STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 11, 2019
[redacted]
AGENCY: MAP
FH #: 7924708H

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 April 3, 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 Health Living

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Long-Term Care Plan's Initial Adverse determination dated February 13, 2019 and the Managed Long-Term Care Plan's Final Adverse determination dated February 14, 2019 to deny the Appellant's request for an increase in Personal Care Services authorization from 24 hours daily Live In daily, times 7 days weekly to 24-hour, continuous ("split-shift") care (168 hours weekly) 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 95, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter "Plan").

2. The Appellant is currently authorized to receive Personal Care Services in the amount of 24 hours daily live in, 7 days weekly.

3. The Appellant's diagnosed health conditions are: [redacted].

4. On August 31, 2018 and again on January 18, 2019, a nursing assessor completed Uniform Assessment System ("UAS") assessments of the Appellant's personal care needs.

5. By Initial Adverse Determination, dated February 13, 2019, and by Final Adverse Determination, dated February 14, 2019, the Plan determined to deny the Appellant's request for an increase in Personal Care Services from 24 hours live in daily, times 7 days weekly to 24-hour, continuous ("split-shift") care (168 hours weekly).

6. On March 11, 2019, the Appellant requested this fair hearing to contest the Plan's February 13, 2019 and February 14, 2019 determinations.

APPLICABLE LAW

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 Medical Assistance or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Section 358-3.3(a)(1) states that, except as provided in subdivision (d) a recipient has a right to a timely and adequate notice when a social services agency:

(i) proposes to take any action to discontinue, suspend, or reduce a Public Assistance grant, Medical Assistance Authorization or services.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services.

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...

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 number 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, [redacted], urinal, walker, wheelchair, etc.

Section 505.14(a)(4) provides a new definition of "Live-in 24-Hour Personal Care Services" as follows: Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

Section 505.14(a)(2) provides a new definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

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 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;
  - (ii) 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:

(a) 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 of 42 CFR Subpart F provides, in part:

(a) Notice. The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in § 438.10.
(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...

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

Section III (Authorization and Notice Requirements for Personal Care Services) of the Guidelines provide:

d. Level and Hours of Service. 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.

e. Terminations and Reductions…

iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice.

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.

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.

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**.**

Completion of accurate and comprehensive assessments are essential to safe and adequate care Medical Plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

DISCUSSION

The uncontroverted evidence in this case establishes that the Appellant, age 95, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan. By Initial Adverse Determination Notice, dated February 13, 2019, and by Final Adverse Determination Notice, dated February 14, 2019, the Plan determined to deny the Appellant's request for an increase in Personal Care Services from 24 hours daily Live In, times 7 days weekly to 24-hour, continuous ("split-shift") care (168 hours weekly). The Plan's Initial Adverse Determination Notice dated February 13, 2019 notice cites the reason for the denial, in pertinent part, as:

> "Your daughter requested an increase in your Personal Care Aide because she wants someone to be available for you during the night hours. A registered Nurse from Centers Plan for Health Living visited you in your home on 1/18/2019 and completed a face-to-face assessment using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs.
>
> Based on this assessment it was identified that:
> You are able to walk with walker and some assistance.
> You need help with bathing, dressing and toileting.
> You can transfer on and off the toilet and take care of your toileting needs with some assistance and you are able to use a bedside [redacted].
> You are able to move from lying position and turn side to side while bed with some assistance.
> You are receiving skilled services from a visiting nurse.
> You have had no recent falls.
> You do not need to be turned and positioned every two hours
> You do not need continuous care for sixteen (16) hours or more.

Your requested increase in Personal Care Aide Service, along with your recent UAS-NY assessment and MD note were thoroughly reviewed by Centers Plan for Healthy Living. Based on clinical documentation presented, your current Personal Care Aide Services of twenty-four (24) hours per day, seven (7) days per week, live-in are appropriately and safely meeting your personal care needs. Therefore, your personal care services will remain the same."

See *MLTC Exhibit 34*, Initial Adverse Determination Denial Notice dated February 13, 2019.

A review of The Managed Long-Term Care Plan's Final Adverse Determination Notice dated February 14, 2019 reads in pertinent part:

"You are getting this notice because on February 12, 2019 at 12:44 PM, your daughter, [redacted] asked for a Plan Appeal on your behalf, about our decision to deny the request for an increase in Personal Care Aide (PCA) services. Your daughter requested, an increase for a total amount of 168 hours per week (split shift).

On February 13, 2019 we decided we are not changing our decision to deny your request for an increase in PCA services.

From January 16, 2019 to February 28, 2019, the plan approved: Personal Care Aide Level 2: Live-In per diem, 24 hours per day, 7 days per week.

On January 25, 2019 you or your provider requested approval for: Personal Care Aide Level 2 x 12 hours per day, 7 days per week; 12 hours per day, 7 days per week, for a total of 168 hours per week.

On February 8, 2019 the plan approved: Personal Care Aide Level 2: Live-in per diem, 24 hours per day, 7 days per week.

On February 13, 2019, the plan approval stays at: Personal Care Aide Level 2: Live-in per diem, 24 hours per day, 7 days per week from February 13, 2019 to July 31, 2019.

Why did we decide to deny the request?

The Medical Director on behalf of Centers Plan for Healthy Living decided to deny the request for an increase in PCA services because the service is not medically necessary.

The request for an increase in PCA services was denied because you do not meet the criteria. This decision was based on:

The denial for an increase in Personal Care Aide Level 2 services at 24 hours per day (split shift), 7 days a week, for a total of 168 hours per week is upheld (continues to be denied).

Your hours stay the same at (Live-in per diem), 24 hours per day, 7 days week.

You live alone in a one-bedroom apartment on the 3rd floor of an elevator accessible building.

You recently underwent a follow-up face-to-face clinical assessment on January 18, 2019 utilizing the New York State Department of Health's Uniform Assessment System Tool that showed most of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on August 31, 2018.

Your abilities to perform physical functioning stayed the same for dressing upper body, personal hygiene (cleaning yourself), bed mobility (moving around the bed), transfer toilet (getting on and off the toilet), toilet use, bathing, walking, meal preparation, medication management, and ordinary housework.

In summary, most of your abilities to perform physical functioning stayed the same; therefore, your hours stay the same at 24 hours per day (Live-In per diem), 7 days a week.

This decision is based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool."

See *MLTC Exhibit 35* Final Adverse Determination Notice dated February 14, 2019.

A review of MLTC Plan Exhibit 3, Uniform Assessment System – New York Comprehensive Community Assessment Report (UAS) dated August 31, 2018 indicates that the Appellant requires assistance as follows:

<u>Total Dependence:</u>
Meal preparation
Ordinary housework
Managing finances
Managing medications
Shopping

<u>Maximal Assistance:</u>
Stairs
Transportation
Bathing
Personal hygiene
Dressing upper body
Dressing lower body
Walking

Locomotion
Transfer toilet
Toilet use
Bed mobility

Extensive Assistance:
Phone use

Limited Assistance:
Eating

See *MLTC Plan Exhibit 3* Uniform Assessment System – New York Comprehensive Community Assessment Report, (UAS) dated August 31, 2018

A review of the *MLTC Plan's Exhibit 2,* Uniform Assessment System – New York Comprehensive Community Assessment Report (UAS) dated January 18, 2019 indicates that the Appellant requires assistance as follows:

Total Dependence:
Meal preparation
Ordinary housework
Managing finances
Managing medications
Shopping

Maximal Assistance:
Stairs
Transportation
Bathing
Personal hygiene
Dressing upper body
Dressing lower body
Walking
Locomotion
Transfer toilet
Toilet use
Bed mobility

Extensive Assistance:
Phone use

Limited Assistance:
Eating

See *MLTC Plan Exhibit 2*, Uniform Assessment System – New York Comprehensive

Community Assessment Report (UAS) dated January 18, 2019.

At the hearing, the Managed Long-Term Care Plan waived its appearance and submitted a waiver packet including 35 exhibits which were all marked and admitted into evidence. The Appellant's daughter and the Appellant's legal advocate (collectively, "Appellant's Representatives"), who appeared on behalf of the Appellant, testified that the Appellant has significant and frequent nighttime needs, which include [redacted].

The Appellant Representative contended that the Appellant is a 95-year-old, homebound individual, residing alone, who was recently diagnosed with [redacted] and is currently undergoing [redacted]. She also suffers from [redacted]. In support of Appellant's claim, the Appellant submitted into evidence a document from Appellant's physician dated February 11, 2019 which states in pertinent part:

"Request for increased hours for personal care by Dr. [redacted]

Date: February 11, 2019
Re: [redacted] D.O.B. [redacted]

Address [redacted]

This is an [redacted] who is under my care. She [redacted].

Recently pt. was discharged from the hospital where she was diagnosed with [redacted]. Her condition progressively deteriorated and she became completely dependent on her caregivers, in all her daily living activities, including [redacted]. Currently pt. developed [redacted]. Pt. cannot turn herself while in the bed. Being [redacted].

To provide a safe environment for the patient she needs assistance at all times 12 x 12 (split shift) 7 days a week.

Feel free to call me if you have any questions.

Sincerely,

[redacted], MD."

See *Appellant Exhibit C,* dated February 11, 2019 Dr. [redacted], MD.

The Appellant Representative further submitted into evidence a document dated March 5, 2019 from Appellant's Doctor, [redacted] MD which stated in pertinent part:

"This is an [redacted].

Recently pt. was discharged from the hospital where she was diagnosed with [redacted] and she became completely dependent on her caregivers, in all of her daily living activities, including [redacted].

Because patient did not get repositioned every two hours as it was required in my previous request to increase her HHA hours 12 x 12 + 24 split shift she developed new [redacted] which will be progressing unless the patient gets repositioned every two hours. Also, the patient's [redacted] did not get addressed and her [redacted] around the clock – this could lead to possible hospitalization and increased Medicare/Medicaid spending for treatment of this patient.

To provide a safe environment for the patient, she needs assistance at all times 12 x 12 (split shift) 7 days a week.

Feel free to call me if you have any questions.

Sincerely,

[redacted], MD."

See *Appellant Exhibit D*, dated March 5, 2019, [redacted] MD

The Appellant Representative submitted into evidence Personal Touch Home Care Progress Notes which stated in pertinent part:

"Created Date: 1/22/2019

Note: As per aides [redacted] and aide [redacted], patient's condition changed patient after she got back from hospital. Patient is very weak and not sleeping. Aide she watched very tightly because Patient tries to get up by herself and she could fell. Aide complains that they don't have any time for rest and sleeping. Aide were instructed to fill out and submit supplemental time sheet."

"Created Date: 01/29/2019
Note: Pt is female 95 years old, alert and oriented x 2, [redacted]. Pt was in the hospital a week ago for several days, [redacted]. In day of the visit pt denies any [redacted], VS WNL at that time. Post hospital pt start to have [redacted] once a month. Pt lives alone. Pt has 7 days live-in service. Per aide, post hospitalization of pt, aide doesn't have adequate sleep or rest at night, because pt call aide every 2-3 hrs. to assist perform ADL's such as [redacted], or pt wants to drink warm tea. Pt takes Ambien 10 mg PO QD prescribed by Doctor, but it is not working. Pt has history of falling. Fall/transferring precaution reviewed with aide, verbalized understanding. I advise to review the pt service hours due to changes in pt condition post hospital. Pts dtr pre-pour medication in pill box, pharmacy bottles not observed in the pts house. Pt use [redacted]. Pt use walker an dw/c to ambulate. Pt follows MD appointments by schedule. Pt reminded about flu season and she will inquire with M.D. about a flu shot. Aide POC update with pt and aide, copy left at pts house for aide to follow. Home environment is clean and clutter free. Aide supervision is done. Pt satisfied with service. Pt. and aide instructed to call PTHC if any changes in pt. condition, verbalized understanding. Pt Doctor is [redacted]."

"Created Date: 1/31/2019
Note: As per aides they exhausted because patient is not sleeping at all every hour she calls aide to put her on [redacted], but most time she doesn't do anything.
Patient complains on stomach ache. Patient condition got dramatically worse after she back from hospital."

See *Appellant Exhibit E,* dated respectively, January 22, 2019, January 29, 2019 and January 31, 2019.

The Appellant Representative also submitted into evidence Care Management Report which states in pertinent part:

"Member is [redacted]. Dtr stated that due to [redacted]. Dtr stated that member wakes up 5-8 times per night, screaming, trying to get out of the bed to use [redacted] and unable to transfer without PCS assistance. [redacted].

As per vendor communication member is not sleeping at all, calls aid every hour to put her to the [redacted]. Member taking [redacted] with no progress. CM discussed

PCP Dr. [redacted] in medication adjustment. As per MD no adjustment could be made. As per SHHA RN who made last visit on 1/30/19, member still very weak, able to ambulate with walker and PCA assistance few steps. Receiving PT 3 times per week. Member has [redacted] spread to all organs. Family deciding regarding [redacted]. RN stated that if family decide not to do [redacted], member will be enroll[ed] to Hospice Program. Medical Review needed due to member not sleeping during the night and PCA does not have 5 hrs. of uninterrupted sleep."

See *Appellant Exhibit F*, Care Management Report.

The Appellant Representative also submitted into evidence Night Shift Duty Logs from the Appellant's Personal Care Services Aide [redacted], dated March 14, 2019 through March 28, 2019 indicating that the Appellant's Personal Care Services Aide from midnight to 07:30 a.m. performed changing the Appellant's diaper, gave Appellant a drink to hydrate, gave Appellant food and cleaned the Appellant almost every hour of the night.

See *Appellant Exhibit G,* Night Shift Duty Log for client, by [redacted], dated March 14, 2019 through March 28, 2019.

Lastly, the Appellant Representative submitted into evidence two affidavits from the Appellant's Personal Care Assistants. The Appellant's *Exhibit H,* affidavit from [redacted] dated March 30, 2019 states:

> "[redacted], being duly sworn, states under penalty of perjury as follows:
> I am a certified home health aide at Personal Touch Health Agency
> I have been employed at Personal Touch Health Agency for ten years.
> I have been [redacted] home health aide for five years.
> I change [redacted]'s diaper frequently due to her [redacted].
> I turn and reposition [redacted] frequently to prevent [redacted]
> I am unable to get more than three hours of uninterrupted sleep at night because [redacted] requires continuous care throughout the night."

See *Appellant Exhibit H*, Affidavit [redacted], dated March 30, 2019.

The *Appellant's Exhibit I*, affidavit from [redacted], dated March 31, 2019, states:

> "I [redacted], being duly sworn, states under penalty of perjury as follows:
> I am a certified home health aide at Personal Touch Health Agency.
> I have been employed at Personal Touch Health Agency for eight and a half years.
> I have been Mili Zoldan's home health aide for three years.
> I change Mili Zoldan's diaper frequently due to her [redacted].
> I turn and reposition [redacted] frequently to prevent [redacted].
> I am unable to get more than three hours of uninterrupted sleep at night because [redacted] requires continuous care throughout the night.

See *Appellant Exhibit I*, affidavit from [redacted], dated March 31, 2019.

The Appellant's daughter testified that the Appellant's medical condition has deteriorated recently because of the Appellant's recently new diagnosis of [redacted]. She further testified that the [redacted] cause [redacted]. She further testified that the Appellant does not sleep during the night; almost each hour of the night requests the personal care assistant to assist the Appellant to the toilet; [redacted] from [redacted]. She lastly testified that the Aides are not getting any rest and are not receiving 5 hours of uninterrupted sleep. Moreover, the Appellant's daughter testified that the Appellant's current night time needs are not merely for safety monitoring and safety supervision, but rather the Appellant requires assistance throughout the night for activities of daily living such as personal hygiene, ambulating to the toilet, [redacted]. Lastly, she stated that the Appellant's activities of daily living, such as toileting during the night cannot be scheduled.

The Appellant Representative contended that the evidence establishes the Appellant requires medically necessary split shift continuous care on the grounds that the Appellant's personal care assistant aides are not able to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight-hour period of sleep as required by 18 NYCRR Section 505.14(a)(2).

Pursuant to 18 NYCRR 505.14(a)(2):

> "Split-shift or 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 or positioning, and needs assistance with such frequency that a live-in 24 hours 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)

The Appellant Representative also contended that the evidence establishes that the Appellant requires 24-hour split shift personal care services on the grounds that the Appellant's personal care aide performs Level II personal care service tasks during the night, such as transferring, toileting, ambulating to the toilet to enable the task be safely completed as pursuant to NYS DOH GIS 03 MA/003. The record establishes that the Appellant's aides are not obtaining at least five hours of uninterrupted sleep each night because the Appellant requires around the clock care.

Pursuant to NYS DOH GIS 03 MA/003:

> "The appropriate monitoring of the patient while a personal care aide 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"

The Appellant Representative also contended that the evidence establishes that a task based assessment is limited in its ability to capture 24 hour needs and the Plan is prohibited to use such task based assessments when evaluating the need for 24-hour care as required in 18 N.Y.C.R.R. Section 505.14(b)(5)(v)(d).

Pursuant to 18 N.Y.C.R.R. Section 505.14 (b)(5)(v)(d):

> "(d) 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." See 18 N.Y.C.R.R. Section 505.14(b)(5)(v)(d)

See also 42 CFR Section 438.210(a)(2) regarding the MLTC Plan is to provide services:

> "in 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." 42 CFR Section 438.210(a)(2).

The evidence has been very carefully evaluated. The evidence establishes that the Appellant is unable to finish normal day to day activities round the clock. The new evidence provided at the fair hearing, indicates that the Appellant requires, in the evening, more than "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, but rather, the evidence establishes that the Appellant requires, in the evening, appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, repositioning in the bed, changing the Appellant's diaper, cleaning the Appellant, personal hygiene, hydrating the Appellant, assisting the Appellant in walking, to assure the task is being safely completed.

The record has been considered. The evidence establishes an increased need by the Appellant in nighttime activities of daily living including [redacted]. The evidence establishes a [redacted]. The evidence establishes that the Appellant suffers from several medical conditions and requires frequent assistance with all Activities of Daily Living around the clock. The evidence establishes that the Appellant has a medical need for 24-hour split-shift Personal Care Services to safely remain in his home.

Based on the foregoing, the Plan's determinations were correct when made, however, in light of the new evidence provided at the fair hearing, cannot be sustained.

DECISION AND ORDER

The Plan's Initial Adverse Determination Notice dated February 13, 2019 and the Plan's Final Adverse Determination Notice dated February 14, 2019 to deny the Appellant's request for an increase in the Appellant's Personal Care Services authorization, from 24 hours per day Live In, times 7 days weekly to 24-hour, continuous ("split-shift") care (168 hours weekly), were correct when made, however:

1. The Plan is directed to provide the Appellant with a Personal Care Services authorization in the amount of 24 hour, split-shift care (168 hours per week).

2. The Plan is directed to notify the Appellant, in writing, of the Plan's determination to increase the Appellant's Personal Care Services authorization, from 24 hours per day Live In, times 7 days weekly to 24-hour, continuous ("split-shift") care (168 hours weekly).

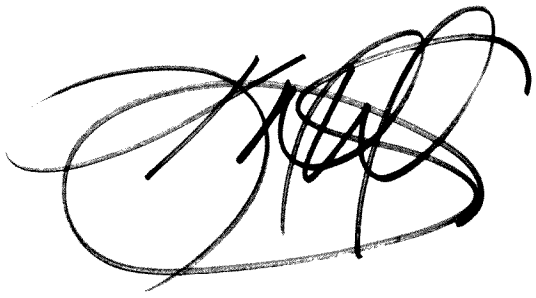
Should the Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
04/09/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee