can complete some parts of this task by yourself.

Meal preparation, ordinary housework-showed no changes from Total Dependence where you depend completely upon someone else to complete all parts of this task, and do not participate in this task at all.

Urinary incontinence-Frequently incontinent but some control present.

Bowel incontinence-Occasionally Incontinent."

Cognitive status-Moderately impaired.

Pain Control You reported your pain is adequately controlled by pain regimen.

7. The Appellant requested this fair hearing on May 14, 2018 to contest the Plan's determination.

APPLICABLE LAW

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

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

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

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

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

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

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

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

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

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

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

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

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

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

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

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

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

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

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

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

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

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

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

In the case of an MCO or PIHP-"Action" means--

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

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

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 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support 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) 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.

(3) Continuous personal care services means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

(5) Live-in 24-hour personal care services means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.

(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.

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.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

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."

12 OHIP/ADM-1 states, in part:

With regard to informal caregivers, such support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.

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.

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. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, 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. 18 NYCRR 358-4.3(b).

Section 358-5.9 of the Regulations provides in part:

(a) At a fair hearing regarding 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.

DISCUSSION

The Appellant's Representative presented sufficient clinical evidence including logs from the Appellant's aides/occasional voluntary caretakers to establish that a PCA increase to 24 hours care is warranted. Having said that, the record does not establish that the Appellant's circumstances fit the criteria for 24 live-in care as the evidence shows that the aide cannot get at least five hours of uninterrupted sleep as required by the Regulations and policy provisions cited above.

The Appellant's Representative at the hearing asserted the following:

That the April 9, 2018 UAS recognized that the Appellant's cognitive skills went from Modified independence of having some difficulty in new situations only to Moderately impaired where decisions are consistently poor or unsafe and requires cues/supervision at all times.

That the April 9, 2018 UAS recognized that her memory ability went from memory Ok to Memory Problem.

That the April 9, 2018 UAS recognized that there was a cognitive decline.

That the April 9, 2018 UAS recognized that the Appellant requires assistance in all areas of ADL's and IADL's due to onset of cognitive decline; lymphoma, OA and related joints and back pain; experiences severe muscle weakness and general fatigue; requires increased need for assistance.

The Appellant's Representative at the hearing presented logs which established both unpredictable daytime and night-time needs which were not addressed by the Plan. For example, the Appellant, who while at times can get to the bathroom herself, sits on the toilet and soils/wets her diaper. She cannot clean and re-dress herself as she experiences fatigue, pain and cognitive impairment. The Appellant's Representative also asserted that the Appellant has had pressure ulcers in the past and due to her medical conditions as well as her inability to toilet and properly clean herself she continues to suffer from skin issues which must be tended to at various points of the day and night. The Appellant's Representative further asserted that the Appellant has sleep apnea, increasing difficulty regarding bed mobility and has experienced dizziness and unsteadiness of gait recently.

Lastly, and importantly, the Plan itself that the Appellant's overall self-sufficiency has deteriorated. The Plan's emphatic contention that only "some changes" had occurred requiring only an additional 14 hours weekly in PCS hours is misguided at best. The record corroborates the need for 24 hours per day continuous care (split shift) 7 days per week.

DECISION AND ORDER

The Plan's determination to partially deny the Appellant's request for an increase in PCS hours is not correct and is reversed. The Agency is directed to:

1. Authorize the Appellant for split shift Personal Care Services in the amount of 24 hours continuous care (split shift) per day, 7 days per week effective immediately.

2. The Plan is directed to notify the Appellant in writing upon its compliance with this Fair Hearing Decision.

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

DATED: Albany, New York
01/17/2019

FH# 7756448Y

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee