STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 19, 2018
[redacted]
AGENCY: MAP
FH #: 7846255R

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 November 14, 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

Deborah Ferguson, representative, Fair Hearing Representative

ISSUE

Was the determination by the Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an authorization to increase Personal Care Services from fifty-six (56) hours per week (8 hours per day x 7 days) to eighty-four (84) hours per week (12 hours per day x 7 days), correct with regard to the adequacy of Medical Assistance and services?

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 ninety-eight (98) has been in receipt of a Medical Assistance authorization, Medicaid benefits, and is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living.

2. The Appellant had been in receipt of an authorization of Personal Care Services in the amount of fifty-six (56) hours per week (8 hours per day x 7 days).

3. The Appellant requested an authorization for an increase in Personal Care Services to twelve (12) hours per day, seven (7) days per week, for a total of eighty-four (84) hours per week.

4. On August 28, 2018, a registered nurse assessor completed a Uniform Assessment System evaluation and a Care Management Coordination Supplement of the Appellant's personal care needs.

5. On August 28, 2018, the nursing assessor completed a "Client Task Sheet: PCW/PCA Level II" summary of hours recommended which estimates a need for Personal Care Services in the amount of 42 hours per week.

6. The Appellant has a medical diagnosis as follows. Anxiety disorder; atherosclerotic heart disease, dizziness and giddiness, chronic gout, cognitive impairment, edema, epilepsy, essential primary hypertension, gastro-esophageal reflux disease without esophagitis, hyperlipidemia, long term use of anticoagulants, long term use of aspirin, fatigue, recurrent depressive disorders, pain, history of transient ischemic attack and cerebral infarction without residual deficits, external hearing-aid, primary generalized osteoarthritis, sleep disorder, stiffness of joints, type 2 diabetes mellitus, abnormalities of gait and mobility, unspecified convulsions, glaucoma, bilateral hearing loss, urinary incontinence, unsteadiness on feet, vitamin deficiency and weakness.

7. The Plan's nurse assessor found that the Appellant needs the following assistance with the following activities of daily living: total dependence with meal preparation, ordinary housework transportation and shopping; maximal assistance with managing medications, stairs, bathing, personal hygiene, dressing upper and lower body; extensive assistance with walking, locomotion, transfer to toilet and toilet use; limited assistance with bed mobility and eating.

8. By written notice of Initial Adverse Determination Denial Notice which is dated May 2, 2018, the Plan determined not to authorize an increase of the Appellant's Personal Care Services on the grounds that the "plan's tasking tool showed that [the appellant] need[s] eight (8) hours per day, seven (7) days per week (totaling fifty-six [56] hours per week) of PCA services to complete the above-mentioned tasks.

9. An internal review appeal was requested of the Plan.

10. On June 22, 2018, the Appellant requested a fair hearing in this matter.

11. By written Final Adverse Determination Denial Notice which is dated June 26, 2018, the Plan advised the Appellant of the Plan's determination to uphold the Plan's determination not to authorize an increase in Personal Care Services.

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.

18 NYCRR 505.14(a)(5) provides 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.

(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…

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

The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care provides, in part, that:

The assessment process should evaluate and document when and to what degree the member 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. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

The Department's Managed Care Personal Care Services (PCS) Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with Public Health Law (PHL) Article 49, 18 NYCRR 505.14 (a), the Medicaid Managed Care (MMC) Model Contract and these guidelines. As such, denial or reduction in services must clearly set forth a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

GIS 15 MA/24, published on December 31, 2015, advises of the revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR section 505.14 and 18 NYCRR section 505.28, and notes the following changes:

The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

Pursuant to Office of Health Insurance Programs MLTC Policy 16.07, "Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services," issued on November 17, 2016, the New York State Department of Health has not approved the use of any particular task-based assessment tool. Managed Long-Term Care plans, however, are allowed to choose to use such tools as guidelines for determining an enrollee's plan of care. In any event, if the 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,
- 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.
- 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.

The federal Center for Medicare and Medicaid Services State Medicaid Manual states, in part, at section 4480 regarding Personal Care Services (speaking of activities of daily living, or "ADL's"):

1. Cognitive Impairments.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

18 NYCRR 505.14(a)(4) provides a new definition of "Live-in 24-Hour Personal Care Services" as follows: 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.

18 NYCRR 505.14(a)(2) provides a new definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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.

DISCUSSION

The record in this matter establishes that the Appellant is seeking an authorization of twelve (12) hours per day, seven (7) days per week, for a total of eighty-four (84) hours per week. The Appellant, age ninety-eight (98), is extremely aged.

At the hearing the Appellant's representative presented a letter from the Appellant's physician which is dated October 29, 2018, and which states that the Appellant requires "assistance with transferring her in and out of her bed… feeding and transferring her on and off the commode." The Appellant's niece testified that the Appellant is unable to get into her chair lift to make it to the second floor of her home, where her bedroom is located, and is also unable to get into bed without assistance of a home attendant. The Appellant's niece also testified that the Appellant needs assistance with getting on and off of her commode. It is noted that the Appellant's niece also provided further testimony which establishes that the Appellant needs assistance overnight with toileting approximately twice per night, and that there has been an arrangement for informal support for overnight assistance. The Appellant's niece also testified that the Appellant wears diapers/pull-ups. The testimony of the Appellant's niece is plausible, persuasive and, therefore, credible particularly in light of the Appellant's age, age related debility and medical status, all of which are documented in this matter.

Although duly notified of the date, time and location of the hearing as well as the issue (s) to be addressed at same, the Plan did not refute the contention of the Appellant's niece and of the Appellant's advocate that the Appellant requires twenty-four (24) hour daily care and assistance, though the Appellant is seeking only twelve (12) hours per day of care. The determination by the Plan to deny the Appellant's request for an authorization to increase the Appellant's Personal Care Services is not correct and cannot be sustained.

DECISION AND ORDER

With regard to the determination by Centers Plan for Healthy Living to deny the Appellant's request for an authorization to increase Personal Care Services to eighty-four (84) hours per week (12 hours per day x 7 days), the record establishes that an authorization of twenty-four- hour daily care is appropriate in this matter, such that the Plan's determination is not correct and is reversed.

Centers Plan for Healthy Living is directed to:

1. Immediately provide to the Appellant an authorization of Personal Care Services in the amount eighty-four (84) hours per week (12 hours per day x 7 days), in lieu of twenty-four (24) hour daily care and pursuant to the provision of informal care services as per the Appellant's request.

2. Continue the authorization of Personal Care Services in the amount of eighty-four (84) hours per week (12 hours per day x 7 days) 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 and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's Representative must provide it to the Managed Long-Term Care Plan promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
11/16/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee