STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 20, 2018
[redacted]
AGENCY: MAP
FH #: 7863884N

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 March 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 (Centers Plan for Healthy Living)

Debra Ferguson, Fair Hearing Representative

ISSUE

Was the Initial Adverse Determination, dated November 5, 2018, of the Managed Long-Term Care Plan, to deny Appellant's request dated October 22, 2018 for an increase in personal care service hours from 36 hours weekly (6 hours daily x 6 days weekly) to 24 hour-Live In per day x 7 days per week, and to partially approve the Appellant's request by granting an increase in personal care service authorization to 49 hours weekly (7 hours daily x 7 days weekly) correct?

Was the Final Adverse Determination, dated November 8, 2018, of the Managed Long-Term Care Plan, to deny Appellant's request dated October 22, 2018 for an increase in personal care service hours from 36 hours weekly (6 hours daily x 6 days weekly) to 24 hour-Live In per day x 7 days per week, and to partially approve the Appellant's request by granting an increase in personal care service authorization to 49 hours weekly (7 hours daily x 7 days weekly) 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 67, resides alone, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Long-Term Care plan with Centers Plan for Healthy Living.

2. The Appellant is currently authorized to receive 49 hours weekly of personal care services (i.e., 7 hours daily x 7 days weekly).

3. The Appellant's diagnosed health conditions include [redacted] 3. On October 22, 2018, the Appellant's Representative, on behalf of Appellant, requested an increase in the personal care hours, claiming a need for 24 hour-Live In per day x 7 days per week of personal care assistance. At the time of the Appellant's request the Appellant had been receiving 36 hours of weekly personal care services times (i.e., 6 hours daily x 6 days weekly).

4. On June 20, 2018, the plan completed an Aide Task Service Plan which found that the Appellant requires personal care services in the amount of 39.00 hours weekly.

5. On June 20, 2018, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview of the Appellant by a registered Nurse Assessor on June 20, 2018.

7. On October 25, 2018, the plan completed an Aide Task Service Plan which found that the Appellant requires personal care services in the amount of 49.00 hours weekly.

8. On October 25, 2018, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview of the Appellant by a registered Nurse Assessor on October 25, 2018.

9 By Notice of Initial Adverse Determination, dated November 5, 2018 the plan advised the Appellant that the request for an increase in personal care hours to 24 hours per day Live In per day x 7 days per week was denied on the grounds that "the health care service is not medically necessary" and partially approved the Appellant's request by authorizing 49 hours per week of personal care services (7 hours per day x 7 days per week).

10. By Notice of Final Adverse Determination, dated November 8, 2018, the plan advised the Appellant that the request for an increase in personal care hours to 24 hours per day Live In per day x 7 days per week was denied on the grounds that "the health care service is not

medically necessary" and partially approved the Appellant's request by authorizing 49 hours per week of personal care services (7 hours per day x 7 days per week).

11. On November 20, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

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

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

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

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:
  (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
  (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.
  (3) Provide that the MCO, PIHP, or PAHP--
    (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
    (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;
    (iii) May place appropriate limits on a service
      (A) On the basis of criteria applied under the State plan, such as medical necessity; or
      (B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and
  (4) Specify what constitutes "medically necessary services"' in a manner that:
    (i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and

other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

In the case of an MCO or PIHP -"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. The notice must explain the following:
(1) The action the MCO or PIHP or its contractor has taken or intends to take;
(2) The reasons for the action...

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. 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) of the Regulations provides in part that:

Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:
(i) Level I shall be limited to the performance of nutritional and environmental

support functions.

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.

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

(a) Personal care functions shall include some or total assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;
(2) dressing;
(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;
(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;
(6) transferring from bed to chair or wheelchair;
(7) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
(8) feeding;
(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;
(10) providing routine skin care;
(11) using medical supplies and equipment such as walkers and wheelchairs; and
(12) changing of simple dressings.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

Pursuant to GIS 03 MA/003, task based assessments must be developed which meet the

scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

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

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

Section 505.14(a) of the Regulations provides:

(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.

(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.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), effective December 23, 2015, provides:

The purpose of this policy directive is to inform Managed Long Term Care Plans (MLTCPs) of revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR § 505.14 and 18 NYCRR § 505.28, respectively. These revised regulations are effective on December 23, 2015.

These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous ("split-shift") PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, MLTCPs must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the New York State Register on December 23, 2015.

Regulatory changes for PCS and CDPA applicable to MLTCP's include:

1. 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.

2. “Turning and positioning” is added as a specific Level II personal care function and as a CDPA function.

3. The definitions and eligibility requirements for “continuous personal care services,” ”live-in 24-hour personal care services,” “continuous consumer directed personal assistance” and “live-in 24-hour consumer directed personal assistance” are revised as follows:

a. *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.

b. *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.

c. *Continuous consumer directed personal assistance* means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the consumer’s medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight hour period of sleep.

d. *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer’s medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant 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 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:

It is the Department’s policy that 24-hour split-shift care should be authorized only when a person’s nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside

commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

With regard to adaptive or specialized equipment (the "efficiencies"), the nursing assessment shall include a professional evaluation whether such adaptive or specialized equipment or supplies can meet the recipient's need for assistance and whether such equipment or supplies can be provided safely and cost-effectively when compared to the provision of aide services. Such adaptive or specialized equipment or supplies include, but are not limited to, bedside commodes, adult diapers, urinals, walkers and wheelchairs.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released 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. In relevant portion, this GIS Message states:

> 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**.**

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater

amount of assistance or benefits

DISCUSSION

The record in this matter establishes that the Appellant's Managed Long-Term Care Plan (MLTC Plan), Centers Plan for Healthy Living, has authorized Personal Care Services to the Appellant in the amount of thirty-six (36) hours weekly (i.e., 6 hours daily x 6 days weekly). The Appellant, requested on October 22, 2018, an increase of Personal Care Service hours to 24 hours per day Live In hours x 7 days per week. The Managed Long-Term Care Plan, by Initial Adverse Determination Notice dated November 5, 2018 denied the Appellant's request for an increase in personal care services with a 24 hour live in x 7 days per week, however, partially approved Appellant's request by authorizing forty-nine (49) hours per week of personal care services. The record in this matter also establishes that the Appellant's Managed Long-Term Care Plan, Centers Plan for Health Living, by Final Adverse Determination Notice dated November 8, 2018, upheld its Initial Denial Notice and also upheld its partial approval of authorizing the Appellant's request for an increase in personal care services by increasing the Appellant's authorization for personal care services to forty-nine (49) hours per week (7 hours per day x 7 days weekly). The Appellant requested this fair hearing.

At the hearing the Managed Long-Term Care Plan submitted into evidence the MLTC Plan's Initial Adverse Determination Notice dated November 5, 2018 which states in pertinent part:

"On 11/02/2018, Centers Plan for Healthy Living decided to partially approve this service because the health care service is not medically necessary.

The request for Personal Care Aide (PCA) services was partially approved. This decision was based on:

You requested an increase in your Personal Care Aide (PCA) services because you want someone to be available for you during the night hours to assist with your Activities for Daily Living. A Registered Nurse from Centers Plan for Healthy Living visited you in your home on 10/25/2018 and completed a face-to-face assessment using the New York State Uniform Assessment System (UAS-NY).

Based on this assessment, it was identified that:
You are able to move around indoors and outdoors with a wheelchair with human assistance.
You need help with bathing, dressing and toileting.
You are able to move from lying position and turn side to side while in bed with some assistance.
No unscheduled daytime or nighttime needs have been identified.
You are self-directing.

To best meet your needs, your Care Management Team has contacted your Certified Home Health Agency (CHHA) MJHS and have received progress reports on 10/24/2018. Your case is currently active with the agency.

Your requested increase in Personal Care Aide Service, along with your recent UAS-NY assessment were thoroughly reviewed by Centers Plan for Healthy Living. Based on clinical documentation present, CPHL will increase your Personal Care Aide Services to 7 (seven) hours per day 7 (seven) days per week (totaling 49 (forty-nine) hours per week). This increase will ensure that your personal care needs will continue to be met appropriately.

Centers Plan for Healthy Living will continue to assess your health care needs. If you have any questions regarding your care, your Care Management team is available to assist at 1-855-270-1600 (toll free), 7 days a week, 8 AM-8PM."

See MLTC Plan Exhibit 1, Initial Adverse Determination Notice dated November 5, 2018.

At the hearing the Managed Long-Term Care Plan submitted into evidence the MLTC Plan's Final Adverse Determination Notice dated November 8, 2018 which states in pertinent part:

"The Medical Director on behalf of Centers Plan for Healthy Living decided to deny this request for an increase in Personal Care Aide services because the service is not medically necessary.

The Request for an increase in Personal Care Aide services was denied because you do not meet the criteria.

This decision was based on:

The denial for an increase in Personal Care Aide Level 2 services for (Live-In per diem), 7 days a week is upheld (continues to be denied).

Your hours were increased at 7 hours per day, 7 days a week for a total of 49 hours per week. Before this decision you were receiving 6 hours per day, 6 days a week for a total of 36 hours per week.

You live alone on the 16th floor of a one-bedroom apartment in an elevator accessible apartment building.

You recently underwent a follow-up face -to-face clinical assessment on October 25, 2018 utilizing the New York State Department of Health's Uniform Assessment System Tool) that showed some of your abilities to perform physical functioning stayed the same and some declined since your prior assessment that was completed by Centers Plan for Healthy Living on June 20, 2018.

You showed that your abilities to perform physical functioning stayed the same for dressing upper and lower body, personal hygiene (cleaning yourself), bed mobility (moving around the bed), and bathing.

You showed that your abilities to perform physical functioning declined for walking, transfer toilet (getting on and off the toilet), eating, meal preparation, medication management and ordinary housework.

In summary, you showed that some of your abilities to perform physical functioning stayed the same and some declined; therefore, your hours were increased to 7 hours per day, 7 days a week for a total of 49 hours per week.

This decision is based on the NYS Department Health Uniform Assessment System (UAS-NY) and the plan's client tasking tool."

See MLTC Plan Exhibit 2, Final Adverse Determination Notice dated November 8, 2018.

A review of the Managed Long-Term Care Plan's Uniform Assessment System-New York Comprehensive Community Assessment Report (UAS) dated June 20, 2018, indicates that the Appellant requires:

<u>Total Dependence:</u>
Ordinary housework
Stairs

Shopping
Transportation
Walking
Locomotion
Transfer Toilet

Maximal Assistance:
Meal preparation
Managing finances
Bathing
Dressing lower body

Extensive Assistance:
Personal hygiene
Dressing upper body
Toilet use
Bed mobility

Limited Assistance:
Managing medications

Comments:
Member needs limited assistance with medications, PCA/family provides reminders at times. Member ambulates dependent with wheelchair, and wheeled by himself indoors and by others outdoors. Member requires assistance with ADLs due to suffered from Paraplegia and inability to fully flex or extend the fingers. Member is unable to stand and walk but he is able to move his legs by himself.

See *MLTC Plan Exhibit 6*, Uniform Assessment System – New York Comprehensive Community Assessment Report dated June 20, 2018.

A review of the *MLTC Plan Exhibit 5*, Client Task Sheet: PCW/PCA Level II, dated June 20, 2018, indicates that the Appellant requires 39 hours of Personal Care Services.

A review of the *MLTC Plan Exhibit 3,* Client Task Sheet: PCW/PCA Level II, dated October 25, 2018, indicates that the Appellant requires 49 hours of Personal Care Services.

A review of the Managed Long-Term Care Plan's Uniform Assessment System – New York Comprehensive Community Assessment Report (UAS) dated October 25, 2018 indicates that the Appellant requires:

Total dependence:
Ordinary housework
Stairs
Shopping

Transportation
Locomotion

Maximal Assistance:
Meal preparation
Managing finances
Bathing
Dressing lower body
Walking
Transfer toilet

Extensive Assistance:
Managing medications
Phone use
Personal hygiene
Dressing upper body
Toilet use
Bed mobility

Comments:
Member is diagnosed with **paraplegia,** also he complains of stiffness on his hand; he is unable to stand and walk. Member states that he requires significant weight bearing assistance from PCA when transferring; he was observed wheeling by himself indoors, but he requires someone to wheel him outdoors. Member requires some weight bearing assistance from PCA help him to turn side to side when he is in bed. Member requires significant weight being assistance from PCA for bathing and adjusting cloths on lower body. Member requires assistance from PCA to use the toilet; perform personal grooming and adjust cloths on upper body with some weight bearing assistance from PCA or family. Member is unable to perform housework; he needs assistance with meal from PCA. Member needs assistance with medications, PCA and family assist him from opening bottles and provides reminders to ensure compliance. Educated member and PCA on fall prevention. Verbalized understanding.

Bladder continence: Occasionally incontinent – less than daily
Bowel continence: Occasionally incontinent – Less than daily
Member uses urinal and underpads.

See *MLTC Plan Exhibit 4*, Uniform Assessment System – New York Comprehensive Community Assessment Report dated October 25, 2018.

At the fair hearing, the Appellant testified via telephone and stated that he suffers from medical diagnoses of: [redacted]

[redacted].

The Appellant further testified that he requested a 24-hour Live-In x 7 days per week, because he requires assistance at night with toileting. He further testified that he requires an increase in personal care hours because his ambulation and locomotion skills have deteriorated. In support of his contention, he indicated that the Managed Long-Term Care Plan's own evidence, in particular the Managed Long-Term Care Plan's Exhibit 8, Care Management Report states in pertinent part:

"Member dx: chronic paraplegia, DMII with neuropathy, chronic kidney disease, hx of falling, dependence on wheelchair. A&Ox3, lives alone, per CIR completed on 09/24/18 by CM, member fell again on 8/24/18 after PCA left and was unable to get back up into bed, so he laid on the floor all night and waited until PCA came in the next day to assist him to get up. No major injuries.
Member was seen by PCP on 09/12/18. PCP referred CHHA PT, member currently receiving CHHA PT from MJHS CHHA, PHI faxed to MJHS, but MJHS refused to send progress notes. Per CHHA SW, CHHA SOC 10/04/18, PT 1xw, 1-2w x 6w, OT 1-2w x 7w, RN QW.

CM will follow up with CHHA MJHS regarding supplementing hours temporarily as case is active with CHHA.

Per member, he currently has only 6d x 6 h, 9-3 pm, since his functional condition has declined, PCW put his dinner next to his bed, so that he can reach it at night. PCW puts milk and bread before leaving on Saturday, so that he can have something to eat on Sunday. Member uses urinal and chux, he urinates and has BM on his bed, takes out the chux and leaves it on the floor, PCW will assist him to take a shower on Monday when she arrives at 9 a.m., because he cannot clean himself appropriately after BM on his bed on Sunday. Nobody helps him, he lives alone, never been married, no children, his brother visits him once in a while only. He is A&Ox3, self-directing, can administer his medication with setup assist. His level of personal care has increased, has frequent falls, and cannot stand by himself, uses wheelchair at home, lives alone, and very limited informal support. PCW will assist him with all ADLs and IADLs….

Rationale notes for Denied, Stays the Same or Partial Approval determination:

As per UAS, member would benefit from 70 x 7 HRS."

See, *MLTC Exhibit 8,* Care Management Report dated November 2, 2018.

The record shows and the Appellant has established that the Appellant's medical condition [redacted] and [redacted] have worsened, resulting in the Appellant having increased falls and bowel movement accidents in his bed at

nighttime. The Appellant resides alone, was never married, has no children and his brother visits "sometimes" and therefore does not have family support to assist the Appellant with his activities of daily living.

The November 5, 2018, Initial Adverse Determination of the MLTC Plan and the November 8, 2018 Final Adverse Determination of the MLTC Plan to deny the Appellant's request for an increase in Personal Care Services to 24 Hour Live-In x 7 days per week and to partially approve the Appellant's request by authorizing forty-nine (49) hours of personal care services were correct when made, however, in light of the new evidence at the fair hearing, cannot be sustained.

DECISION AND ORDER

The Initial Adverse determination, dated November 5, 2018, of the Managed Long-Term Care plan, and the Final Adverse determination dated November 8, 2018, to deny Appellant's request for an increase in personal care hours to 24-hour Live-In x 7 days weekly (i.e., 24 hour Live In daily, x 7 days weekly) is not correct and is reversed.

1. The Managed Long-Term Care Plan, is directed to immediately provide the Appellant with an authorization of Personal Care Services in the amount of 24-hour Live-In x 7 days weekly (i.e., 24 Hour Live In hours daily, x 7 days weekly).

2. The Managed Long Term Care Plan is directed to notify the Appellant in writing of the plan's authorization increasing Personal Care Services to 24 hour Live In x 7 days weekly (i.e., 24 hour Live In hours daily, x 7 days weekly) in compliance with this decision.

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.

FH# 7863884N

DATED: Albany, New York
03/13/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee