STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 1, 2019
[redacted]
AGENCY: Nassau
FH #: 8004173Z

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 August 29, 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

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in her Personal Care Services authorization to continuous care by more than one aide/split shift for 5 days per week 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. The Appellant, age 77, has been enrolled in a Medicaid Managed Long Term Care Plan through Centers Plan for Healthy Living (hereinafter, the "Plan") and has been in receipt of a Personal Care Services (hereinafter, "PCS") and Consumer Self Directed Personal Assistance Services (hereinafter, "CDPAS") authorization in the total amount of 10.5 hours per day 7 days per week.

2. On May 13, 2019, the Plan's nurse completed a reassessment of the Appellant to determine the extent of Appellant's need for human assistance with her activities of daily living.

3. On July 19, 2019, Appellant's daughter requested an increase in Appellant' PCS hours to continuous care by more than one aide/split shift for 5 days per week on the ground that she can longer assist the Appellant with her daytime and nighttime personal care needs.

4. Along with the request, the Appellant's daughter submitted a letter dated July 26, 2019 from a Nurse Practitioner who stated in the letter that Appellant has been under her care; that she suffers from several medical conditions including Alzheimer's dementia, atrial premature contractions, Barrett's esophagus and dysphagia and that she requires two 12 hour personal care aide shifts, 5 days a week because she is "at risk of aspiration, impaired skin integrity and falls and it is medically necessary for this change to be made in order to prevent further decline in health."

5. By Initial Adverse Determination dated August 1, 2019, the Plan determined to deny the request on the ground that the current hours are "appropriately and safely" meeting Appellant's personal care needs. The Plan acknowledged in this notice that the increase in hours was requested "because there is a change in caregiver availability"; that Appellant has ambulating limitations and requires "a lot of assistance" with toileting transfers and needs.

6. On August 1, 2019, this fair hearing was requested contesting the Plan's determination to deny the request for an increase in Appellant's PCS hours.

7. On the same date, Appellant's daughter appealed the Plan's Initial Adverse Determination internally with the Plan.

8. The Plan upheld such Initial Adverse Determination and so advised the Appellant by Final Adverse Determination dated August 5, 2019. The Plan reasoned therein that, per Plan's nurse's assessment of May 13, 2019, Appellant's needs stayed the same since her prior assessment on February 19, 2019; that the most current assessment did not support the need for nighttime hours and that hours are no provided for companionship, safety supervision or when tasks are not being performed.

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.

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 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.

GIS 01 MA/044 reminds districts that regulations provide that a determination to reduce, discontinue or deny a client's prior authorization must be stated in the client notice. The regulations set forth several examples of appropriate reasons and notice language to be used when reducing, discontinuing or denying services. 18 NYCRR 505.14(b)(5)(v)(c)(1)-(10).

For example, the new regulations provide that one reason for reducing or discontinuing personal care services is "the client's medical, mental, economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously". 18 NYCRR 505.14 (b)(5)(v)(c)(1). Consistent with the Court ruling in Mayer, the State requires that client notices citing this reason for reducing or discontinuing services must identify the specific medical, mental, social or economic change in the client's circumstances that justifies the proposed reduction or discontinuation in services. The client notice must explain why the change in the client's circumstances results in the need for fewer hours of services.

Plans are reminded that State policy, as reflected in the new regulations, requires that when Plans determine to reduce, discontinue or deny personal care services, the client notice must identify the specific reason (whether a prior mistake in the authorization, the client's refusal to cooperate with the required assessment or other specific reason set forth in the regulations) that justifies the action. The client notice must also explain why the cited circumstance or event necessitates the reduction, discontinuance or denial of services.

In addition to clarifying requirements for client notices under Mayer, the Department's new 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. For a further explanation of this requirement, districts should consult GIS message 97 MA/033, issued on November 26, 1997.

Federal Regulations (Title 42) state, in pertinent part:

§ 438.210 Coverage and authorization of services.

(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).

§431.211 Advance notice.
The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

§431.213 Exceptions from advance notice.
The agency may send a notice not later than the date of action if—
(a) The agency has factual information confirming the death of a beneficiary;
(b) The agency receives a clear written statement signed by a beneficiary that—
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;
(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);
(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the beneficiary's physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

§431.214 Notice in cases of probable fraud.
The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and

(b) The facts have been verified, if possible, through secondary sources.

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.

(i) The notice of action shall include:

…

(f) the enrollee's right to a fair hearing and the procedures for exercising this right, including:

…

(11) if an MMCO or its management contractor has determined to reduce, suspend, or terminate a service or benefit currently authorized: the circumstances under which the enrollee's benefits will be continued unchanged; how to request that benefits be continued; explanation that a request for an MMCO appeal is not a request for the enrollee to have benefits continue; and the circumstances under which the enrollee may be required to pay the costs of continued services. Such notice shall be issued within the timeframes required by federal regulations at 42 CFR 438.404(c)(1) and sections 358-2.23, 358-3.3(a)(1), and 358-3.3(d)(1) of this Title.

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for a Public Assistance or Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Public Assistance or Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Public Assistance or Medical Assistance in another district.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

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.

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

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

(9) preparing meals, including simple modified diets.

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

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

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

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient,

positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

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

(13) changing of simple dressings.

(b) Before continuous personal care services or live-in 24-hour personal care services may be authorized, additional requirements for the authorization of such services, as specified in clause (b)(4)(i)(c) of this section, must be met.

***

(b)(4) The initial authorization process shall include additional requirements for authorization of services in certain case situations:

(i) An independent medical review of the case shall be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the local social services department to review personal care services cases when:

(a) there is disagreement between the physician's order and the social, nursing and other required assessments; or

(b) there is question about the level and amount of services to be provided; or

(c) the case involves the provision of continuous personal care services or live-in 24-hour personal care services as defined in paragraphs (a)(2) and (a)(4), respectively, of this section. Documentation for such cases is subject to the following requirements:

(1) The social assessment shall demonstrate that all alternative arrangements for meeting the patient's medical needs have been explored and are infeasible including, but not limited to, the provision of personal care services in combination with other formal services or in combination with voluntary contributions of informal caregivers. In cases involving live-in 24-hour personal care services, the social assessment shall also evaluate whether the patient’s home has sleeping accommodations for a personal care aide. When the patient’s home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient’s circumstances change and sleeping accommodations for a personal care aide become available in the patient’s home, the district must promptly review the case. If a reduction of the patient’s continuous personal care services to live-in 24-hour personal care services is appropriate, the district must send the patient a timely and adequate notice of the proposed reduction.

(2) The nursing assessment shall document the following:

(i) 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;

(ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day;

(iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day;

(iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and

(v) whether, were live-in 24-hour personal care services to be authorized, the 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.

(ii) The local professional director, or designee, must review the physician's order and the social and nursing assessments in accordance with the standards for services set forth in subdivision (a) of this section, and is responsible for the final determination of the amount and duration of services to be authorized.

(iii) When determining whether continuous personal care services or live-in 24-hour personal care services should be authorized, the local professional director, or designee, must consider the information in the social and nursing assessments.

(iv) The local professional director or designee may consult with the patient's treating physician and may conduct an additional assessment of the patient in the home. The final determination must be made with reasonable promptness, generally not to exceed seven business days after receipt of the physician's order and the completed social and nursing assessments, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized.

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.

18 NYCRR 505.28 (b) includes the following definitions:

…

(2) "consumer directed personal assistance" means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a

consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated directive.

…

(5) "designated representative" means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assist and to perform the consumer's responsibilities specified in subdivision (g) of this section who is willing and able to perform these responsibilities. With respect to a non-self-directing consumer, a "designated representative' means the consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

…

(8) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14 (a)(6) of this Part.

(d) Assessment process. When the social services district receives a request to participate in the consumer directed personal assistance program, the social service district must assess whether the individual is eligible for the program. The assessment process includes a physician's order, a social assessment and a nursing assessment and, when required under paragraph (5) of this subdivision, a referral to the local professional director or designee.

General Information system message GIS02MA/024, dated September 3, 2004, describes the scope of services under the Consumer Directed Personal Assistance Program (CDPAP) and advises that such program authorized by Social Services Law Section 465-f, enables Medicaid recipients who are eligible for home care services to have greater flexibility and freedom of choice in obtaining needed services. CDPAP participants may hire, train, supervise and discharge their aides and, in particular, my exercise greater control regarding the manner in which their aides complete the various personal task and other services for which the CDPAP participant has agreed to accept responsibility under the program.

Medicaid recipients eligible to participate in the CDPAP may need assistance with personal care services and/or other home care services. The CDPAP aide may perform home health aide and skilled nursing services when a registered professional nurse has determined that the individual who will instruct the CDPAP aide is self-directing and capable of providing such instruction. [Education Law Section 6908 (i)(a)(iii)]. The scope of services that a CDPAP aide may provide thus includes all services provided by a personal care services aide as well as all services provided by a home health aide, registered nurse, licensed practical nurse, physical therapist, occupational therapist or speech pathologist.

Accordingly, social services district's CDPAP assessments and authorizations should include the full scope of home care services that the Medicaid recipient may require and for which he or she, or his self-directing representative, agrees to be responsible under CDPAP program. When issuing an authorization, districts must include not only the personal care or

home health aide services tasks with which the recipient needs assistance but also any skilled therapy or speech pathology services. The social services district should determine the amount of time required to complete a task by evaluating the task to be performed and discussing with the Medicaid recipient, or representative, the steps needed to complete the tasks. Tasks that are needed, but for which the Medicaid recipient or his or her representative is unwilling or unable to assume responsibility under CDPAP may be provided through another source.

At a fair hearing concerning the denial of an application for assistance, the Appellant must establish that the Agency's denial of assistance was not correct. 18 NYCRR 358-5.9(a).

MLCT Policy 16.07 provides guidance to Managed Long Term Care Plans on the use of task-based assessment tools for Personal Care Services and states:

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.

- 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.

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

- 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.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at mltcworkgroup@health.ny.gov.

MLTC Policy 16.07.

DISCUSSION

At issue is the Plan's determination to deny a request for an increase in Appellant's PCS hours to continuous care (split shift) for 5 days per week.

In a fair hearing concerning a denial of an application for assistance, the Appellant must establish that such denial was not correct. 18 NYCRR 358-5.9(a). It was so established in this case, as set forth below.

As indicated in the Plan's nurse's report of the assessment completed on May 13, 2019, the Appellant, age 77, suffers from a number of ailments, including but not limited to Alzheimer's disease, COPD, aphasia, osteoarthritis and Vitamin D deficiency, which causes severe impaired cognition, lack of ability to communicate, shortness of breath, fatigue, weakness, stiffness, limited range of motion, increased risk of infection and increased risk of injury.

The nurse indicated in the report that Appellant's cognitive skills are severely impaired; that she is disoriented to person, place and time due to aphasia related to Alzheimer's; that she requires direction with care and is unable to verbalize emergency plan and that she requires substantial assistance with all of her activities of daily living (ADLs), as follows:

- Appellant is **totally dependent** on others for locomotion, toilet use, bed mobility, bathing, personal hygiene, dressing, eating, meal preparation, ordinary housework,

managing finances, managing medications, phone use, negotiating stairs, shopping, transportation and equipment management; and

- She requires **maximal assistance** of others for toilet transfers and walking.

The Plan's nurse further indicated in the report that Appellant requires complete assistance with bed mobility, toilet use and eating and that Appellant is occasionally incontinent of bowel and frequently incontinent of bladder (daily, but some control present); that Appellant wears pullups and goes through 2 of those a day, per Appellant's daughter. The nurse acknowledged in the report that Appellant is on oxygen and has a history of aspiration pneumonia in 2015 and that she is on a pureed diet with thickened liquids.

The nurse also indicated in the report that, though Appellant did not have any pressure ulcers, Appellant's daughter had reported to the nurse a history of sacral pressure ulcer, which is consistent with Appellant's Nurse Practitioner's letter, indicating that Appellant is at risk for "impaired skin integrity". The nurse stated that she "educated on turning member regularly". This is consistent with Appellant's undisputed inability to ambulate on her own, move around in bed, toileting and urinary incontinence needs. The Appellant was noted to use a hospital bed with side rails up for fall precautions.

Consistently with the nurse's report of May 13, 2019 and the statements made in Appellant's Nurse Practitioner's letter, Appellant's daughter testified that Appellant does not have any current pressure ulcers but had two in the past that are currently healed, but that, because of history of such pressure ulcers coupled Appellant's urinary incontinence and total inability to move around in bed, Appellant is put on the commode every few hours during the day, which is also the reason she goes through only two diapers daily. Appellant's daughter testified that, at night, when the personal care aide is not there, Appellant's daughter would check the Appellant every few hours, at which time Appellant's diaper would be wet most of the time and she would change it for her and that she would also turn and reposition the Appellant to avoid skin breakdown.

Appellant's daughter further testified that, although she was able to assist the Appellant with her personal care needs in the past because she was not working, she found a full-time job as a nurse, which job she had started on August 12, 2019; that as soon as she found out she was hired she had advised the Plan in July 2019 that she will no longer be able to take care of her mother's personal care needs during the week, but will be able to do so during the weekend and that, though job training was during the day, she is commencing a night shift starting August 31, 2019.

Although the Plan acknowledged in its Initial Adverse Determination that the increase in hours was requested "because there is a change in caregiver availability", the record fails to establish that the Plan considered same in determining to deny the increase in Appellant's PCS hours. Indeed, the Plan's bases for its subject determination do not address the very reason the request for an increase in PCS hours was made.

Appellant's daughter's entire testimony is found to be credible as it was consistent with the nurse's report of May 13, 2019, Appellant's Nurse Practitioner's letter and Physician's Order for PCS services for the Appellant, dated May 6, 2019 and submitted by the Appellant's daughter at the hearing, wherein a physician stated, in describing Appellant's current treatment plans and goals, that Appellant is to avoid aspiration and requires frequent repositioning to avoid skin breakdown.

According to Mayo Clinic, a not for profit organization committed to clinical practice, education and research, pressure sores or pressure ulcers are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. The degree of skin and tissue damage ranges from red, unbroken skin to a deep injury involving muscle and bone. People most at risk of pressure sores are those with a medical condition that limits their ability to change positions and requires them to use a wheelchair or confines them to a bed for a long time. To treat pressure ulcers for bed-bound patients, such as the Appellant, it is generally accepted and widely recommended that such patients be repositioned about **once every two hours**, to relieve the pressure on the skin. See https://www.mayoclinic.org/diseases-conditions/bed-sores/diagnosis-treatment/drc-20355899.

Although it is undisputed that Appellant does not currently have any pressure ulcers, she was noted to be at risk for same due to her inability to move around and urinary incontinence needs. Indeed, the Plan's own nurse indicated that Appellant requires frequent repositioning due to the above.

The State Regulations define continuous personal care services as 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**.

Based on all of the foregoing, due to Appellant's documented extensive daytime and nighttime needs for human assistance, related to her inability to move around on her own, her toileting and incontinence needs and the associated risk of skin breakdown due to history of pressure ulcers, the record supports a split shift authorization for the Appellant for five days per week, as Appellant's daughter has indicated ability and willingness to provide assistance to her mother for two days per week only when she is off work.

Based on all of the foregoing, the Plan's determination at issue here is overturned.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in her Personal Care Services

authorization to continuous care by more than one aide/split shift for 5 days per week is not correct and is reversed.

1. The Plan is directed to cancel such determination and authorize additional hours of Personal Care Services for the Appellant to arrive to continuous care by more than one aide/split shift for 5 days per week.

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

DATED: Albany, New York
09/04/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee