STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 1, 2018
[redacted]
AGENCY: MAP
FH #: 7749758M

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 May 31, 2018, 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

No appearance by Plan; evidentiary packet and waiver request received from the Plan AFTER the scheduled fair hearing

ISSUE

Was the determination by the Managed Long-Term Care plan, Centers Plan for Healthy Living, to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours from fifty-nine and one-half (59.5) hours per week (8.5 hours x 7 days), with regard to the adequacy of Personal Care Services, 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 eighty-four (84), has been in receipt of a Medical Assistance authorization, Medicaid benefits, and has been enrolled in a Medicaid Managed Long-Term Care plan with Centers Plan for Healthy Living.

2. The Appellant resides with her daughter, age fifty-three (53).

3. The Appellant has been in receipt of a Personal Care Services authorization in the amount of fifty-nine and one-half (59.5) hours per week (8.5 hours x 7 days).

4. The Appellant requested an authorization to increase her Personal Care Services.

5. The Appellant has a medical diagnosis which includes diabetes, hypertension, high cholesterol, right eye blindness, left sided hearing loss, lumbar fracture due to fall, recurrent urinary tract infections, recent right hip fracture due to fall and requiring surgery.

6. The Appellant requires overnight assistance with activities of daily living including toileting transfers and toilet use.

7. Centers Plan For Healthy Living made a determination not to provide the Appellant with an authorization for an increase in Personal Care Services.

8. The Appellant and her advocates requested an internal review of the Plan's determination to deny the Appellant's request for an authorization to increase Personal Care Services.

9. The Plan has failed to provide the Appellant with a written determination with regard to the Plan's denial of the Appellant's request for an authorization to increase Personal Care Services.

10. On May 1, 2018, the Appellant requested a fair hearing in this matter.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance 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.

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

Office of Administrative Hearings Procedures Transmittal 13-02, published on September 23, 2013, entitled "Waiver of Personal Appearance Instructions for Agencies," sets forth that, with regard to waiver requests and evidentiary packets, "[i]t is essential that the packets are received in the Albany Central Office to allow sufficient time for forwarding to the hearing site – allow at least five calendar days prior to the hearing date. If the packets are not received within this timeframe, there is no guarantee that they will be available at the hearing. The Administrative Law Judge may decide to proceed with the hearing without the input of the Agency." The transmittal also advises that "it is the responsibility of the agency to provide a copy of the evidentiary packet to the appellant and/or representative, in addition to that required above, if requested. When the hearing is scheduled as a telephone hearing, since the appellant will not appear, it is essential that the agency mail the appellant and/or representative a copy of the evidence packet prior to the hearing even when not requested by the client. Also, when the agency's representative appears in person, it is essential that two copies of the evidence packet are brought to the hearing, one for the Administrative Law Judge and one for the client." The transmittal further instructs that the waiver request should "contain the fair hearing number, date of hearing, and a summary of the specific facts relevant to the issue under review at the hearing." With regard to fax transmission of waiver packets, the transmittal instructs that "[w]hen faxing, please include on the fax transmittal the name of the appellant, the fair hearing number, the date of the hearing, and the number of pages contained in each package to assist in matching the submission to the appropriate fair hearing file."

The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care (published May 31, 2013), Section III (Authorization and Notice Requirements for Personal Care Services) subsection d (Level and Hours of Service), requires that the authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;
ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
iii. that are authorized for the new authorization period; and
iv. the original authorization period and the new authorization period, as applicable.

By Dear Health Plan Administrator letter dated March 2, 2015, the Department advised of the implementation of model notices as of May 15, 2015, for use by Managed Long Term Care (MLTC) Partial Cap and Medicaid Advantage Plus (MAP) plans, as follows:

Model MLTC Initial Adverse Determination Notice

This model notice was developed for all administrative and medical necessity Actions, except for Actions based on a restriction to benefits. The model contains gray placeholder fields for both static (unchanging) plan-specific information, such as the time allowed to file an appeal, and dynamic fields that change with each Action notice. It is important that plans create mechanisms to ensure the various dynamic placeholders are utilized correctly to match the

Action being taken. The model only addresses content requirements, all other notice procedures and requirements such as determination timeframes, provider notice, translations, special needs formats, clinical peer/health professional review, etc., remain the same.

As a reminder, the clinical rationale MUST:

- State the enrollee and the nature of his/her medical condition;
- State the medical service, treatment or procedure in question;
- State the basis or bases on which the plan/utilization review agent determined that the service, treatment or procedure is or was not medically necessary, experimental/investigational, or not materially different from an alternate in-network service, which demonstrates that the plan/agent considered enrollee-specific clinical information in its determination.
- Be sufficiently specific to enable the enrollee and the enrollee's health care provider to make an informed judgment regarding 1) whether or not to appeal the adverse determination, and 2) the grounds for such an appeal; and
- Be written in easily understood language.

Managed Long Term Care Action Taken – Denial, Reduction or Termination of Benefits (211) (LDSS-4687 02/15)

This model notice is designed to ensure enrollees are made aware of their due process rights and must be included with the Model MLTC Initial Adverse Determination Notice and all other Action notices, including those for restrictions to benefits. Considerable input from the advocate community was solicited to help clarify the language, *e.g.* regarding aid continuing rights for services that are stopped, reduced, or restricted. Plans must develop mechanisms to ensure the form is appropriately completed for the Action being taken.

Below is a list of certain new and noteworthy aspects of this model notice:

The “MLTC reference number” may be any number the plan utilizes to track actions, authorizations, or notices.

“will not be increased” checkbox is to be utilized when an enrollee asks for more of a service during an authorization period, but the increase is denied. This is particularly relevant for enrollees in receipt of CBLTCS or who are homebound.

“detailed explanation of change in medical condition or social circumstances.” This information MUST be included in the reason for denial if the Action determines to reduce or stop CBLTCS the enrollee has been receiving.

“ADD SPECIFIC BENEFIT CITATION AS APPLICABLE; for common actions and their corresponding citations, see the citation reference table” The regulatory citations have been updated and cover most medically necessary decisions. However, where there are specific regulations or statutes that govern the Medicaid managed care benefit, the plan must complete

this section with additional appropriate citations. The Department will be providing a reference table of common citations that apply to MLTC, such as 18 NYCRR 505.14(a) for personal care services. However, it is the duty of each plan to research and include appropriate citations for every form it sends. Deadline "Date+60" This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.

- Deadline "Date+60" This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.

- Essential action information is repeated in the box on the Fair Hearing Request Form sheet. This sheet is separate to allow the enrollee to request a fair hearing by mail and still retain their original notice. The information is repeated to facilitate OTDA processing of the fair hearing request.

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.

18 NYCRR 505.14(a)(5) provides that:

Personal care services include, but are not necessarily limited to, the following:

(ii) Level II shall include the performance of nutritional and environmental support functions 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 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.

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate 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.

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.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. 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.

Completing accurate and comprehensive assessments is essential to safe and adequate care plan development and appropriate service authorization. Adhering to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

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 (SDNY, 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.)

In addition to clarifying requirements for client notices under Mayer, the Department's regulations also reflect a Court ruling in Mayer regarding the use of task based assessments [18 NYCRR 505.14(b)(5)(v)(d)]. Specifically, social services districts are prohibited from using task-based assessments when authorizing or reauthorizing personal care services for any recipient whom the district has determined needs 24-hour care, including continuous 24-hour services (split-shift), 24-hour live-in services or the equivalent provided by a combination of formal and informal supports or caregivers. In addition, the district's determination whether the recipient needs such 24-hour personal care must be made without regard to the availability of formal or informal supports or caregivers to assist in the provision of such care. GIS 01 MA/044, issued on December 24, 2001.

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 task-based assessment (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 (SDNY, 1997).]

Pursuant to GIS 03 MA/003, issued on January 24, 2003, task-based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated 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 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 NYCRR 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.

In accordance with GIS 12 MA/026, published October 3, 2012, pursuant to the directives of the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, the GIS directs that, 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.

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

GIS 15 MA/24, published on December 31, 2015, advises of the revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR section 505.14 and 18 NYCRR section 505.28, and notes the following changes:

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.

"Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.

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 Services shall not be authorized to the extent that the individual's need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of "some assistance" and "total assistance" are repealed.

The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

The social assessment in live-in 24-hour PCS and CDPA cases must evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

Appellant right to fair hearing and appeal rights: 42 CFR section 438.402 (c)(1)(i) and 438 (f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld. 42 CFR section 438.402 (c)(1)(i)(A), 438.408 (c)(3) and 438.408 (f)(1)(i)

provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applied when: an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan; an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State – specified timeframes; or a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR section 438.408. 42 CFR section 438.408 (f) (2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing. Pursuant to 42 CFR section 438.424 (a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

Aid Continuing: Pursuant to requirements under 42 CFR section 438.420, NYS Social Services Law section 365 – a (8), and 18 NYCRR section 360 – 10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR section 438.420.

DISCUSSION

The record in this matter establishes that the Appellant, age eighty-four, is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living. The uncontroverted evidence establishes that the Appellant requested an authorization for an increase in Personal Care Services to eighty-four (84) hours per week (12 hours per day x 7 days) from the current authorization of fifty-nine and one half (59.5) hours per week (8.5 hours per day x 7 days). At the hearing the Appellant's daughter testified that the Appellant also requires assistance overnight with walking, locomotion, toileting and toilet use.

It is preliminarily noted that the Plan did not appear at the hearing in this matter although duly notified of the date, time and location of the fair hearing as well as of the issue(s) to be addressed at the fair hearing. It is further noted that after the hearing record in this matter was closed, the Plan submitted to the Office of Administrative Hearings a copy of an evidentiary "waiver" packet and request for waiver of personal appearance. Said evidentiary packet has not been entered into the record, said record having been previously closed upon the conclusion of the hearing on the morning of June 4, 2018. It is further noted that the Appellant's daughter (her representative at the fair hearing) testified at the hearing that neither a written determination has been received by the Appellant with regard to the Plan's denial of the requested authorization to increase Personal Care Services, nor did the Plan provide the Appellant with any internal review despite the fact that the Appellant's daughter, on behalf of the Appellant, had requested same at the time that she was verbally advised by a Plan representative that the Plan would not authorize an increase in the Appellant's Personal Care Services. Thus, the record in this matter satisfies the exhaustion of the preliminary internal appeals process pursuant to 42 CFR 438.408 has been met via "deemed exhaustion" of said process.

At the hearing the Appellant's daughter presented credible and persuasive testimony that that the Appellant has had a change in circumstances, a recent fractured right hip, such that there has been a substantial change in her ability to engage in her activities of daily living. The Appellant's daughter persuasively contended that the Appellant requires a home attendant on a daily, twenty-four (24) hour "live-in" basis. The Appellant's daughter presented documentation from the Appellant's primary care physician which sets forth the Appellant's current medical condition and which states that the Appellant requires assistance with all activities of daily living, including the Appellant's inability to ambulate or to toilet without assistance. The Appellant's physician also noted that the Appellant has the "beginning stages of sacral decubitus, likely due to her being in an unchanged diaper for over 16 hours a day."

The Appellant's daughter testified that the Appellant had fallen and broken her right hip and had been hospitalized sometime in January, 2018, and spent approximately three months in rehabilitation until late April, 2018. The Appellant's daughter also testified that the Appellant has urinary incontinence so severe that she uses diapers and chux. The Appellant's daughter testified that the Appellant "lays all night" in the same diaper and that she otherwise requires assistance with toileting approximately three times every overnight period. The Appellant's daughter further testified that the Appellant requires assistance with eating as well as prompting and cueing with regard to eating, and that the Appellant's home may accommodate a "live-in" home attendant. It is noted that the aforesaid testimony is supported by the medical documentation which was submitted at the fair hearing.

As noted above, the Plan did not appear in this matter and therefore did not present evidence which might rebut the aforesaid persuasive, credible and documented contentions of the Appellant's representative. Again, it is noted that said contentions are supported by the narrative statement which was provided by the Appellant's physician. The contention of the Appellant's representative as to the Appellant's need for overnight assistance is plausible, persuasive and therefore credible. Based upon the evidence as presented in this matter, the Plan's determination not to provide the Appellant with an authorization increasing Personal Care Services cannot be sustained and must be reversed.

DECISION AND ORDER

The determination by the Managed Long-Term Care plan, Centers Plan for Healthy Living, to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours from fifty-nine and one-half (59.5) hours per week (8.5 hours x 7 days), with regard to the adequacy of Personal Care Services, is not correct and is reversed.

Centers Plan for Healthy Living is directed to:

1. Immediately provide to the Appellant a Personal Care Services authorization in the amount of twenty-four (24) hours daily services via "live-in" aide.

2. Continue the Personal Care Services authorization of twenty-four (24) hours daily services via “live-in” aide unchanged.

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 and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's Representative must provide it to the Managed Long Term Care plan 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.

DATED: Albany, New York
06/07/2018

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee