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

**REQUEST:** July 2, 2018
[redacted]
**AGENCY:** MAP
**FH #:** 7786447Q

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| In the Matter of the Appeal of [redacted] | **DECISION AFTER FAIR HEARING** |
| from a determination by the New York City Department of Social Services | |

## JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on July 31, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Medicaid Managed Long Term Care Plan

Agency appearance waived by the Office of Administrative Hearings

## ISSUE

Was the Medicaid Managed Long Term Care Plan's April 30, 2018 determination to partially deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, from 49 hours per week (7 hours per day x 7 days per week) to 24 hour, continuous ("split-shift") care (168 hours per week), correct?

## FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 94, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living (hereinafter "Plan").

2. The Appellant is currently authorized to receive 59.5 hours per week (8.5 hours per day x 7 days per week) in Personal Care Services.

3. The Appellant's diagnosed health conditions include abnormalities of gait, angina pectoris, anxiety disorder, atherosclerotic heart disease, benign prostatic hyperplasia, calculus of gallbladder without cholecystitis, constipation, dementia, dizziness and giddiness, dry eye syndrome, edema, essential primary hypertension, fatigue, fecal urgency, gastro-esophageal reflux disease, hearing loss, heart failure, insomnia, irritability and anger, laceration of the left elbow, major depressive disorder, muscle weakness (generalized), osteoarthritis, pain, presence of aortocoronary bypass graft, shortness of breath, urinary incontinence, and vision loss.

4. On March 19, 2018, a registered nursing assessor completed a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

5. On April 13, 2018, a registered nursing assessor completed a Uniform Assessment System ("UAS") assessment of the Appellant's personal care needs.

6. At an unspecified date, the Appellant's daughter requested an increase in the Appellant's Personal Care Services Authorization, from 49 hours per week (7 hours per day x 7 days per week) to 24 hour, continuous ("split-shift") care (168 hours per week).

7. By Initial Adverse Determination, dated April 30, 2018, the Plan determined to partially deny the Appellant's daughter's request for an increase in the Appellant's Personal Care Services Authorization. The Plan determined to approve an increase to 59.5 hours per week (8.5 hours per day x 7 days per week), not 24 hour, continuous ("split-shift") care (168 hours per week).

8. On May 4, 2018, the Appellant's daughter appealed the Plan's April 30, 2018 determination.

9. By Final Adverse Determination, dated May 24, 2018, the Plan upheld its April 30, 2018 determination.

10. On July 2, 2018, the Appellant's daughter requested this fair hearing to contest the Plan's determination to partially deny the request for an increase in the Appellant's Personal Care Services Authorization.

## 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 Public Assistance, HEAP, SNAP benefits, 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.

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

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:
- (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
- (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.
- (3) Provide that the MCO, PIHP, or PAHP--
  - (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
  - (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;
  - (iii) May place appropriate limits on a service
    - (A) 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 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). 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 Section 505.14; 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 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides in part that 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.

(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.

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 <u>in combination with any informal support contributions</u>, 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.

In <u>Rodriguez v. City of New York,</u> 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.

Pursuant to GIS 03 MA/003, 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. 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.

Social services districts should authorize assistance with recognized, medically necessary Personal Care Services tasks. As previously advised, social services districts are NOT required to allot time for safety monitoring as a separate task as part of the total Personal Care Services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed**.**

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

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

Section 505.14(a)(2) of the Regulations provides that 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.

MLTC Policy 16.07 provides, in pertinent part:

**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.

**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**.

MLTC Policy 15.09 provides, in pertinent part:

**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.

**DISCUSSION**

The uncontroverted evidence in this case establishes that the Appellant, age 94, has been in receipt of Medicaid benefits provided through a Medicaid Managed Long Term Care Plan and is currently authorized to receive 59.5 hours per week (8.5 hours per day x 7 days per week) in Personal Care Services (hereinafter "PCS"). The Appellant's diagnosed health conditions include abnormalities of gait, angina pectoris, anxiety disorder, atherosclerotic heart disease, benign prostatic hyperplasia, calculus of gallbladder without cholecystitis, constipation, dementia, dizziness and giddiness, dry eye syndrome, edema, essential primary hypertension, fatigue, fecal urgency, gastro-esophageal reflux disease, hearing loss, heart failure, insomnia, irritability and anger, laceration of the left elbow, major depressive disorder, muscle weakness (generalized), osteoarthritis, pain, presence of aortocoronary bypass graft, shortness of breath, urinary incontinence, and vision loss.

The evidence further establishes that at an unspecified date, the Appellant's daughter requested an increase in the Appellant's PCS Authorization, from 49 hours per week (7 hours per day x 7 days per week) to 24 hour, continuous ("split-shift") care (168 hours per week). By Initial Adverse Determination, dated April 30, 2018, the Plan determined to partially deny the Appellant's daughter's request for an increase in the Appellant's PCS Authorization. The Plan

determined to approve an increase to 59.5 hours per week (8.5 hours per day x 7 days per week), not 24 hour, continuous ("split-shift") care (168 hours per week). The Plan's notice stated, in pertinent part:

> …[The Appellant has] demonstrated no changes in [the Appellant's] abilities to perform [the Appellant's] Activities of Daily Living (ADLs) and no changes in [the Appellant's] Instrumental Activities of Daily Living (IADLs)…The NYS Department of Health Uniform Assessment System (UAS-NY) conducted on 04/13/2018 and the [P]lan's client tasking tool showed that [the Appellant] need[s] PCA services eight and a half (8.5) hours per day, seven (7) days per week (totaling fifty-nine and a half [59.5] hours per week) of PCA services to complete the above mentioned tasks…This is a sufficient amount of time to complete the above mentioned tasks and adequately meet your needs…

The evidence further establishes that on May 4, 2018, the Appellant's daughter appealed the Plan's April 30, 2018 determination. By Final Adverse Determination, dated May 24, 2018, the Plan upheld its April 30, 2018 determination.

At the hearing, the Appellant's daughter testified that the Appellant's Personal Care Aide (hereinafter "PCA") arrives at 9:00 AM and leaves at 5:30 PM. The Appellant's daughter testified that between the hours of 5:30 PM and 9:00 AM the next morning, she and her daughter (the Appellant's granddaughter) tries to manage the Appellant's nighttime care needs, but that they can no longer do so. The Appellant's daughter testified that the Appellant's condition has significantly deteriorated since the passing of his wife in September 2017, who the Appellant shared a mutual split shift PCS Authorization with. The Appellant's daughter testified that the Appellant's PCS hours were reduced to 49 hours per week upon his wife's death, which is insufficient to cover the Appellant's nighttime needs. The Appellant's daughter testified that although a 24 hour, live-in ("live-in") care (91 hours per week) PCS Authorization would be sufficient to meet the Appellant's PCS needs, the request to increase the Appellant's PCS Authorization to 24 hour, continuous ("split-shift") care (168 hours per week) was made at the suggestion of one of the Plan's nurses, who visited the Appellant at his home (presumably because the Appellant shared a 24-hr split shift Authorization with his late wife). The Appellant's daughter then asked that the request be amended to a request for 24 hour, live-in, since the Plan's nurse misadvised her. The Appellant's daughter's testimony has been found credible and, therefore, the issue to be decided by this hearing has been amended to the adequacy of the Appellant's PCS Authorization with respect to 24 hour, live-in PCS Authorization.

With respect to the Appellant's need for assistance with activities of daily living ("ADLs"), the Appellant's daughter testified that the Appellant needs extensive assistance with toileting throughout the night. The Appellant's daughter testified that although the Appellant uses diapers, he sometimes tries to get up to use the commode, but immediately falls. The Appellant's daughter further testified that when the Appellant does not try to get up on his own to use the commode, he ends up staying in the same diaper all night. The Appellant's daughter submitted into evidence, a doctor's letter, dated July 19, 2018, from the Appellant's doctor, Dr. [redacted], which advised, in pertinent part, that the Appellant

underwent abdominal surgery in March 2018, is unable to walk, suffers from multiple falls, is incontinent of the bladder, and "needs continuous attendant support."

With regard to the Appellant's need for assistance with ADLs, the Plan's contentions that there were no changes in the Appellant's ability to perform ADLs and IADLs prior to the request for an increase in the Appellant's PCS Authorization, and that 8.5 hours of PCS a day is sufficient to meet the Appellant's PCS needs, are not supported by the evidence. In the Plan's April 13, 2018 UAS assessment, submitted into evidence by the Plan, the Plan's registered nursing assessor found that the Appellant requires maximal assistance with toileting (use and transfer), that the Appellant is incontinent of the bowel and bladder, and that the Appellant is totally dependent on the assistance of others with regard to locomotion. In the "Section F Comments," on page 5 of 24, the registered nursing assessor noted that the Appellant "has been steadily declining since the passing of his wife in Sept 2017" and that the Appellant "is currently weak, has difficulty with ambulation, and requires maximal assistance with ADLs." In fact, the Plan's registered nursing assessor specifically noted, on p. 9 of 24, that the Appellant's "daughter and granddaughter are supportive but are experiencing caregiver burnout." This evidence is consistent with the Appellant's daughter's testimony and the medical evidence presented at the hearing.

The record has been considered. In this case, the evidence establishes that, with regard to the Appellant's need for assistance with ADLs, the Appellant's daughter's credible contentions, which are supported by the evidence adduced at the hearing, establish that the Appellant, a 94-year-old, requires extensive scheduled and unscheduled assistance during a calendar day, with tasks such as toileting, locomotion, walking and transferring. Section 505.14(a)(4) of the Regulations provides that live-in 24-hour PCS means the provision of care by one PCA for a patient who, because of the patient's medical condition, needs assistance during a **calendar day** with toileting, walking, transferring, turning and positioning, and/or feeding. Therefore, the Appellant's documented care needs establish that the Appellant qualifies for 24-hour, live-in care.

With regard to 24-hour care, MLTC Policy 16.07 provides that, when it is determined that an enrollee has a need for this level of care, the Plan must "evaluate and document when and to what extent the Appellant requires assistance with IADLs and ADLs, and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night, in order to "assure that the plan of care that is developed [for the Appellant] can meet any unscheduled or recurring daytime or nighttime needs that the [Appellant] may have for assistance." If it is determined that an enrollee has a need for 24-hour care (as is the case here), the Plan may not use task-based assessment tools to authorize or reauthorize PCS and must, instead, determine whether, and the extent to which, the Appellant's need for assistance can be met by voluntary assistance from informal caregivers. Previously, the Appellant's PCS needs, in excess of the time authorized by the Plan, were being met by voluntary assistance from the Appellant's daughter and granddaughter, who were the Appellant's informal caregivers. However, the Appellant's daughter and granddaughter can no longer provide that care. The Plan is reminded that the Regulations provide that the Plan may take into consideration any informal support, but cannot require that the Appellant's daughter or granddaughter do so. Therefore, since the

Appellant's daughter previously advised the Plan – and testified to same at the fair hearing – that she and the Appellant's granddaughter are no longer able to provide voluntary, informal support to the Appellant – the Plan must now provide a care Plan that meets all of the Appellant's PCS needs.

Based on the foregoing, the record establishes that the Appellant's current plan of care does not meet the requirements of MLTC Policy 16.07, as the Appellant requires 24 hour, live-in care. It is noted that the Appellant's daughter was advised of the requirement to provide a 24 hour, live-in PCA with appropriate accommodations for sleeping and changing, which she stated she understood. Accordingly, the Plan's determination cannot be sustained.

**DECISION AND ORDER**

The Plan's determination to partially deny the Appellant's request for an increase in the Appellant's Personal Care Services Authorization, is not correct and is reversed.

1. The Plan is directed to immediately provide the Appellant with a Personal Care Services Authorization in the amount of 24 hour, live-in care (91 hours per week).

2. The Plan is directed to notify the Appellant, in writing, of the Plan's determination to increase the Appellant's Personal Care Services Authorization from 59.5 hours per week (8.5 hours per day x 7 days per week) to 24 hour, live-in care (91 hours per week).

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

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

DATED: Albany, New York
09/07/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee