STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: September 20, 2018
[redacted]
AGENCY: MAP
FH #: 7829326R

In the Matter of the Appeal of

[redacted]

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

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on October 16, 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

Julie Rolffot, Manager of Appeals and Grievances, Fair Hearing Representative

ISSUE

Was the Appellant's request for a fair hearing to review the determination by the Managed Long-Term Care plan, Centers Plan for Healthy Living, to deny a request for an authorization to increase Personal Care Services timely?

Assuming the request was timely, was the determination by Centers Plan for Healthy Living to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours to eighty-four (84) hours per week (12 hours per day x 7 days) from thirty-five (35) hours per week (5 hours per day x 7 days)/forty-five and one-half (45.5) hours per week (6.5 hours per day x 7 days) correct with regard to the adequacy of Medical Assistance?

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 fifty-seven (57), has been in receipt of a Medical Assistance authorization, Medicaid benefits, and has been enrolled in a Medicaid Managed Long Term Care plan with Centers Plan for Healthy Living.

2. The Appellant resides alone.

3. The Appellant had been in receipt of an authorization of Personal Care Services in the amount of thirty-five (35) hours per week (5 hours per day x 7 days) via participation in the Consumer Directed Personal Assistance Program.

4. The Appellant requested that the Plan provide him with an authorization to increase his Personal Care Services to eighty-four (84) hours per week (12 hours per day x 7 days0.

5. On June 29, 2018, a registered nurse assessor completed a Uniform Assessment System (UAS) evaluation based upon an in-person visit with the Appellant on June 28, 2018.

6. The UAS report identifies the following degree of need for assistance with the following activities of daily living: total dependence with meal preparation, ordinary housework, stairs, transportation and shopping; maximal assistance with bathing, dressing lower body, walking, and toilet transfers; extensive assistance with personal hygiene, dressing upper body, locomotion and toilet use; and limited assistance with bed mobility. The nurse reported that the Appellant's abilities to participate in his activities of daily living has declined and deteriorated over the 90 days preceding the report. The nurse also reported that the Appellant is occasionally incontinent of bowel and bowel.

7. On June 28, 2018, a registered nurse assessor completed a "Person Centered Service Plan which identifies the Appellant's Personal Care Needs as thirty-five (35) hours per week.

8. The Appellant has a medical diagnosis which includes the following: below the knee amputation ("acquired absence of left leg below the knee, June, 2018); second degree burn of right foot; constipation, dependence on wheelchair; difficulty in walking; essential (primary) hypertension; abnormalities of gait and mobility; chronic pain; fatigue; idiopathic peripheral autonomic neuropathy; obesity; primary osteoarthritis; shortness of breath; type diabetes mellitus with diabetic neuropathy; varicose veins; and xerosis cutis.

9. By written notice of "Initial Adverse Determination Denial Notice" which is dated July 16, 2018, the Plan determined to deny the Appellant's request for an authorization to increase the Appellant's Personal Care Services from thirty-five (35) hours per week (5 hours per day x 7 days) to eighty-four (84) hours per week (12 hours per day x 7 days) on the grounds that

the Plan has determined that forty-five and one half (45.5) hours per week is sufficient to meet the Appellant's needs.

10. The notice advises of the Plan's determination to "partially approve" the Appellant's request for an authorization increasing Personal Care Services via approval of such services in the amount of forty-five and one half (45.5) hours per week (6.5 hours per week x 7 days).

11. The notice also advised the Appellant that a fair hearing must be requested within sixty days of the Plan's action concerning Medical Assistance.

12. The Plan mailed the notice to the Appellant's address.

13. The Appellant requested an internal appeal.

14. By written notice of "Final Adverse Determination Denial Notice" which is dated September 18, 2018, the Plan advised that the Plan was upholding the Plan's July 16, 2018 determination to deny the Appellant's request for an authorization to increase the Appellant's authorization of Personal Care Services to eighty-four (84) hours per week (12 hours per day x 7 days).

15. On September 20, 2018, the Appellant requested a fair hearing in this matter.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

Appellant right to fair hearing and appeal rights: 42 CFR section 438.402 (c)(1)(i) and 438 (f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld. 42 CFR section 438.402 (c)(1)(i)(A), 438.408 (c)(3) and 438.408 (f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applied when: an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan; an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State – specified timeframes; or a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR section 438.408. 42 CFR section 438.408 (f) (2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing. Pursuant to 42 CFR section 438.424 (a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services

promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

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

The Department's Managed Care Personal Care Services (PCS) Guidelines dated May 2013 advises 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.

The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care (published May 31, 2013), Section III (Authorization and Notice Requirements for Personal Care Services) subsection d (Level and Hours of Service), requires that the authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;
ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
iii. that are authorized for the new authorization period; and
iv. the original authorization period and the new authorization period, as applicable.

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 include, but are not necessarily limited to, the following:

(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.

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. Social services districts are NOT required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

Completing accurate and comprehensive assessments is essential to safe and adequate care plan development and appropriate service authorization. Adhering to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

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 (SDNY, 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.)

In addition to clarifying requirements for client notices under Mayer, the Department's regulations also reflect a Court ruling in Mayer regarding the use of task based assessments [18 NYCRR 505.14(b)(5)(v)(d)]. Specifically, social services districts are prohibited from using task-based assessments when authorizing or reauthorizing personal care services for any recipient whom the district has determined needs 24-hour care, including continuous 24-hour services (split-shift), 24-hour live-in services or the equivalent provided by a combination of formal and informal supports or caregivers. In addition, the district's determination whether the recipient needs such 24-hour personal care must be made without regard to the availability of formal or informal supports or caregivers to assist in the provision of such care. GIS 01 MA/044, issued on December 24, 2001.

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 task-based assessment (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 (SDNY, 1997).]

Pursuant to GIS 03 MA/003, issued on January 24, 2003, task-based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies.

Social services districts, including those using locally developed task-based assessment instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patient's appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 NYCRR 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

In accordance with GIS 12 MA/026, published October 3, 2012, pursuant to the directives of the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, the GIS directs that, 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.

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 nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of "some assistance" and "total assistance" are repealed.

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.

DISCUSSION

The record in this matter establishes that the Appellant is seeking an authorization for an increase of Personal Care Services to eighty-four (84) hours per week. The Plan has denied 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) but authorized an increase to forty-five and one half (45.5) hours per week (6.5 hours per week x 7 days) from the prior authorization of thirty-five (35) hours per week (5 hours per day x 7 days).

Preliminarily, it is noted that the Plan's fair hearing representative objected to the jurisdiction of the Commissioner and Commissioner's designee to resolve the matter at issue because the Appellant's request for a fair hearing was made on September 20, 2018, which date is sixty-six (66) days after the Plan's July 16, 2018, notice. It is noted that the Appellant's request for a plan appeal appears to have been made on September 12, 2018, via the Appellant's vascular health physician, Nilesh Balar, M.D. Review of the July 16, 2018, Initial Adverse Determination advises that an internal appeal may be requested within sixty (60) days of the notice date, to wit – the notice advises that "[y]ou have 60 calendar days from the date of this notice to ask for a Plan Appeal. The deadline to file a Plan Appeal is 09/14/2018." The Plan's notice also advised that, with regard to the applicable time limit for a request regarding a New York State fair hearing, as follows: "[y]ou have the right to ask the State for a Fair Hearing about this decision **after** you ask for a Plan Appeal **and** you receive a Final Adverse Determination. You will have 120 days from the date of the final Adverse Determination to ask for a Fair Hearing OR The time for us to decide your Plan Appellant has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing**." The aforesaid information is incorrect with regard to the Appellant's right to request a fair hearing.

The applicable regulations pertaining to the applicable statute of limitations in this matter does NOT require that the Appellant wait until after the Plan's Final Adverse Determination and/or the expiration of sixty (60) days, which is the time limit the notice provides to the Appellant for making an internal appeal. As shown above, the request for the internal appeal had been timely made insofar as same was made in accordance with the instructions provided in the

written initial adverse determination. Review of the internal appeal request also shows that the Appellant's physician had requested an expedited determination. The Plan, however, issued to the Appellant the Final Adverse Determination on September 18, 2018, which is after the 60-day time period pertaining to the applicable statute of limitations in this matter. Because the Plan's information pertaining to the Statute of Limitations is inaccurate and confusing, the record shows that the Appellant has good cause for having made the request for a fair hearing six days after the applicable time limit. It is also noted that the provision of two days for the mailing of the notice to the Appellant and of the Appellant's request for a fair hearing would mean that the actual lateness of request would come down to one full day. Given the plausibility of confusion regarding the internal appeals process and the overlapping of same with the applicable statutes of limitations, the statute of limitations in this matter is properly tolled.

With regard to the adequacy of the Personal Care Services authorization, the Appellant's advocates contended at the fair hearing that the Appellant requires a span of time increase in Personal Care Services to twelve (12) hours per day in order to provide the Appellant with adequate assistance particularly pertaining to provision of assistance with necessary insulin injections, with actual provision of meals, and with regard to toileting. It is undisputed that the Appellant requires assistance with walking, locomotion, toilet transfer and toilet use, as well as with meal preparation, medication management and preparation for bed. At the fair hearing the Appellant's advocates plausibly and persuasively testified that the Appellant is unable to access his own kitchen because he cannot walk unassisted and without use of either a wheelchair or a walker and that these two assistive devices will not fit through the kitchen door. The Appellant's advocates also plausibly testified that the Appellant's insulin, which he is required to take by needle injection four times per day, is kept in the Appellant's refrigerator in the Appellant's kitchen. The Appellant's advocates also testified that the CDPAP Personal Care Aide is required to help put together the Appellant's insulin medication and to assist the Appellant in the morning at breakfast, at lunch, at dinner and at bedtime. The Appellant's advocates also testified that the Appellant requires assistance with toileting approximately every two hours. With regard to overnight toileting, the Appellant's advocates plausibly and persuasively testified that the Appellant uses a mobile urinal. Finally, the Appellants' advocates credibly testified that the Appellant's CDPAP provider has been returning to the Appellant's home in the hours after the current scheduled work period to provide informal support with regard to the Appellant taking his insulin and provision of meals but that the informal supporter cannot continue to provide these additional unpaid hours of services.

The record in this matter has been carefully reviewed and considered. The record establishes that the Appellant requires at least twelve (12) hours per day of Personal Care Services particularly in regard to the Appellant's span of time needs for provision of medications and meals. The Plan's determination to deny the Appellant's request for an authorization of twelve (12) hours per day cannot, therefore, be sustained.

DECISION AND ORDER

The determination by Centers Plan for Healthy Living, to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours to eighty-four (84) hours

per week (12 hours per day x 7 days) is not correct with regard to the adequacy of necessary services and is reversed.

Centers Plan for Healthy Living is directed to:

1. Immediately provide to the Appellant a Personal Care Services authorization in the amount of eighty-four (84) hours per week (12 hours per day x 7 days).

2. Continue to provide the Appellant with 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 Centers 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
10/22/2018

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee