STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 30, 2018
[redacted]
AGENCY: MAP
FH #: 7799467M

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 September 13, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Long-Term Health Care Plan (Centers Plan For Healthy Living/Constant Care Health Services)

D. Ferguson, Plan Representative

ISSUE

Was the determination by the Appellant's Managed Long-Term Care Plan (Centers Plan For Healthy Living/Constant Care Health Services) to deny the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from 4 hours per day, 5 days per week (20 hours per week) to 8 hours per day, 5 days per week (40 hours 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 sixty-three) has been receiving Consumer Directed Personal Assistance Services (CDPAS) 4 hours per day, 5 days per week (20 hours weekly).

2. On May 16, 2018 the Appellant requested an increase in CDPAS from hours from 4 hours per day, 5 days per week days per week (20 hours weekly) to 8 hours per day, 5 days per (40 hours weekly).

3. By Initial Adverse Determination Denial Notice dated May 29, 2018 the Plan decided to deny the request for an increase in CDPAS hours. The Plan's determination stated:

On 05/25/2018, Centers Plan for Healthy Living decided to deny this service based on the NYS Department of Health Uniform Assessment System (UAS-NY0 and the plan's tasking tool. A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted on 3/8/2018. The UAS-NY assessment showed the level of assistance you need to perform your Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's). The UAS-NY assessment produces a Nursing Facility Level of Care (NFLOC) score. Your NFLOC on 3/8/2018 was 14.

Dressing Upper Body, Dressing Lower Body, Personal Hygiene, Bed Mobility, Bathing and Toilet Use: Limited Assistance (need little or no physical touch and direction throughout the task).
Walking, Locomotion, and Toilet Transfer Capacity: Extensive Assistance (You need some physical touch and direction throughout the task, but you can complete the task without someone to lean on or help you lift any body parts).
Bowel Continence (continent) and Bladder Continence (continent): Continent.
You did not show any changes in your Eating ability: Independent (You are able to complete this task by yourself, without any physical help or supervision).
Meal Preparation and Ordinary Housework: Maximal Assistance (You need physical help to complete most parts of this task, like someone to lean on or help you lift a body part, however you can complete some parts of this task by yourself).
Medication Management Capacity: Maximal Assistance (You need physical help to complete most parts of this task, like someone to lean on or help you lift a body part, however you can complete some parts of this task by yourself).

4. On June 7, 2018 the Appellant appealed the Plan's determination dated May 29, 2018 to deny the increase in CDPAS hours.

5. By Final Adverse Determination Denial Notice dated July 11, 2018 the Plan decided to uphold its initial determination to deny the requested increase on the same grounds.

6. On July 30, 2018 the Appellant requested this fair hearing to contest the Plan's June 21, 2018 determination.

APPLICABLE LAW

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid

Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

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

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

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

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

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

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

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

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Consult with the requesting provider when appropriate.

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

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

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

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

In the case of an MCO or PIHP-“Action” means--

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

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home...".

Section 505.14(a) of the Regulations provides in part that:
(2) Some or total assistance shall be defined as follows:
(i) Some assistance shall mean that a specific function or task is performed and completed by the patient with help from another individual.
(ii) Total assistance shall mean that a specific function or task is performed and completed for the patient.
(3) Continuous personal care services means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.
(5) Live-in 24-hour personal care services means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.
(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:
(i) Level I shall be limited to the performance of nutritional and environmental support functions.
Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.
(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.
(a) Personal care functions shall include some or total assistance with the following:
(1) bathing of the patient in the bed, the tub or in the shower;
(2) dressing;
(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;
(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;
(6) transferring from bed to chair or wheelchair;
(7) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
(8) feeding;
(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(10) providing routine skin care;
(11) using medical supplies and equipment such as walkers and wheelchairs; and
(12) changing of simple dressings.

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

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

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

General Information Service message 97 MA 033 includes a reminder concerning "statements of understanding". The GIS Message advises that the contribution of family members or friends to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.) In New York City, the form statement of understanding is entitled "Agreement of Friend or Relative."

12 OHIP/ADM-1 states, in part:

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

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following:

(1) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and

(2) voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

• The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;
• The specific task or tasks with which the person requires frequent assistance during the night;
• The frequency at which the person requires assistance with these tasks during the night;
• Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;
• The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;
• The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and
• Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released 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. In relevant portion, this GIS Message states:

> Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, 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**.**

18 NYCRR 505.14(b)(3)(1)(a), provides, in pertinent part, as follows:

(3) Such medical professional must not recommend the number of hours of personal care services that the patient should be authorized to receive.

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care, dated May 31, 2013, Section I (a) provides, in pertinent part, as follows:

viii. Services provided outside of the home. The scope of the benefit includes PCS provided not only in the enrollee's home but also in other locations in which the enrollee's life activities may take them such as school, work, and other locations, such as a provider's office. NOTE: When a PCS worker accompanies the member to a provider office it is to assist the member with a task and not to act as a medical facilitator. A medical facilitator is someone who provides information and receives information about the member's medical condition, such as a family member or health care agent. The MCO is not required to authorize hours beyond the hours assessed as appropriate for the home, but the hours authorized can be provided in the home or other locations, such as a family gathering.

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). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Section 358-5.9 of the Regulations provides in part: (a) At a fair hearing regarding the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record established the relevant facts as stated above. At the hearing the Plan's Representative credibly contended that there was no clinically documented significant change in the Appellant's condition. At the hearing the Appellant contended that her conditions have worsened as reflected by recent eye surgeries and therapeutic services but did not corroborate that contention by presenting clinical evidence of same. It is also noted however that the clinicals submitted by the Appellant merely lists the Appellant's infirmities but do not link any of the diagnosed conditions as particular impediments to the performance of any of the Appellant's ADLs. It is additionally noted that no observational evidence is contained therein such that the treating providers could be said to have recorded the frequency of occurrence and amount of time of any identified ADL. Accordingly, the Appellant's request for an increase in PCS hours is unsustainable at this time because the record demonstrates that the Appellant's functional needs had not changed at the time that the Plan made its determination.

The Appellant is informed of the right to submit clinical documentation of recent surgical and therapeutic procedures in support of the Appellant's request for increased hours **and** to include a request from a medical provider clearly explaining how diagnosed conditions impact the Appellant's ability to perform ADLs.

It is noted that the regulations and the Rodriguez case make clear that the purpose of an aide is to assist with tasks and not to act as a prophylactic safety device in case of vertigo, loss of consciousness, seizures, falls or the like. It is further noted that the Plan can make arrangements for escort to medical appointments. At the hearing it was clear from the CDPAS provider that the main reason for requesting additional hours was that her hours were insufficient to get the Appellant to and from medical appointments. The Appellant is advised herein as she was at the hearing that door-to-door transportation (with assistance in and out by the driver) could easily be arranged for her. It may also be that in certain other limited circumstances, additional hours for her Aide could be approved on a case by case basis should the hours provided be insufficient.

Accordingly, the Plan's determination must be sustained.

DECISION

The Plan's determination by the Appellant's Managed Long-Term Care Plan, (Centers Plan For Healthy Living/Constant Care Health Services) to deny the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from 4 hours per day,

5 days per week (20 hours per week) to 8 hours per day, 5 days per week (40 hours per week), is correct.

DATED: Albany, New York
01/18/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee