STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 10, 2019
[redacted]
AGENCY: MAP
FH #: 7942032R

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on May 6, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long-Term Care plan

Marina Portnaya, Fair Hearing Representative

ISSUE

Was the determination by the Managed Long-Term Care plan, Senior Whole Health, to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours from thirty (30) hours per week (4 hours per day x 5 days + 5 hours per day x 2 days) to seventy (70) hours per week (10 hours per day x 7 days) 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 seventy-two and wheelchair bound, has been in receipt of a Medical Assistance authorization, Medicaid benefits, and has been enrolled in a Medicaid Managed Long Term Care plan with Centers Plan for Healthy Living.

2. The Appellant resides alone in an assisted living community.

3. The Appellant has been in receipt of an authorization of Personal Care Services in the amount of thirty (30) hours per week (4 hours per day x 5 days + 5 hours per day x 2 days).

4. The Appellant requested from the Plan an authorization to increase her Personal Care Services to seventy (70) hours per week (10 hours per day x 7 days).

5. On February 8, 2019, a registered nurse assessor completed a Uniform Assessment System (UAS) evaluation based upon a visit with the Appellant on February 7, 2019.

6. The nurse assessor reported in the UAS that the Appellant requires the following degree of assistance with the following tasks of daily living: maximal assistance with meal preparation, ordinary housework and shopping; extensive assistance with stairs, transportation, bathing, dressing upper and lower body, walking, locomotion, and toilet use; limited assistance with managing finances, managing medications, equipment management, personal hygiene, and bed mobility; supervision with eating.

7. The Appellant has a medical diagnosis which includes the following: acquired deformity of neck, dystonia, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, constipation, Parkinson's disease, primary generalized (osteo) arthritis, and abnormalities of gait and mobility.

8. By written notice of Initial Adverse Determination which is dated March 2, 2019, the Plan determined to deny the Appellant's request for an authorization to increase the Appellant's Personal Care from thirty (30) hours per week (4 hours per day x 5 days + 5 hours per day x 2 days) to forty-two (42) hours per week (6 hours per day x 7 days) on the grounds that the requested increase in Personal Care Services hours is not medically necessary.

9. The Appellant requested an internal review.

10. By written notice of Final Adverse Determination Denial Notice which is dated April 2, 2019, the Plan advised that the Plan was upholding the Plan's determination to deny the Appellant's request for an authorization to increase the Appellant's authorization of Personal Care Services.

11. On March 15, 2019, the Appellant requested a fair hearing in this matter.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance benefits or Services, the Appellant must establish that the Agency's denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

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

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

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

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

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

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

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

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

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

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

(13) changing of simple dressings.

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. Social services districts are NOT required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS

99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between “safety monitoring” as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

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

General Information System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (SDNY, 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

Districts were first advised of the Mayer case in May 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24-hour care, including continuous 24-hour services ("split-shift"), 24-hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.

This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split-shift or live-in services.

When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Remember that the contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split-shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

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

Pursuant to GIS 03 MA/003, issued on January 24, 2003, task-based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies.

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

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

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

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

The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

DISCUSSION

The record in this matter establishes that the Appellant is seeking an authorization for an increase of Personal Care Services from her current task based thirty (30) hours per week (4 hours per day x 5 days + 5 hours per day x 2 days) to seventy (70) hours per week (10 hours per day x 7 days). It is noted that the Plan's written notices makes reference to a request for forty-two (42) hours per week (6 hours per day x 7 days). The Appellant's representatives contend that the request has been made for seventy (70) hours (10 hours per day x 7 days) and not the 42 as referenced in the Plan's two written notices. Although duly advised of the date, time and location of the hearing as well as of the issue(s) to be addressed at the hearing in this matter, the Plan did not present evidence which might verify in some plausible manner a request for an increase limited to forty-two (42) hours per week. It is also noted that the Plan did not present evidence which might show how the Plan arrived at the provision of thirty (30) hours per Personal Care Services per week, such as a tasking tool sheet or nurse's narrative explanation.

With regard to the adequacy of the Appellant's Personal Care Services, the record establishes that the registered nurse who last evaluated the Appellant reported that the Appellant requires the following degree of assistance with the following tasks of daily living: maximal assistance with meal preparation, ordinary housework and shopping; extensive assistance with stairs, transportation, bathing, dressing upper and lower body, walking, locomotion, and toilet use; limited assistance with managing finances, managing medications, equipment management, personal hygiene, and bed mobility; supervision with eating.

At the hearing the Appellant's sons testified that the family has been providing the Appellant with informal care to fill in for the care hours during which the Appellant is not receiving services after the aide leaves. The Appellant's sons contend that the family cannot continue to provide such informal care on a regular basis due to other various personal and typical life obligations of each family member. The Appellant's sons explained that the Appellant's dystonia has become so severe that the Appellant requires a contraption which was purchased, along with the wheelchair, by the Appellant's family and that the contraption must be strapped to the Appellant's head. This contraption, they further explained, must be removed at regular intervals in order to allow the Appellant to eat and also to toilet. The Appellant's sons also explained that the Appellant is not able to apply and remove the contraption and that this must be done with the assistance of the home attendant.

The contention of the Appellant's sons is plausible, persuasive and supported by the record. The Plan, it is noted, did not present evidence which might rebut this plausible and persuasive claim. It is again noted that the Plan failed to present evidence which might show how the Plan's

registered nurse assessor had arrived at a recommendation of Personal Care Services in the amount of thirty (30) hours per week.

The evidence as presented by both parties in this matter has been carefully reviewed and the contention of the parties fully considered. The Plan's determination not to provide an authorization for the requested increase in services, therefore, cannot be sustained as the record shows a medical necessity for the requested increase in services.

DECISION AND ORDER

The determination by Senior Whole Health to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours from thirty (30) hours per week (4 hours per day x 5 days + 5 hours per day x 2 days) to seventy (70) hours per week (10 hours per day x 7 days) cannot be sustained and is reversed.

Senior Whole Health is directed to:

1. Immediately provide to the Appellant a Personal Care Services authorization in the amount of seventy (70) hours per week (10 hours per day x 7 days).

2. Continue the authorization of seventy (70) hours per week (10 hours per day x 7 days) unchanged

Should Senior Whole Health need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's Representative must provide it to the Managed Long-Term Care plan promptly to facilitate such compliance.

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

FH# 7942032R

DATED: Albany, New York
05/13/2019

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee