STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 15, 2018
[redacted]
AGENCY: MAP
FH #: 7774847K

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 July 11, 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

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Long Term Care Plan's determination to deny the Appellant's application for an increase in Personal Care Services in the amount of 56 hours per week (8 hours per day, 7 days per week) to 112 hours per week (16 hours per day, 7 days per week) 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 98, has been in receipt of personal care services (PCS) through Centers Plan for Healthy Living Managed Long Term Care Plan (the Plan).

2. The Plan has authorized the Appellant to receive PCS at the rate of 8 hours per day, 7 days weekly.

3. The Appellant's diagnoses are osteoporosis and anemia and is legally blind.

4. On May 22, 2018, a registered nurse for the Plan conducted a Uniform Assessment System Community Assessment Uniform Assessment System (UAS) report at the Appellant's home. The Appellant was also assessed by a registered nurse, who conducted a Uniform Assessment System (UAS) report on February 22, 2018.

5. In the May 22, 2018 UAS assessment, the nurse found the Appellant to be frequently incontinent daily as to bladder, but with some control present. The nurse found the Appellant to have complete control regarding bowel movements.

6. The Appellant requires maximal assistance for bathing, dressing lower body, personal hygiene, walking, toilet use, dressing upper body and bed mobility. To the question whether there had been a change in the Appellant's activities of daily living status the Plan submitted a copy of the February 22, 2018 UAS assessment. There was no difference in the description of the Appellant's requirements regarding activities of daily living between the two assessments, but nurse indicated a decline in the ADL activities and deterioration in overall self-sufficiency in the May 22, 2018 UAS.

7. By notice dated May 31, 2018, the Agency advised Appellant of its determination to deny the Appellant's request for an increase the Appellant's PCS hour to 112 hours per week and authorized the Appellant's personal care services to remain at the rate of 56 hours per week.

3. On June 15, 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 MLTCPs (PIHPs), Prepaid Ambulatory Health MLTCPs (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 MLTCP, 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 MLTCP, 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.

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 MLTCP 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 MLTCP provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the MLTCP.

(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 MLTCP] 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 4403-f of the Public Health Law pertains to Managed Long Term Care MLTCPs.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation MLTCP Enrollees dated July 2, 2015, provides:

For all MLTC partial capitation MLTCP decisions made on or after July 1, 2015, that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately.
This change in policy has the following effects:

1) enrollees are no longer required to exhaust their MLTCP's internal appeals processes before obtaining a State fair hearing;

2) aid-continuing is no longer available if the enrollee asks only for an internal appeal of a MLTCP's proposed reduction or discontinuance of services and does not also timely request a State fair hearing;
3) to obtain aid-continuing, enrollees must request a State fair hearing within 10 days of the date of the Managed Long Term Care Action Taken notice;
4) enrollees do not need to specifically request aid-continuing to obtain it, but they may tell OTDA that they specifically decline it; and
5) the 60 day deadline to request a State fair hearing begins on the date of the Managed Long Term Care Action Taken notice.

Until further notice, this policy change applies only to enrollees in MLTC partial capitation MLTCPs. Enrollees in other MLTC products, such as MAP and PACE MLTCPs, must continue to exhaust their MLTCP's internal appeals processes before obtaining a State fair hearing.

Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a MLTCP of care; and supervised by a registered professional nurse.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), dated December 30, 2015, effective December 23, 2015, provided:

The purpose of this policy directive is to inform Managed Long Term Care MLTCPs (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.

4. Services shall not be authorized to the extent that the individual’s need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

5. The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of “some assistance” and “total assistance” are repealed.

6. The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

7. The social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

8. The regulations also revise the Department's regulations governing the content of notices for denials, reductions or discontinuances of PCS and CDPA. In subparagraph 505.14(b)(5)(v), the provisions governing social services districts' notices to recipients for whom districts have determined to deny, reduce or discontinue PCS are revised and reorganized. Paragraph 505.28(h)(5) is amended to provide additional detail regarding the content of social services district notices when the district denies, reduces or discontinues CDPA. All MLTCPs must ensure that their notices denying, reducing or discontinuing PCS or CDPA are consistent with these regulations and, in particular, include the specific reason for the action and, if applicable, the clinical rationale. All MLTCPs should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements.

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. 18 NYCRR 505.14(a)(2)

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. 18 NYCRR 505.14(a)(4)

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from

informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in sub
clauses (a)(1) through (a)(3) of this subparagraph. 18 NYCRR 505.14 (a)(3)(iii)(b)

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services, issued November 17, 2016, provides in relevant part that:

MLTCPs cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising MLTCPs of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

GIS message GIS 12 MA/ 026, dated October 3, 2012, provides that the Department has been directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicted and for Medicaid recipients whose only nighttime need is turning and positioning.

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.

The intent of the regulation 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. The Department is considering changes to the regulations to better achieve this goal.

In the meantime, the Department provides 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.

MLTC Policy 13.09(b): Frequently Asked Questions on Uniform Assessment System for New York, dated December 10, 2013, provides in relevant part:
1. Is it permissible for an MLTC MLTCP to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.
No. All MLTC MLTCPs (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC MLTCPs to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

2. The MLTCP conducted an initial assessment on August 20 for a person to be enrolled October 1. Is the six-month reassessment date based on the date of the assessment or based on the enrollment date?
The reassessment date is calculated based on the date of assessment not on the date of enrollment. Reassessments must be conducted every six-months or following a significant change in condition.
6. Currently, when a referral is received the UAS-NY Community Assessment is completed within 30 days of the referral. If the enrollment is deferred for various reasons past 42 days, is a reassessment required before enrollment? How long is a UAS-NY assessment "valid" for before enrollment?
Managed Long Term Care (MLTC) MLTCPs are required to conduct a UAS-NY Community Assessment prior to enrollment and every six months or sooner if there is a significant change in condition. In certain cases, an individual may not be enrolled in an MLTC MLTCP within 30 days from the date of the assessment. In these situations, the MLTC MLTCP must review the UAS-NY Community Assessment with the applicant and verify the information is unchanged. If there are no changes, the MLTC MLTCP will document this review by logging into the UAS-NY and signing the completed assessment as a "reviewer or consulting participant."
If changes in patient condition are noted that would affect care MLTCPning and the delivery of services, the MLTC MLTCP will conduct a new UAS-NY Community Assessment.
If the individual does not enroll in an MLTC MLTCP within six months of the assessment, a new UAS-NY Community Assessment must be completed.
7. In the UAS-NY Community Assessment, Intake/History, should the reason for a deferred assessment be entered as routine or return?
As stated in the MLTC Policy 13.09 dated April 26, 2013, the UAS-NY does not have the option to indicate that a reassessment was deferred. If a reassessment is completed in variance to MLTC policy rules (within the month the reassessment is due), the member's record should indicate the reason for the late reassessment. The nurse should record these comments in the "Sign/Finalize" section of the UAS-NY.
The reason used for the assessment must follow the definitions included in the UAS-NY Community Assessment Reference Manual.
Routine reassessment – A regularly scheduled follow-up assessment to ensure that the care/service MLTCP is appropriate and current.
Return assessment — An assessment conducted when the person returns from the hospital or otherwise re-enters the same organization after a discharge or disenrollment.

MLTC Policy 14.04: MLTCP Potential Enrollee Assessments, dated May 22, 2014, provides:
This policy guidance is intended to clarify the current required potential enrollee assessment process conducted by a Managed Long Term Care MLTCP (MLTCP) prior to a consumer's actual enrollment.

A Potential Enrollee means a Medicaid recipient who is eligible to enroll in a managed long term care MLTCP, but is not yet an Enrollee of a Managed Long Term Care MLTCP.
An initial assessment may be conducted at an institutional residence, such as a residential health care
facility (nursing home).

When a MLTCP receives a prospective enrollment referral from a nursing home on behalf of a Medicaid recipient, the MLTCP must assess the consumer in a timely manner, within 30 days of receiving the referral. The MLTCP should assess the consumer where the consumer is located at the time of the referral, i.e., the nursing home. The assessment conducted in the nursing home setting will include and consider: diagnoses; current MLTCP of Care; discharge MLTCP; proposed community residence; tentative discharge date; and need for community based long term care services.
In addition to the assessment conducted in the nursing home, the MLTCP must also assess the potential enrollee's proposed community residence which must be available for viewing prior to the date of discharge. A home visit by the MLTCP is required to determine the potential enrollee's health and safety in the actual residence, identify any risk factors, and develop an effective and efficient MLTCP of Care. The potential enrollee does not need to be at the proposed residence during the home visit.

As the MLTCP is responsible for the consumer's health and safety beginning on the enrollment date, the assessment process must be completed, the final definitive MLTCP of Care established, and MLTCP services must be in place for the consumer on day of discharge to the community setting.

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. Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

The case record establishes that the Appellant, age 98, has been in receipt of personal care services (PCS) through Centers Plan for Healthy Living Managed Long Term Care Plan (the Plan). The Plan has authorized the Appellant to receive PCS at the rate of 8 hours per day, 7 days weekly.

The case record further establishes that the Appellant's diagnoses are osteoporosis and anemia and is legally blind.

On May 22, 2018, a registered nurse for the Plan conducted a Uniform Assessment System Community Assessment Uniform Assessment System (UAS) report at the Appellant's home. The Appellant was also assessed by a registered nurse, who conducted a Uniform Assessment System (UAS) report on February 22, 2018. In the May 22, 2018 UAS assessment, the nurse found the Appellant to be frequently incontinent daily as to bladder, but with some control present. The nurse found the Appellant to have complete control regarding bowel movements.

The UAS report of May 22, 2018 advises that the Appellant requires maximal assistance for bathing, dressing lower body, personal hygiene, walking, toilet use, dressing upper body and bed mobility. To the question whether there had been a change in the Appellant's activities of daily living status the Plan submitted a copy of the February 22, 2018 UAS assessment. There was no difference in the description of the Appellant's requirements regarding activities of daily living between the two assessments, but nurse indicated a decline in the ADL activities and deterioration in overall self-sufficiency in the May 22, 2018 UAS.

On or about May 17, 2018, the Appellant or her representative requested that the amount of her PCS hours be increased from 56 hours per week (8 hours per day, 7 days per week to 112 hours per week (16 hours per day, 7 days per week). The Appellant's representative, at the hearing stated that the additional 8 hours per day should be from midnight to about 8 am. The Appellant's representative stated that the additional 8 hours were needed due to the Appellant's propensity to get up from her sleep to use the toilet during the night.

The Appellant's representative referred to the fact that the Appellant fell on May 12, 2018 between the hours of 3:00 am and 4:00 am while going to the toilet. The description of the incident is referred to starting at the bottom of the May 22, 2018 UAS page 7. The report stated, "Member reported that on 5/12/18 between 3-4 am she was making her way back towards her bed when she believes she lost consciousness, because she does not actually remember the act of falling. The member stated that when she awoke she on the ground lying on the right side of her body next to her bed. Member reported that she did not have PERS with her at the time to activate for help, but after several minutes she was able to successfully get herself off the ground and back into bed. Member reported minor bruising and scratches to her right elbow, which she believes was not due to the impact of the fall, but due to the impact of the fall but due to her attempts to get back to her feet after the fall. Member also reported minor bruising to the upper left arm toward her shoulder…"

By notice dated May 31, 2018, the Agency advised Appellant of its determination to deny the Appellant's request for an increase the Appellant's PCS hour to 112 hours per week and authorized the Appellant's personal care services to remain at the rate of 56 hours per week.

At the hearing, the Appellant's representative submitted a physician's letter, dated June 19, 2018, which stated: "She is very frail as she has developed severe anemia, gait instability and difficult ambulation along with age related osteoporosis which further imposes a hazard of fall and fracture. She does get up in the middle of the night to use the bathroom and urinate when she had a past incidence of falling and sustaining head injury last month along with multiple abrasions on both arms, but luckily did not fracture any bones."

At the hearing, the Appellant's representative's only reason for the increase in hours was generally for safety reasons, to prevent falls when the Appellant might need to urinate when a home health aide was not present. Both the Appellant's representative and the Appellant's physician emphasized the need for additional hours due to safety reasons; mainly to prevent the Appellant from falling. Requiring an aide to perform the tasks mentioned by the Appellant's

physician and the Appellant's representative is safety monitoring. The Plan is not required to provide safety monitoring as an independent Personal Care Services task.

The Appellant's representative also contended that the Appellant had unmet nighttime needs because the Appellant is incontinent. However, the record does not support the Appellant's representative's contentions. While the May 22, 2018 UAS does state that the Appellant is frequently incontinent of bladder, it also says that some control is present and that the Appellant wears pads as needed and uses bedside commode. The UAS states that the Appellant is in complete control regarding bowel movements.

With regard to the May 31, 2018 determination, by Centers Plan for Healthy Living to deny the Appellant's request for authorization to increase Personal Care Services for the Appellant from 56 hours per week to 112 hours per week, the record supports the Plan's determination.

DECISION

The Centers Plan for Health Living's determination to deny the Appellant's request for an increase in the amount of Personal Care Service hours from 56 hours per week to 112 hours per week is correct.

DATED: Albany, New York
08/17/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee