**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** March 30, 2018
[redacted]
**AGENCY:** MAP
**FH #:** 7731132J

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| 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 January 9, 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)

Debra Fergurson, Fair Hearing Representative

## ISSUE

Was the determination of the Appellant's Managed Long-Term Care Program provider (i.e., Centers Plan for Healthy Living) to deny the Appellant's request for an increase in personal care services from forty-two (42) hours weekly (six hours per day, seven days per week), to an increase in personal care services to fifty-six (56) hours weekly (eight hours per day, seven 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 70, has been enrolled in a Managed Long-Term Care Program and has received care and services, including Personal Care Services, through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living (CPHL).

2. The Appellant has been authorized to receive Personal Care Services in the amount of 42 hours weekly (6 hours per day times 7 days per week).

3. The Appellant requested an increase in the Appellant's personal care services hours from 42 hours weekly (6 hours per day times 7 days per week) to 56 hours weekly (8 hours per day times 7 days per week).

4. On July 21, 2017 the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Client Task Sheet: PCW/PCA Level II indicating 6 hours per day, 7 days a week totaling 42 hours per week.

5. On July 21, 2017, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Uniform Assessment-System-New York Community Assessment Level of Care Report of the Appellant.

6. On January 22, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Client Task Sheet: PCW/PCA Level II indicating 6 hours per day, 7 days a week totaling 42 hours per week.

7. On January 22, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Uniform Assessment-System-New York Community Assessment Level of Care Report of the Appellant.

8. On July 13, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Uniform Assessment-System-New York Community Assessment Level of Care Report of the Appellant.

9. On July 13, 2018, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Client Task Sheet: PCW/PCA Level II indicating 5 hours per day, 7 days a week totaling 35 hours per week.

10. On December 14, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Client Task Sheet: PCW/PCA Level II indicating 5.5 hours per day, 7 days a week totaling 38.5 hours per week.

11. On December 14, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living conducted a Uniform Assessment-System-New York Community Assessment Level of Care Report of the Appellant.

12. By Initial Adverse Determination dated March 8, 2018, the Managed Long-Term Care Plan Centers Plan for Healthy Living advised the Appellant of its determination to deny the Appellant's request for an increase of personal care services from 42 hours per week to 56 hours per week based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool.

13. On March 30, 2018, this fair hearing was requested.

**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).

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

Informational Bulletin 09 OHIP/INF-01 states, in part:

> New York also has two integrated care plans designed for dual eligible recipients: Medicaid Advantage and Medicaid Advantage Plus. Both plans allow dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits.
>
> Both plans achieve integration of Medicare and Medicaid through a State contract with Medicare Advantage Plans (or Medicare Advantage Special Needs Plans) to provide a defined set of Medicaid wrap-around benefits to dual eligible enrollees on a capitated basis. The Medicaid Advantage Plan benefit includes acute care services not covered by Medicare; the Medicaid Advantage Plus Plan benefit also covers Medicaid long-term care benefits. To enroll in a Medicaid Advantage Plus Plan, recipients must be eligible for

nursing home level of care. If such individuals are residing in the community, they must document current resources (RVI 2) and be otherwise eligible in order to participate. If the person enters a nursing home for other than short term rehabilitation, he/she must document resources for the lookback period (RVI 1) in order to continue to be eligible to participate.

Dual eligible beneficiaries may enroll in the same managed care organization's Medicare Advantage Plan or Medicare Advantage Special Needs Plan (SNP) and corresponding Medicaid Advantage or Medicaid Advantage Plus Plan product. The Managed Care Organization (MCO) receives two capitation payments; one from CMS for the Medicare Advantage product and one from the State for the Medicaid Advantage or Medicaid Advantage Plus product. The State capitation paid to the MCO includes the Part C cost sharing (co-payments/deductibles, and Part C premiums, if any) associated with the Medicare Advantage product and the actuarial value of the services covered by the Medicaid Advantage or Medicaid Advantage Plus wrap. Because the State pays the plan directly for any recipient cost-sharing associated with the Medicare Advantage product, Medicaid will not pay Medicaid enrolled providers for co-payments or deductibles for covered benefits for recipients enrolled in Medicaid Advantage or Medicaid Advantage Plus. However, enrollees in Medicaid Advantage or Medicaid Advantage Plus are entitled to all Medicaid services they would normally get under the State Medicaid Plan. Therefore, any Medicaid services not included in the combined Medicare and Medicaid Advantage or Medicaid Advantage Plus benefit package offered by the health plan continue to be available to the enrollee when provided by any Medicaid enrolled provider on a Medicaid fee-for-service basis.

The year 2015 Medicaid Advantage Plus Model Contract provides at section 24.2:

Enrollees in the Contractor's Medicaid Advantage Plus Product may request a fair hearing regarding adverse LDSS determinations concerning enrollment, disenrollment and eligibility, and regarding the denial, termination, suspension or reduction of a service determined by the Contractor to be a Medicaid only benefit or a benefit under both Medicare and Medicaid, if the member elects to use the Medicaid appeal process. For issues related to disputed services, Enrollees must have received a final adverse determination on Appeal from the Contractor or its approved utilization review agent confirming an initial adverse determination to deny services or terminate, suspend or reduce services the Enrollee is currently receiving during his or her service authorization period. An Enrollee may also seek a fair hearing for a failure by the Contractor to act with reasonable promptness with respect to such services. Reasonable promptness shall mean compliance with the time frames established for review of grievances and utilization review in Articles 44 and 49 of the Public Health Law, the grievance system requirements of 42 CFR 438 and Appendix F of this Agreement.

Year 2015 Department of Health Managed Long-Term Care Bulletin number 15-03 announced the "end of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees." The State of New York did not end the internal exhaustion requirement for participants in other kinds of Managed Long-Term Care Plan.

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

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. 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 this section; 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 subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides:

(2) 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.
(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.
(4) 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.
(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:
(i) Level I shall be limited to the performance of nutritional and environmental support functions.
(a) Nutritional and environmental support functions include assistance with the following:
(1) making and changing beds;
(2) dusting and vacuuming the rooms which the patient uses;
(3) light cleaning of the kitchen, bedroom and bathroom;
(4) dishwashing;
(5) listing needed supplies;
(6) shopping for the patient if no other arrangements are possible;
(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(**ii**) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), effective December 23, 2015, provides:

The purpose of this policy directive is to inform Managed Long Term Care Plans (MLTCPs) 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 are 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, MLTCPs 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 applicable to MLTCP's 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 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.

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.

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.

1. With regard to adaptive or specialized equipment (the "efficiencies"), the nursing assessment shall include a professional evaluation whether such adaptive or specialized equipment or supplies can meet the recipient's need for assistance and whether such equipment or supplies can be provided safely and cost-effectively when compared to the provision of aide services. Such adaptive or specialized equipment or supplies include, but are not limited to, bedside commodes, adult diapers, urinals, walkers and wheelchairs.

General Information System message GIS 97 MA 033 notified local districts as follows:

> The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.
>
> Districts were first advised of the Mayer case in May, 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24 hour care, including continuous 24 hour services ("split-shift"), 24 hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.
>
> This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split shift or live-in services.
>
> When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family

members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Remember that the contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

1.Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24 hour split shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24 hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24 hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The district should authorize services in an amount that is less than 24 hour live-in services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that the informal or formal supports are willing

and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of live-in services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

Important Additional Information on TBA Plans:

Until notified otherwise by the Department, the following also apply to the use of TBA plans:

1. A district cannot use a TBA plan unless the TBA plan was already in use on March 14, 1996, or the district had the Department's approval as of that date to implement a TBA plan. This complies with the temporary restraining order in Dowd v. Bane, which the Department notified districts of in a previous GIS message, 96 MA/013, issued April 4, 1996.

2. Districts are not required to include safety monitoring as an independent task on their TBA forms. The Department recently obtained a stay of the August 21, 1997 federal court order that had required safety monitoring to be included as an independent TBA task. [See GIS 97 MA/26, issued November 6, 1997, informing districts of the stay of the order in Rodriguez v. DeBuono (S.D.N.Y., 1997).]

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 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits

**DISCUSSION**

The record establishes that the Appellant is in receipt of authorization for Medical Assistance and in receipt of 42 hours weekly (6 hours per day times 7 days per week) of Managed Long-Term Care Personal Care Services through Centers Plan for Healthy Living. The Appellant requested an increase of personal care service hours from 42 hours weekly (6 hours per day times 7 days per week) to 56 hours per week (8 hours per day times 7 days per week). By Initial Adverse Determination Notice dated March 8, 2018, the Managed Long-Term Care Plan, Centers Plan for Healthy Living advised the Appellant of its decision to deny the Appellant's request "based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool." The Appellant requested this fair hearing to challenge the Managed Long-Term Care Plan Centers Plan for Healthy Living determination.

The record establishes that the Appellant, age 70 years old, resides alone, has diagnoses which include: [redacted].

The MLTC Plan Centers Plan for Healthy Living Initial Adverse Determination Notice dated March 8, 2018 advised the Appellant that it had determined to deny the Appellant's request for an increase of personal care service hours from 42 hours per week (6 hours per day times 7 days per week) to 56 hours per week (8 hours per day times 7 days per week) on that grounds that:

"The plan is taking this action based on the NYS Department of Health Uniform

Assessment System (UAS-NY) and the plan's client tasking tool.

A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted on 1/22/2018. A comparison of the UAS-NY assessments completed on 7/21/2017 and 1/22/2018 showed that you have demonstrated some changes in your abilities to perform your Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The UAS-NY assessment produces a Nursing Facility level of Care (NFLOC) Score. Your NFLOC scores changed from 21 on 7/21/2017 to 20 on 1/22/2018.

Dressing Upper Body, Personal Hygiene, Eating: No change from limited assistance, where 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.

Dressing Lower Body, Toilet Use, Toilet Transfer, Bathing, Walking, Bed Mobility, Medication Management, Locomotion: No Change from extensive assistance, where you need physical help to complete some parts of this task, like someone to lean on or help you lift a body part, however you can complete most parts of this task by yourself.

Meal preparation and Ordinary Housework: You showed no change from total dependence, where you depend completely upon someone else to complete all parts of this task. You do not participate in this task depend completely upon someone else to complete all parts of this task. You do not participate in this task at all.
Urinary incontinence: You showed no change from frequently incontinent.
Bowel incontinence: You are continent.
Pain Control: No paint reported
Falls: You reported 2 falls in the past 90 days.
Cognitive Status: Your cognitive status is borderline intact.

You have been receiving Personal Care Aide (PCA) services six (6) hours per day, seven (7) days per week (totaling forty-two (42) hours per week). You requested to increase your PCA services to eight (8) hours per day, seven (7) days per week (totaling fifty-six (56) hours per week). The NYS Department of Health Uniform Assessment System (UAS-NY conducted on 1/22/2018 and the plan's client tasking tool showed that you need six (6) hours per day, seven (7) days per week (totaling forty-two (42) hours per week) of PCA services to complete the above mentioned tasks.

Therefore, your PCA services will remain the same: six (6) hours per day, seven (7) days per week (totaling fort- two (42) hours per week).

Your Services will be reassessed in July, 2018 or earlier if any significant change is reported".

See MLTC Plan Centers Plan for Healthy Living Initial Adverse Determination Notice dated March 8, 2018 marked as *MLTC Plan Exhibit 3*.

At the fair hearing, the Appellant testified via telephone, stating that his medical conditions

have worsened and that he requested the increase in personal care service hours to assist him with tasks of daily living that he needs greater amounts of assistance in. In support of his claim, the Appellant submitted into evidence a letter dated February 14, 2018 from his doctor which stated:

"Mr. [redacted] is a patient of mine since 2001. He was treated due to multiple medical problems including but not limited to [redacted].

Mr. [redacted]'s condition is significantly deteriorating due to [redacted]. He suffers from [redacted] for [redacted]. Mr. [redacted] has significantly decreased mobility, poor balance, very unsteady gait. He suffers from [redacted].

Mr. [redacted] lives alone. He will benefit from getting help of home care worker with ambulating, bathing, dressing, all tasks of everyday living to prevent falls and injuries.

Mr. [redacted] is on multiple medications. Due to [redacted] he needs reminding with his medications.

In my opinion, Mr. [redacted] will benefit from home care services increased to prevent future falls and help with tasks of daily living.

Thank you for your thorough consideration of this matter. Please feel free to contact me with any concerns regarding care of [redacted].

Sincerely

[redacted] MD
Lic. # [redacted]

See Appellant Exhibit A, dated 02/14/2018 from [redacted], MD.

Regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. In this case, the Appellant has done so. The record has been considered; the credible evidence establishes that the Appellant's medical conditions have deteriorated and accordingly, the Appellant requires an increase amount of personal care services to assist him in activities of daily living in ambulating, bathing, dressing and with medication management. Accordingly, the Managed Long Term Care Plan, Centers Plan For Healthy Living Notice of Initial Adverse Determination dated March 8, 2018 advising the Appellant of its decision to deny the

Appellant's request for an increase of personal care services from 42 hours per week (6 hours per day times 7 days per week) to 56 hours per week (8 hours per day times 7 days per week) was correct when made, however, in light of the new evidence presented at the fair hearing by the Appellant, the Managed Long Term Care Plan's determination cannot be sustained.

**DECISION AND ORDER**

The determination of 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 services from 42 hours weekly (6 hours per day times 7 days per week) to 56 hours weekly (8 hours per day times 7 days per week), was correct when made, however the Managed Long-Term Care Plan, Centers Plan for Healthy Living is directed to:

1. cancel its notice and take no action thereon;

2. authorize Appellant for 56 hours of personal care services (8 hours per day times 7 days per week); and

3. notify Appellant's representative, in writing, upon compliance with this fair hearing Decision.

Should Centers Plan for Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant's representative must provide it to Centers Plan for Healthy Living promptly to facilitate such compliance.

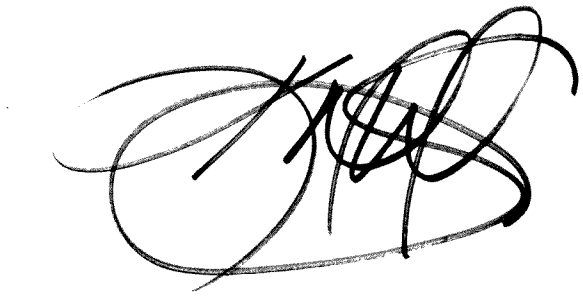
As required by Section 358-6.4 of the Regulations, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

FH# 7731132J

DATED: Albany, New York
01/28/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee