STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 9, 2018
[redacted]
AGENCY: Nassau
FH #: 7859014Q

In the Matter of the Appeal of

[redacted]

from a determination by the Nassau County 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 March 5, 2019, in Nassau County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan

D. Ferguson, Fair Hearing Representative (December 3, 2018 only)

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny Appellant's request for an increase in her Personal Care Services authorization from 10 hours per day 7 days per week (70 hours per week) to 24 hours per day 7 days per week live-in correct?

FACT FINDINGS

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. Appellant, age 93, has been enrolled in a Medicaid Managed Care Long Term Plan, Centers Plan for Healthy Living (hereinafter, the "Plan), and, through the Plan, has been in receipt of a Personal Care Services (hereinafter, "PCS") authorization in the amount of 10 hours per day 7 days per week, for a total of 70 hours per week.

2. On September 18, 2018, the Plan's nurse completed a reassessment of the Appellant.

3. On September 26, 2018, Appellant's family requested an increase in the Appellant's PCS authorization to 24 hours per day 7 days per week live-in.

4. By Amended Initial Adverse Determination dated October 9, 2018, the Plan determined to deny the above request for an increase in Appellant's PCS authorization, on the ground that such service is not medically necessary, reasoning, among other things, that no unscheduled nighttime needs have been identified.

5. On internal appeal, the Plan upheld its Initial Adverse Determination and, by Final Adverse Determination of October 15, 2018 so advised the Appellant's daughter, reasoning, among other things, that, compared to a prior assessment of June 5, 2018, most of Appellant's abilities to perform physical functioning stayed the same.

6. On November 9, 2018, this fair hearing was requested.

APPLICABLE LAW

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

42 CFR 438.236 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.

42 CFR 438.400 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...

42 CFR 438.210 (Coverage and authorization of services) states, 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 § 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…

(c) ***Notice of adverse action***. Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

(d) ***Timeframe for decisions.*** Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—
(i) The enrollee, or the provider, requests extension; or
(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
(2) *Expedited authorization decisions.*

(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
(ii) The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

§438.404 Notice of action.
(a) ***Language and format requirements.*** The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.
(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.
(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
(5) The procedures for exercising the rights specified in this paragraph.
(6) The circumstances under which expedited resolution is available and how to request it.
(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
(c) ***Timing of notice.*** The MCO or PIHP must mail the notice within the following timeframes:
(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.
(2) For denial of payment, at the time of any action affecting the claim.
(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).
(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—
(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

The Department's Regulations 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. For a further explanation of this requirement, districts should consult GIS message 97 MA/033, issued on November 26, 1997.

18 NYCRR 360-10.8(e)(2)(i)(f)(11) provides, in part, that:

(e) Notices

…

(2) An MMCO or its management contractor shall notify an enrollee in writing of their right to a fair hearing and how to request a fair hearing in a manner and form determined by the department whenever a notice of action is issued. For the purposes of this paragraph, *MMCO* means an HMO, PHSP or HIV SNP. A notice of action that sets forth all of the information required by subparagraph (i) of this paragraph will be considered an adequate notice for the purposes of section 358-2.2 of this Title…

Pursuant to 18 NYCRR 358-2.2, 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. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;
- when the agency action or proposed action is a reduction, discontinuance, restriction or suspension of public assistance, medical assistance, SNAP benefits or services, the circumstances under which public assistance, medical assistance, SNAP benefits or services will be continued or reinstated until the fair hearing decision is issued; that a fair hearing must be requested separately from a conference; and a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services; and that participation in an agency conference does not affect the right to request a fair hearing;
- a statement that a fair hearing must be requested separately from a conference;

- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, SNAP benefits or services;

- a statement that participation in an agency conference does not affect the right to request a fair hearing;

- the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;

- an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;

- the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;

- the right to present written and oral evidence at the hearing;

- the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;

- information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and

- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

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

The Regulations at 18 NYCRR 505.14 discuss Personal Care Services and state, in pertinent part:

> (a) Definitions and scope of services.
>
> (1) Personal care services means 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.

(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.

(i) The patient's medical condition shall be stable, which shall be defined as follows:

(a) the condition is not expected to exhibit sudden deterioration or improvement; and

(b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and

(c)(1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or

(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

(ii) The patient shall be self-directing, which shall mean that he/she is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. Patients who are nonself-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services, except under the following conditions:

(a) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or

(b) supervision or direction is provided on an interim or part-time basis as part of a plan

of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

(c) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization. The local social services department may be the outside agency.

(iii)(a) Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

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

(b) The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

(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.

Managed Long Term Care Plans were advised of the revisions set forth in the above Regulations by policy directive entitled "MLTC Policy 15.09 (Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA))" issued by the Department of Health Office of Health Insurance Programs and effective as of December 23, 2015.

General Information Service message 97 MA 033 includes a reminder concerning "statements of understanding". The GIS Message advises that the contribution of family members or friends to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever.

General Information Service Message GIS 3 MA/03 states:

The purpose of this GIS is 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.

Social services districts, including those using locally developed task based assessment (TBA) instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patient's appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 N.Y.C.R.R.§ 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

The assessment process should evaluate and document when and to what degree the patient 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 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, commode, urinal, walker, wheelchair, etc.

When the district, in accordance with 505.14 (a)(4), has 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 amount 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.

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 is essential to safe and adequate care 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.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Policy directive entitled “MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services” issued on November 17, 2016 by the Department of Health Office of Health Insurance Programs states, in pertinent part:

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee’s plan of care.

If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or “one size fits all” limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized

assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance. [Emphasis added]

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring, supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates. [Emphasis added].

  NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

  Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

- **All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and**

ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link: http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf [Emphasis added].

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTC Policy 16.07 (November 17, 2016).

At a fair hearing concerning the denial of an application for or the adequacy of Public Assistance, Medical Assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

At issue is the Plan's determination to deny Appellant's request for an increase in her Personal Care Services authorization from 10 hours per day 7 days per week (70 hours per week) to 24 hours per day 7 days per week live-in.

In its Amended Initial Adverse Determination dated October 9, 2018, the Plan determined to deny the above request for an increase in Appellant's PCS authorization, on the ground that such service is not medically necessary, reasoning, among other things, that no unscheduled nighttime needs have been identified.

On internal appeal, the Plan upheld its Initial Adverse Determination and, by Final Adverse Determination of October 15, 2018 so advised the Appellant's daughter, reasoning,

among other things, that, compared to a prior assessment of June 5, 2018, most of Appellant's abilities to perform physical functioning stayed the same. Nevertheless, the Plan's nurse's assessment report of September 18,2 018 indicates that Appellant's functioning has declined and her overall self-sufficiency has deteriorated within the last 90 days or since the last assessment (if less than 90 days).

According to the Plan's nurse's assessment report of September 18, 2018, Appellant suffers, among other illnesses, dementia, Parkinson's disease, coronary heart disease, macular degeneration, depression and cancer (monitored but not active). Per Appellant's daughter Appellant has total hearing loss in the right ear and wears a hearing aid in the left ear, and has vision difficulties due to macular degeneration.

Appellant's cognitive skills were noted to be moderately impaired. Further, Appellant was noted to not be able to walk on her own and was noted to use wheelchair (propelled by others) to ambulate.

The Plan's nurse further indicated in the report that the Appellant

- is **totally dependent** for the following PCS tasks: bathing, dressing lower body, walking, locomotion, toilet use, meal preparation, ordinary housework, managing finances, shopping, negotiating stairs and transportation;

- requires **maximal assistance** with the following PCS tasks: personal hygiene, dressing upper body, toilet transfers, bed mobility, managing medications and phone use;

- requires **extensive assistance** with eating.

Appellant was noted to be incontinent of bowel and bladder with no control present, and was noted to wear pullups.

Appellant was noted to have fallen on June 17, 1018 while walking to the bathroom, was admitted to a hospital, discharged on June 20, 2019 and transferred into a rehabilitation facility, fell again on June 27, 2018 while at the facility and readmitted to a hospital with a fracture to her right femur, discharged on July 30, 2018 and transferred into a rehabilitation facility where she fell again on September 8, 2018. She was discharged from that facility into the community on September 17, 2018.

All of the above findings were corroborated by Appellant's daughter at the hearing. Appellant lives in her own apartment in the same house as Appellant's daughter who testified at the hearing, but in a separate part of the house. Appellant's daughter testified that she works two jobs, one full-time and one part-time and is, therefore, unable to take care of the Appellant. She testified that Appellant has gotten much weaker since June 2018, whereby she cannot bear her own weight and needs total assistance to move or get out of bed. She testified that Appellant does not walk and uses wheelchair wheeled by others to ambulate. She testified that Appellant

never asks to go to the bathroom and that her diapers are always wet when she wakes up in the morning, even though she makes sure Appellant goes on the commode right before going to sleep for the night. She testified that Appellant's diapers need to be changed several times per day.

Appellant's daughter submitted a letter from Appellant's doctor, dated November 19, 2018, corroborating that Appellant requires diaper changes during the nighttime hours and total assistance with all of her activities of daily living.

24-hour live-in care is defined as 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**. See 18 NYCRR 505.14.

Given Appellant's toileting needs, including diaper changes due to full incontinence of bowel and bladder, toilet transfers and bed mobility, with all of which Appellant needs total or maximal human assistance, as documented in the Plan's nurse's assessment report of September 18,2018, the Plan was incorrect to deny the request for an increase in Appellant's PCS hours to a 24-hour live-in care. Toileting needs are, by definition, unscheduled, especially given Appellant's documented full bowel and bladder incontinence.

It is noted that, at the hearing Appellant testified and presented some evidence indicating that, due to Appellant's medical conditions, her inability to move or reposition herself in bed or wheelchair and bladder/bowel incontinence, Appellant may be prone to pressure ulcers/bed sores. However, it was not established at the hearing that these conditions existed at the time of the Plan's determination here at issue. Given these alleged conditions, the Plan must reassess the Appellant's PCS hours to determine if the Appellant is eligible for 24 hours 7 days of continuous split shift care.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny Appellant's request for an increase in her Personal Care Services authorization from 10 hours per day 7 days per week (70 hours per week) to 24 hours per day 7 days per week live-in was not correct and is reversed.

1. The Plan is directed to immediately authorize 24-hour live-in Personal Care Services authorization for the Appellant.

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

FH# 7859014Q

DATED: Albany, New York
03/25/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee