STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 12, 2019
[redacted]
AGENCY: MAP
FH #: 7910376Z

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 March 27, 2019, 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)

D. Ferguson, Fair Hearing Representative

ISSUE

Was the determination by the Appellant's Managed Long-Term Care Plan, Centers Plan For Healthy Living, to deny the Appellant's request for an increase in Personal Care Service from 9.5 hours a day, 7 days per week (66.5 hours per week) to 24 hours daily continuous care (split shift), 7 days per week 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 eighty-one) 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 (Plan).

2. The Appellant had been receiving Consumer Personal Care Service Services Level II 9.5 hours a day, 7 days per week (66.5 hours per week).

3. On December 18, 2018 the Appellant or her provider requested approval for Personal Care Services Level II 24 hours per day continuous care (split shift), 7 days per week.

4. By Initial Adverse Determination Denial Notice dated January 11, 2019, the Plan approved Personal Care Services Level II 9.5 hours a day, 7 days per week (66.5 hours per week).

6. On January 14, 2019 the Appellant or her provider asked for a Plan Appeal regarding the Plan's decision to deny the increase in personal care assistance services from 9.5 hours a day, 7 days per week (66.5 hours per week) to 24 hour split shift.

7. By Final Adverse Determination Denial Notice dated January 16, 2019 the Plan advised the Appellant that the Plan is not changing its decision to deny the Appellant's request. The cited reason for the denial was that it was not medically necessary. The Determination noted that:

Ms. [redacted] lives in a one bedroom apartment with her spouse on the second floor.

Ms. [redacted] recently underwent a follow-up face-to-face clinical assessment on December 31, 2018 utilizing the New York State Department of Health's Uniform Assessment System Tool that showed most of her abilities to perform physical functioning stayed the same since her prior assessment that was completed by Centers Plan for Healthy Living on August 13, 2018.

Ms. [redacted] showed that her abilities to perform physical function stayed the same to perform walking, toilet use, transfer toilet (getting on and off the toilet), dressing upper and lower body, eating, ordinary housework, eating, meal preparation, medication management, bed mobility (moving around the bed), and personal hygiene (cleaning yourself).

In summary, Ms. [redacted] showed that most of her abilities to perform physical functioning stayed the same; therefore, her hours stayed the same at 9.5 hours per day, 7 days a week, for a total of 66.5 hours per week.

7. The Appellant's Representative presented into evidence a letter dated February 8, 2019 prepared by the Appellant's physician as well as nighttime logs prepared in February 2019 March 12, 2019, all of which were presented to the Plan for the Plan's review.

8. The Appellant requested this fair hearing on February 12, 2019 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 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. **The notice must explain** the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) **The reasons for the action**...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

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.

GIS 15 MA/024 informs local departments of social services (LDSS) eligibility and managed care staff of revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR § 505.14 and 18 NYCRR § 505.28, respectively. These revised regulations were effective on December 23, 2015.

These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous ("split-shift") PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, LDSS workers must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the **New York State Register** on December 23, 2015.

Regulatory changes for PCS and CDPA include:

1. 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.

2. "Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.

3. The definitions and eligibility requirements for "continuous personal care services," "live-in 24-hour personal care services," "continuous consumer directed personal assistance" and "live-in 24-hour consumer directed personal assistance" are revised as follows:

- *a. 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-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.
- *b. 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.
- *c. Continuous consumer directed personal assistance* means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the consumer's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.
- *d. Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

Services shall not be authorized to the extent that the individual's need for assistance can be met by **voluntary** assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

5. 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.

6. The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

7. The social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

8. The regulations also revise the Department's regulations governing the content of notices for denials, reductions or discontinuances of PCS and CDPA. In subparagraph 505.14(b)(5)(v), the provisions governing social services districts' notices to recipients for whom districts have determined to deny, reduce or discontinue PCS are revised and reorganized. Paragraph 505.28(h)(5) is amended to provide additional detail regarding the content of social services district notices when the district denies, reduces or discontinues CDPA. All districts must ensure that their notices denying, reducing or discontinuing PCS or CDPA are consistent with these regulations and include the specific reason for the action and, if applicable, the clinical rationale. All districts should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements. If you have any questions, please services@health.ny.gov

Revisions to 505.14 effective December 23, 2015

I. Scope of the Personal Care Services Benefit

A. Slightly revised definition of Personal Care Services

Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.
[18 NYCRR § 505.14(a)(1)]

B. Repeal of "some assistance" and "total assistance" definitions

C. Addition of "turning and positioning" as a Level II personal care function
[18 NYCRR § 505.14(a)(5)(ii)(a)(7)]

D. New definition of "Continuous Personal Care Services" ("Split-Shift Care")

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.
[18 NYCRR § 505.14(a)(2)]

E. New definition of "Live-in 24-Hour Personal Care Services"

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)(4)]

F. Personal care services, including continuous personal care services and live-in 24-hour personal care services, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;
(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or
(3) 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.
[18 NYCRR § 505.14(a)(3)(iii)]

G. The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.
[18 NYCRR § 505.14(a)(3)(iii)]

H. Live-in 24-Hour Cases that Lack Sleeping Accommodations for a Live-in Aide

When the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient's circumstances change and sleeping accommodations for a personal care aide become available in the patient's home, the district must promptly review the case. If a reduction of the patient's continuous personal care services to live-in 24-hour

personal care services is appropriate, the district must send the patient a timely and adequate notice of the proposed reduction.
[18 NYCRR § 505.14(b)(4)(i)(c)(1)]

II. New Nursing Assessment Requirements in Continuous Personal Care Services and Live-in 24 Hour Personal Care Services Cases

The nursing assessment in continuous (split-shift) and live-in cases shall document the following:

(i) whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;

(ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day;

(iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day;

(iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and

(v) whether, were live-in 24-hour personal care services to be authorized, the 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)(5)(ii)(b), 505.14(b)(4)(i)(c)(2)]

III. New Social Assessment Requirement in Live-in 24-Hour Personal Care Cases

In cases involving live-in 24-hour personal care services, the social assessment shall also evaluate whether the patient's home has sleeping accommodations for a personal care aide. When the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient's circumstances change and sleeping accommodations for a personal care aide become available in the patient's home, the district must promptly review the case. If a reduction of the patient's continuous personal care services to live-in 24-hour personal care services is appropriate, the district must send the patient a timely and adequate notice of the proposed reduction.
[18 NYCRR § 505.14(b)(4)(i)(c)(1)]

IV. Slight Revision to Language Barring Task-Based Assessments in Continuous and Live-In Cases

The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.
[18 NYCRR § 505.14(b)(5)(v)(d)]

V. Slightly Revised Notice Requirements For Denials of Personal Care Services
Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

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

(ii) the client's medical condition is not stable. The notice must identify the client's medical condition that is not stable;
(iii) the client is not self-directing and has no one to assume those responsibilities;
(iv) the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;
(v) the client refused to cooperate in the required assessment;
(vi) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
(vii) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

[18 NYCRR § 505.14(b)(5)(v)(c)(1)]

VI. Slightly Revised Notice Requirements For Reductions/Discontinuations of Personal Care Services

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

(i) the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;
(ii) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;
(iii) the client refused to cooperate in the required reassessment;
(iv) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;
(v) the client resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed personal care services; and
(vi) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify.

[18 NYCRR § 505.14(b)(5)(v)(c)(2)]

As outlined in GIS 01 MA/044, the New York State Department of Health advises local Districts that when a determination is made to reduce, discontinue or deny personal care services, the notice must identify the specific reason that justifies the action, and explain why the stated reason justifies the reduction, discontinuance, or denial of such services.

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

It is of great import to note that the Plan, in its Final Adverse Determination stated: “most of her abilities to perform physical functioning stayed the same”. The Plan therefore was observant of cognizant of changes in the Appellant’s needs level. Curiously, the changes were not reflected in any measurable way in the assessments or the Plan’s records. The Plan also took no note of the night logs which clearly evidence that the Appellant has unplanned needs arising both day and night. Also, none of these functions are stand-alone safety monitoring functions as all are related to and consequences of the Appellant’s many serious and chronic medical conditions. The Plan also ignored the Appellant’s physician’s letter which will herein be paraphrased and/or cited as it is a significantly detailed and weighty letter.

The Appellant’s physician reported that the Appellant suffers from: Dementia due to Parkinson’s disease with behavioral disturbance, repeated falls, polypharmacy, orthostatic hypertension, recurrent syncope, dysphagia, urinary incontinence and partial symptomatic *epilepsy* with complex partial seizures (emphasis added) not intractable, without status epilepticus.

To quote the physician:

The above diagnoses severely impact Ms. [redacted]'s daily functioning and she requires assistance with all activities of daily living. She requires prompting to bathe and assistance with bathing given her imbalance, increasingly frequent episodes of mobility freezing (emphasis added), and high risk for falling. She needs prompting for personal hygiene, including brushing her teeth in the morning and evening before bedtime. She even often needs assistance with feeding, particularly during episodes of freezing. Ms[redacted] is dependent to get dressed. She is able to sit at the table to eat all meals of the day, and requires assistance for preparation. She also wears incontinence briefs due to leakage of urine and bowel, and not being able to get to the toilet on time. (emphasis added) She also needs assistance to wipe herself after toileting, as she is unable to do so on her own. (emphasis added) A lack of assistance with this puts her at a higher risk for infection. She is also dependent for all instrumental activities of daily living, including medication administration, finances, and housekeeping.

Ms. [redacted]'s sleep is irregular and disrupted. She awakens during the night to urinate and needs assistance due to nighttime immobility (emphasis added).

As her condition is a progressive neurocognitive disorder, her health is in a constant state of decline (emphasis added), and there is no possibility for improvement. Her decline has been more rapid in recent months, and especially notable on her follow up visits to my office. In addition to more frequent episodes of mobility freezing, she also has hallucinations that are becoming increasingly more frequent and disruptive to her care. Perhaps most threatening to her safety are the increasing episodes of syncope, which are unpredictable, have caused significant injury, and have required two recent hospital stays in the past few weeks. Lack of around the clock assistance in light of these changes in her physical and behavioral health can lead to adverse outcomes that may result in higher healthcare utilization, as has already begun to occur in the setting of her currently inadequate home care.

The physician goes on to explain:

Of note, Ms. [redacted] has a waxing and waning level of alertness. She may have a brief time at the beginning of the day (lasting no more than a few hours), when she is able to verbally communicate more effectively, and her physical abilities are at their peak (after waking in the morning). Even during these times (which are becoming less frequent), however, she is still dependent for her IADLs, and requires assistance for her ADLs. Her overall abilities may be miscalculated if she is visited for an assessment during one of these times.

The physician then addresses her family member's caregiving roles. The Plan describes the Appellant's spouse's (age eighty) and stepdaughter's role as strong caregivers. Oddly, this finding was placed in capital letters by the Plan. The Appellant's Representative and the Appellant's physician successfully refute the Plan's finding. The Appellant's physician clarifies their roles as follows:

Finally, though she has a husband and stepdaughter who have been trying to assist her at home, neither is able to take on the caregiver role. Her husband has himself been physically

incapacitated by a trauma that required surgery in the past few weeks, rendering him incapable of participating in her care. That trauma occurred as he was trying to catch Ms. [redacted] when she became imbalanced while she was toileting in the middle of night. Her stepdaughter, who is disabled herself, does not live in the home and as such, is unable to provide adequate care.

Several other factors of which to take notice. The Appellant's husband suffers from kidney disease. The Appellant has recently been diagnosed with skin cancer creating additional likely skin care needs both day and night. The night time logs indicate the need to turn the Appellant due to the immobility caused by her co-morbidities.

Based upon the foregoing considerations the Plan's determination cannot be sustained. The Plan's stated reason that the Appellant's condition does not warrant split shift services is not correct.

DECISION AND ORDER

The Managed Long-Term Care Plan's to deny the Appellant's request for an increase in Personal Care Services (PCS) to 24 hours daily continuous care (split shift), 7 days per day is not correct and is reversed.

1. The Plan is directed to authorize the Appellant to receive Personal Care Services (PCS) Authorization in the amount of twenty-four hours per day consisting of 12 hours of "split shift" care by more than one aide for seven days per week.

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
04/25/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee