STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 23, 2019
[redacted]
AGENCY: MAP
FH #: 8016484K

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 24, 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)

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was 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 of Personal Care Services Authorization from 5.5 hours daily, 7 days weekly to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care and partially approve 7 hours daily, 7 days 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[redacted], and who lives alone, is enrolled in a managed long term care plan operated by Centers Plan for Healthy Living and has been in receipt of Personal Care Services Authorization of 5.5 hours daily, 7 days weekly.

2. The Appellant requested an increase in Personal Care Services of Twenty-Four (24) hours per day, 7 days a week "Live-In" Care.

3. On February 25, 2019, a nursing assessor completed a Uniform Assessment System -New York Comprehensive Community Assessment Report of the Appellant's personal care needs and an Aide Task Service Plan.

4. On June 20, 2019, a nursing assessor completed a Uniform Assessment System -New York Comprehensive Community Assessment Report of the Appellant's personal care needs and an Aide Task Service Plan.

5. On June 26, 2019, Centers Plan for Healthy Living advised the Appellant by an Initial Adverse Determination Letter of its intent to deny the Appellant's request for an increase of Personal Care Services Authorization from 5.5 hours daily, 7 days weekly to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care and partially approve 7 hours daily, 7 days weekly "because the health care service is not medically necessary."

6. An Internal Plan Appeal was requested to review Centers Plan's denial of the Appellant's request for an increase of Personal Care Services Authorization from 5.5 hours daily, 7 days weekly to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care and partially approve 7 hours daily, 7 days weekly.

7. On June 27, 2019, Centers Plan advised the Appellant by Final Adverse Determination Letter, of its intent to uphold its denial of Appellant's request for an increase of Personal Care Services Authorization from 5.5 hours daily, 7 days weekly to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care and partially approve 7 hours daily, 7 days weekly.

8. On August 23, 2019, this fair hearing was requested on the Appellant's behalf to contest Center Plan's determination.

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)

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;

(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 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...

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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I. Scope of the Personal Care Benefit

a. As required by federal regulations, the personal care services benefit afforded to MCO enrollees must be furnished in an amount, duration, and scope that is no less

than the services furnished to Medicaid fee-for-service recipients.[42 CFR §438.210]…

i. The assessment process should evaluate and document when and to what degree the member requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night. 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 member's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

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 further 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.

MLTC Policy memo 13.09(a): Transition of Semi-Annual Assessment of Members to Uniform Assessment System for New York, dated September 24, 2013 reminds Plans of MLTC Policy 13.09: Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York which in turn indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM). As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective October 1, 2013; the SAAM assessment must not be used for these new enrollees. Additionally, the UAS-NY must be used for all reassessments beginning October 1, 2013.

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.

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

For all MLTC partial capitation plan decisions made on or after July 1, 2015, that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately.

This change in policy has the following effects:
1) enrollees are no longer required to exhaust their plan's internal appeals processes before obtaining a State fair hearing;
2) aid-continuing is no longer available if the enrollee asks only for an internal appeal of a plan's proposed reduction or discontinuance of services and does not also timely request a State fair hearing;
3) to obtain aid-continuing, enrollees must request a State fair hearing within 10 days of the date of the Managed Long Term Care Action Taken notice;
4) enrollees do not need to specifically request aid-continuing to obtain it, but they may tell OTDA that they specifically decline it; and
5) the 60 day deadline to request a State fair hearing begins on the date of the Managed Long Term Care Action Taken notice.

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

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.

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:

(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(b) of 42 CFR Subpart F provides in part:

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

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

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

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

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

The Managed Long Term Care Model Contract provides that "New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing."

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:

(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.

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(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.

Administrative Directive 12 OMM/ ADM-1 advised in relevant part that new language has been incorporated defining continuous personal care services and continuous consumer directed

personal assistance as constituting uninterrupted care provided by more than one person to a consumer who requires total assistance with toileting and/or walking and/or transferring and/or feeding and which involves more than 16 hours of care per day during times that cannot be predicted or scheduled. The amended regulations also provide definitions of live-in 24 hour personal care services and live-in 24 hour consumer directed personal assistance, where no such definitions previously existed in regulation.

Specifically, the new definitions of continuous personal care services or continuous consumer directed personal assistance mean the provision of uninterrupted care, by more than one person, for more than 16 hours per day, for a consumer who, because of his or her medical condition and disabilities, requires total assistance with toileting, transferring, walking or feeding at times that cannot be predicted or scheduled. As in the past, the consumer's need for assistance is not capable of being scheduled; that is, it occurs at times that cannot be predicted, which is the language used in the amended regulations.

"Total assistance" remains defined in the regulations as meaning that a specific function or task (for continuous care, the tasks of toileting, walking, transferring or feeding) is performed and completed for the patient.

In instances when continuous personal care services or continuous consumer directed personal assistance is being considered, the nursing assessment must determine and document that the consumer requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted or scheduled [§505.14 (b)(4)(i)(c)(2) and §505.28 (d)(3)(ii)(g)].

Definitions of **live-in 24 hour personal care services** and live-in 24 hour consumer directed personal assistance have been added to the regulations [§505.14 (a)(5) and §505.28 (b)(8)]. This level of service has existed, but is now defined in the Department's regulations. Potentially eligible **individuals must have a medical condition and disabilities (functional deficits) requiring some or total assistance** with one or more personal care or CDPAP functions during the day and night and **have a need for such assistance during the night that is infrequent or that can be predicted or scheduled**. "Some assistance" remains defined in the regulations as meaning that a specific function or task is performed and completed by the patient with help from another individual.

The regulations require that, **for recipients who may be eligible for live-in 24 hour services, the social assessment must include an evaluation whether the recipient's home has adequate sleeping accommodations for a live-in aide** [§505.14 (b)(3)(ii)(c) and §505.28 (d)(2)(v)]. Examples of adequate accommodations include an available spare bedroom, room partition or a fold-out sofa. Availability of sleep-in space for the aide shall be determined on a case by case basis by the local district, taking into account the consumer's living situation. In determining the appropriateness of live-in 24 hour services, the local district should also assess whether the client can be safely left alone without care for a period of one or more hours per day.

The regulations promote the efficient use of resources designed to enhance the independence of individuals in support of their desire to remain in the community. To that end, the regulations

require that personal care services and consumer directed personal assistance shall not be authorized if the patient's need for assistance can be met by:

adaptive or specialized equipment or supplies including, but not limited to, beside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely, and, by promoting the consumer's independence in the home or other location, services provided would also be cost-effective; or

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. [§§ 505.14(a)(4)(iii) and 505.28(e)(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

[§§ 505.14(b)(3)(iii)(b)(5) and (b)(3)(iv)(a)(7)and §505.28(d)(3)(ii)(f)].

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

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.

GIS message GIS 12 MA/ 026 advises that **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.

Administrative Directive 92 ADM-49 clarifies State policy with regard to the requirement that an applicant for/ recipient of Personal Care Services have a stable health condition, and be able to self-direct, and be able to direct a Personal Care Services worker. The ADM reiterates that responsibility for making certain choices can be delegated to a self-directive individual, or to an organization.

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**.**

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 hearing record establishes that the Appellant [redacted], and who lives alone, is enrolled in a managed long term care plan operated by Centers Plan for Healthy Living ("Centers Plan") and has been in receipt of Personal Care Services Authorization of 5.5 hours daily, 7 days weekly.

The hearing record further establishes that a request was made on behalf of the Appellant, for an increase in Personal Care Services to twenty-four (24) hours per day, 7 days a week "Live-In" care.

On June 26, 2019, Centers Plan advised the Appellant by an Initial Adverse Determination Letter of its intent to deny the Appellant's request for an increase of Personal Care Services Authorization from 5.5 hours daily, 7 days weekly to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care and partially approve 7 hours daily, 7 days weekly on the grounds that "health care service is not medically necessary."

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.

At the hearing, the Appellant's representatives testified that the Appellant has a medical history of chronic atrial fibrillation, chronic obstructive pulmonary disease, essential hypertension, gait disorder, gallstones, hematoma, hyperlipidemia, hypertension, hyperthyroidism, pulmonary nodules, thoracic aortic aneurysm, trigeminal neuralgia, iron deficiency, anemia, spinal stenosis of lumbar region with neurogenic claudication, enthesopathy of hip region on both sides, primary osteoarthritis of both knees, primary osteoarthritis of both hips, high fall risk, cognitive impairment, functional impairment. To corroborate their testimony, Appellant's representative submitted into evidence as Appellant's Exhibit E, a September 20, 2019 medical letter from [redacted] that states-

"(Appellant) is a patient under my professional care. She is 89 y.o. female with history of chronic atrial fibrillation S/P watchman device, essential hypertension, hyperlipidemia and thoracic aortic aneurysm. At the time of her last evaluation, her ambulation had been very limited she was using a walker and a wheelchair. Since that time, she has fallen multiple times and she can no longer walk independently. Now as of this visit, she is even more limited and completely dependent at home. Using walker and wheelchair that she cannot propel. She now requires 24 hour home care as she is no longer capable of doing her daily living activities independently. With this change in her condition, it is considered to be medically necessary for this patient to be able to have 24 hour home care."

At the hearing, Centers Plan for Healthy Living submitted into evidence the June 26, 2019,
that advised Appellant that –

"The request for Personal Care Aide Services was partially approved. This decision was based on:

…A Registered Nurse from Centers Plan for Healthy Living (CPHL) visited you in your home on 06/20/2019 and completed a face-to-face assessment, using the New York State Uniform Assessment System (UAS-NY)."

The hearing record has been reviewed. 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. The record of the hearing has established that Appellant's representatives have submitted sufficient documentation including detailed documentation of Appellant's deteriorating and declining medical condition, in support of their request for an increase and have established a medical necessity for such request.

Further, and relevant to the issued of the appropriates of the request for a live-in aide, the Appellant's Representatives testified that Appellant would benefit from a live-in aide and

confirmed as part of their testimony that Appellant has the required accommodation for a live-in aide. The availability of sleeping accommodations is a crucial issue, as a live-in aide by definition, must have the opportunity to reside in the premises of the patient for whom the care is provided. The amended Section 505.14(a) of the Regulations, which became effective after October 4, 2011, provides in part that "when live-in 24-hour personal care services is indicated, the social assessment shall evaluate whether the patient's home has adequate sleeping accommodations for a personal care aide." Furthermore, based on the credible testimony that Appellant is able to sleep through the night and thus, a live-in aide would get five hours of uninterrupted sleep.

It is noted, that since Centers Plan for Healthy Living stated in its adverse determination letter that it is taking the action to deny and partially approve the request for an increase based on the NYS Department of Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool, review was made of the most recent UAS dated June 20, 2019. It is found that June 20, 2019 UAS-NY found that Appellant's "Change in ADL status as compared to 90 days ago or since last assessment of less than 90 days" had "Declined". In addition, the Assessment reported that Appellant's "Overalls self-sufficiency has changed significantly as compared to status 90 days ago, or since last assessment if less than 90 days" had "Deteriorated."

Based on the foregoing, Centers Plan for Healthy Living's determination to deny the Appellant's request for an increase of Personal Care Services Authorization from 5.5 hours daily, 7 days weekly to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care and partially approve 7 hours daily, 7 days weekly, cannot be sustained.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination to deny a request for an increase in Personal Care Services to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care is not correct and is reversed.

1. Centers Plan for Healthy Living is directed to increase Appellant's Personal Care Services to Twenty-Four (24) hours per day, 7 days a week "Live-In" Care.

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 promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to Centers Plan for Healthy Living promptly to facilitate such compliance.

FH# 8016484K

As required by 18 NYCRR 358-6.4, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
10/18/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee