STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 23, 2018
[redacted]
AGENCY: MAP
FH #: 7848842Z

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 December 12, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long-Term Care Plan (Centers Plan for Healthy Living)

Debra Ferguson, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long-Term Care Plan to not increase the Appellant's personal care service hours from 84 hours per week (12 hours per day for 7 days per week) to live-in 24-hour personal care services correct?

FINDINGS OF FACT

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

1. The Appellant has been in receipt of Medical Assistance and has been enrolled in a Managed Long-Term Care Plan operated by Centers Plan for Healthy Living (hereinafter, the Plan).

2. The Appellant has been in receipt of personal care services in the amount of 84 hours

per week (12 hours per day for 7 days per week).

3. On February 28. 2018, a nurse, on behalf of the Plan, completed a Uniform Assessment System – Comprehensive Assessment (UAS) as well as an Aide Task Service Plan as part of a reassessment of Appellant.

4. On August 14, 2018, a nurse, on behalf of the Plan, completed a Uniform Assessment System – Comprehensive Assessment as well as an Aide Task Service Plan as part of a reassessment of Appellant.

5. On September 18, 2018, a nurse, on behalf of the Plan, completed a Uniform Assessment System – Comprehensive Assessment as well as an Aide Task Service Plan as part of a reassessment of Appellant.

6. The Appellant, age 93, resides alone in a three-bedroom apartment.

7. The Appellant's health conditions consist of, but not limited to coronary heart disease, heart failure, cardiovascular accident, age-related physical debility, osteoarthritis, chronic kidney disease, constipation, dizziness, edema, hypertension, history of falling, hyperlipidemia, low vision in both eyes, fatigue, shortness of breath, abnormalities of gait and mobility, urinary incontinence and weakness. The Appellant uses a walker for ambulation.

8. The Appellant needs dialing assistance with ordinary housework, medication management, bathing, personal hygiene, dressing (upper and lower body), walking, toilet use and transfers, transferring, positioning (bed mobility) and eating. The Appellant needs assistance three times per night for toileting.

9. On September 4, 2018, a request to increase the Appellant's personal care services from 84 hours per week to live-in 24-hour personal care services was submitted on Appellant's behalf.

10. By Initial Adverse Determination dated September 27, 2018, the Plan informed the Appellant of its determination to deny the request to increase Appellant's personal care services from 84 hours per week to live-in 24-hour personal care services.

11. On behalf of Appellant, a request for an internal appeal was submitted to the Plan.

12. By Final Adverse Determinations dated October 3, 2018, the Plan informed the Appellant of its determination to uphold its Initial Adverse Determination of September 27, 2018.

13. On October 23, 2018, this fair hearing was requested on behalf of Appellant.

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, Medical Assistance, HEAP, SNAP benefits or Services, the Appellant must establish that the Agency's denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a).

In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Medical Assistance benefits or services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

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 438.236 of 42 CFR Subpart D provides, in pertinent part, that each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines. In addition, it provides that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. The New York State Department of Health Office of Health Insurance Programs established the “Guidelines for the Provision of Personal Care Services in Medicaid Managed Care”.

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. Additionally, Section 505.14(a)(1) states that such services must be essential to the maintenance of the patient's health and safety in his or her own home.

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.

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)(5) 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:

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(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.

The authorization of a personal care services authorization must be based, in relevant part, a physician's order, social assessment and a nursing assessment.

GIS 03 MA/003 clarifies and elaborates on the assessment of personal care services pursuant to a court ruling in Rodriguez v. Novella. In pertinent part, GIS 03 MA/003 states that it is not required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized. GIS 03 MA/003 further states there is a distinction 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.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides, in part, the intent of 18 NYCRR 505.14 is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping.

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

Department guidelines provide the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

• The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;

• The specific task or tasks with which the person requires frequent assistance during the night;

• The frequency at which the person requires assistance with these tasks during the night;

• Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;

• The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;

• The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and

• Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

Reauthorization for personal care services requires similar assessments as for the initial authorization; however, a nursing assessment is not required for Level I services if the physician's order indicates that the patient's medical condition is unchanged. Reauthorization of Level II services must include an evaluation of the services provided during the previous authorization period and must include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

When there is a change in the patient's services needs, which results solely from a change in his/her social circumstances, including, but not limited to, loss or withdrawal of support provided by informal caregivers, the social services department must review the social assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new physician's order and nursing assessment is not required.

When there is a change in the patient's services needs, which results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the social services department must review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated.

When there is a change in the patient's services needs, which results from a change in his/her medical condition, the social services department must obtain a new physician's order and a new nursing assessment and shall complete a new social assessment. If the patient's medical condition continues to require the provision of personal care services, and the nursing assessment cannot be obtained within five working days of the request from the local social services department, the local department may make changes in the authorization in accordance with the procedures specified in 18 NYCRR 505.14(b)(5)(iv).

DISCUSSION

In this matter, the uncontroverted evidence establishes the Appellant has been in receipt of personal care services in the amount of 84 hours per week (12 hours per day for 7 days per week). It further establishes that on February 28. 2018, August 14, 2018 and September 18, 2018, a nurse, on behalf of the Plan, completed a Uniform Assessment System – Comprehensive Assessment (UAS) as well as an Aide Task Service Plan as part of a reassessment of Appellant.

The uncontested evidence establishes that on September 4, 2018, a request to increase the Appellant's personal care services from 84 hours per week to live-in 24-hour personal care services was submitted on Appellant's behalf. It further establishes that by Initial Adverse Determination dated September 27, 2018, the Plan informed the Appellant of its determination to deny the request to increase Appellant's personal care services from 84 hours per week to live-in 24-hour personal care services. On behalf of Appellant, a request for an internal appeal was submitted to the Plan. Thereafter, by Final Adverse Determinations dated October 3, 2018, the Plan informed the Appellant of its determination to uphold its Initial Adverse Determination of September 27, 2018.

At the hearing, the Appellant's daughter testified that she manages Appellant's affairs such as daily contact with Appellant's medical providers and personal care aide. The Appellant's daughter further testified that she visits Appellant twice per week from 6 p.m. until midnight and she assists Appellant with activities of daily living upon the personal care aide's 8 p.m. departure. She explained that Appellant's personal care aide assists Appellant from 8 a.m. until 8 p.m. The Appellant's daughter explained that Appellant's has several ailments including weakness, low vision, constipation, urinary incontinence and osteoarthritis.

She stated that although Appellant uses a walker for ambulation, he still requires hands-on assistance due to his weakness and low vision. The Appellant's daughter testified that Appellant requires hands-on assistance with toilet use and transfers. Additionally, she explained that she has stayed overnight at Appellant's home three times, and Appellant needed assistance with toileting approximately three times per night. The Appellant's daughter stated that on the night of August 9, 2018, the Appellant fell while walking from his bathroom to his bedroom. She

explained that Appellant remained on the floor overnight and his personal care aide found Appellant in the morning. The Appellant's daughter testified that Appellant urinated on himself while he spent the night on the floor. In support of her testimony, the Appellant's daughter presented a nighttime log. Notably, the Appellant fall was documented in the September 18, 2018 assessment and medical records. The testimony of Appellant's daughter was credible as it was consistent detailed and supported by documentation.

Based on the evidence submitted by both parties, the evidence establishes the Appellant, age 93, resides alone in a three-bedroom apartment. It further establishes that Appellant's health conditions consist of, but not limited to coronary heart disease, heart failure, cardiovascular accident, age-related physical debility, osteoarthritis, chronic kidney disease, constipation, dizziness, edema, hypertension, history of falling, hyperlipidemia, low vision in both eyes, fatigue, shortness of breath, abnormalities of gait and mobility, urinary incontinence and weakness. The Appellant uses a walker for ambulation. The undisputed evidence also establishes the Appellant needs dialing assistance with ordinary housework, medication management, bathing, personal hygiene, dressing (upper and lower body), walking, toilet use and transfers, transferring, positioning (bed mobility) and eating. The Appellant needs assistance three times per night for toileting.

The weight of the credible evidence establishes the Appellant needs assistance during a calendar day with toileting, walking and transferring. The credible evidence also establishes that the Appellant's need for such 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. Based thereon, the credible evidence establishes that the Appellant is entitled, under the Regulations, to a Personal Care Services authorization in the amount of live-in 24-hour personal care services.

DECISION AND ORDER

The determination of the Appellant's Managed Long-Term Care Plan to not increase the Appellant's personal care service hours from 84 hours per week (12 hours per day for 7 days per week) to live-in 24-hour personal care services was not correct and is reversed.

The Managed Long-Term Care plan is directed to:

1. Authorize Personal Care Services to the Appellant in the amount of live-in 24-horu personal care services.

Should the Managed Long-Term Care 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 Managed Long-Term Care Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
12/20/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee