STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 18, 2018
[redacted]
AGENCY: MAP
FH #: 7880727P

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 January 11, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Debora Ferguson, Fair Hearing Representative

ISSUE

Was Centers Plan for Healthy Living's determination to deny the Appellant's request for an increase in the weekly number of hours of personal care services from 56 hours to 84 hours correct?

FINDINGS OF FACT

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

1. The Appellant, age 94, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living.

2. The Appellant requested that Centers Plan for Healthy Living increase the

Appellant's weekly number of hours of personal care services from 56 hours to 84 hours.

3. Centers Plan for Healthy Living determined to deny the Appellant's request for an increase in the weekly number of hours of personal care services from 56 hours to 84 hours.

4. On December 18, 2018, the Appellant requested this fair hearing.

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 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.

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

GIS 11 MA/009 provides that effective August 1, 2014, personal care services for non-dual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract.

Pursuant to Social Services Law §365-a(2)(e) Medicaid provides personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Social Services Law §365-a(2)(e)(iv) provides that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Personal care services in Medicaid Managed Care

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i. Personal care services include some or total assistance with:
    1. Level I functions as follows:
        a. Making and changing beds;
        b. Dusting and vacuuming the rooms which the member uses;
        c. Light cleaning of the kitchen, bedroom and bathroom;
        d. Dishwashing;
        e. Listing needed supplies;
        f. Shopping for the member if no other arrangements are possible;
        g. Member’s laundering, including necessary ironing and mending;
        h. Payment of bills and other essential errands; and
        i. Preparing meals, including simple modified diets.

2. Level II personal care services include Level I functions listed above and the following personal care functions:
    a. Bathing of the member in the bed, the tub or the shower;
    b. Dressing;
    c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
    d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
    e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
    f. Transferring from bed to chair or wheelchair;
    g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
    h. Feeding
    i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
    j. Providing routine skin care;
    k. Using medical supplies and equipment such as walkers and wheelchairs; and
    l. Changing of simple dressings.

MLTC Policy 16.07, issued on November 17, 2016, provides as follows:

"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 (emphasis in original). 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."

DISCUSSION

The record establishes that the Appellant, age 94, has been in receipt of Medical Assistance coverage, and has been enrolled in a Managed Long Term Care Plan operated by Centers Plan for Healthy Living ("the Agency").

The record establishes that the Appellant first requested that the Agency increase the Appellant's weekly number of hours of personal care services from 49 hours to 84 hours and the Agency partially denied that request by an Initial Adverse Determination dated December 7,

2018, increasing the Appellant's weekly number of hours of personal care services from 49 to 56. On December 13, 2018, the Agency issued a Final Adverse Determination restating that conclusion.

At the hearing, the Agency Representative submitted a copy of the December 7, 2018 Initial Adverse Determination and testified that the Agency issued a Final Adverse Determination dated December 13, 2018 that reached the same result. The Initial Adverse Determination was based on a November 29, 2018 assessment. That determination indicated that the Appellant was able to walk with a walker indoors and a wheelchair outdoors, could transfer on and off the toilet and take care of toileting needs with "some assistance", and was able to feed himself and direct his own care.

The Agency Representative submitted a comprehensive Uniform Assessment System dated November 20, 2018 reflecting an assessment made while the Appellant was still in a rehabilitative nursing home after a lengthy hospitalization and rehabilitation. The Agency also submitted a substantially less comprehensive "Summary Report" of an assessment done on November 29, 2018, after the Appellant had returned to his home. The "Summary Report" included statements made by the Appellant's niece, who was present for the assessment, that the Appellant, who suffered a fall on September 11, 2018 that led to his lengthy hospitalization and rehabilitation "requires significant weight bearing assistance with bathing, dressing lower body, toilet use, and transferring from sitting to standing position" in addition to numerous other tasks. She also reported that the Appellant "has decline with bladder/bowel control" and the assessment concluded that the Appellant was frequently incontinent of bladder and occasionally incontinent of bowel. Finally, the Agency Representative submitted a "Client Task Sheet" that allowed 56 hours a week, including 60 minutes a day for toilet transfer, 70 minutes a day for toilet use, 25 minutes a day to address bladder incontinence and 20 minutes a day to address bowel incontinence. That summary task sheet also indicates that the Appellant has impaired cognitive skills for daily decision making, behavioral limitations, a history of falls, wandering and a recent hospitalization.

The Appellant's Representative contended that the Agency has understated the Appellant's needs and submitted recent letters from the Appellant's doctors indicating that the Appellant is [redacted]. As a result of those conditions, he is almost entirely dependent on assistance with all of his activities of daily living and he requires nearly constant care. The Appellant's Representative indicated that the Appellant has actually been receiving many hours of care supplemental to that provided by the Agency-supplied home attendant, including three hours a day of Medicare-financed care and the assistance of family members. She indicated that while the current request is for only 12 hours a day, 7 days a week that the Appellant probably actually requires round-the-clock care.

All the evidence has been considered. The Initial Adverse Determination is itself substantially undermined by the Agency's own report of the assessment it performed on

November 29, 2018 after the Appellant had returned home from rehabilitation. For instance, where the Initial Adverse Determination states that the Appellant can transfer and toilet with "some assistance", the summary assessment report indicates that he needs "significant weight-bearing assistance" with those and other activities. The Client Task Sheet relied upon by the Agency is deficient in that it fails to indicate that the Agency did an individualized assessment of the Appellant's need for assistance, including assessments of the actual time and frequency of needs for this particular Appellant, taking into account his specific conditions and needs. The Agency has also not demonstrated that it first conducted the necessary inquiry preliminary to using a Client Task Sheet, i.e., whether the Appellant needs 24-hour services. The evidence presented at the hearings indicates that the Appellant needs at least 12 hours a day of personal care services for 7 days a week. The Agency's determination to deny the Appellant's request for an increase to 12 hours a day is thus incorrect.

DECISION AND ORDER

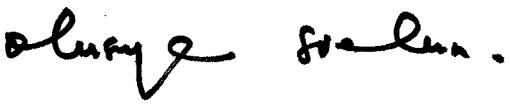
Centers Plan for Healthy Living's determination to deny the Appellant's request for an increase in the weekly number of hours of personal care services from 56 hours to 84 hours was not correct and is reversed.

1. Centers Plan for Healthy Living is directed to authorize increased personal care services to the Appellant in the amount of 12 hours a day, 7 days weekly.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
01/22/2019

NEW YORK STATE
DEPARTMENT OF HEALTH
By



Commissioner's Designee