STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 10, 2018
[redacted]
AGENCY: Westchester
FH #: 7875644Y

In the Matter of the Appeal of

[redacted]

from a determination by the Westchester County 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 February 6, 2019, in Westchester County, 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)

John Horrell, DSS Fair Hearing Representative – 1/4/2019
R. Simpson, Director of Appeals (by telephone) – 2/6/2019 Fair Hearing
J. Rolffot, Manager, Grievances & Appeals (by telephone) – 2/6/2019 Fair Hearing

ISSUE

Was the Managed Long Term Care Plan's Final Adverse Determination dated December 3, 2018, to deny the Appellant's request for an increase in Personal Care Services from 49 hours weekly to 70 hours 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 72, has been in receipt of Medical Assistance benefits through a Managed Long Term Care Plan known as Centers Plan for Healthy Living (hereinafter

"Centers Plan" or "the Plan") and receives a PCS authorization in the amount of 49 hours weekly (7 hours daily, 7 days weekly).

2. On September 20, 2018, the Managed Long Term Care Plan completed a Personal Care Assessment Tool that indicated that the Appellant's Personal Care Services needs could be met with a Personal Care Services authorization in the amount of 49 hours weekly (rounded up).

3. On, or about, November 7, 2018, a request was made on the Appellant's behalf for an increase of the Appellant's PCS authorization from 49 hours weekly to 10 hours per day, 7 days per week, or 70 hours weekly.

4. On November 13, 2018, the Managed Long Term Care Plan completed a Uniform Assessment System New York (UASNY) Assessment (Comprehensive) Report.

5. By Initial Adverse Determination dated November 20, 2018, the Plan determined to deny the request for an increase of the Appellant's PCS authorization because the service was not medically necessary.

6. Following an internal appeal request, the Plan issued a Final Adverse Determination advising the Appellant of its determination to uphold its initial adverse determination to deny the request for an increase in PCS services.

7. On December 10, 2018, this fair hearing was requested.

APPLICABLE LAW

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, 2011, 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.

18 NYCRR 505.14(a) governs the scope of personal care services available under the Medicaid Program for both fee-for-service and Medicaid Managed Care.

Section 505.14(a)(1) of the regulations defines “Personal Care Services” to mean assistance with nutritional and environmental support functions and personal care functions. Such services must be essential to the maintenance of the patient’s health and safety in his or her own home….”.

(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.

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(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.

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(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.

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(b) The authorization for Level I services shall not exceed eight hours per week.

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning

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

(9) feeding;

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

(11) providing routine skin care;

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

(13) changing of simple dressings.

Section 505.14(a)(3)(iii) of the regulations provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

(1) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends, or other responsible adult;

(2) formal services provided or funded by an entity, agency or program other than the medical assistance program; or

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.

When a person's nighttime needs cannot be met by the use of adaptive or specialized equipment or supplies or voluntary assistance from informal caregivers or formal services, a determination must be made whether the person needs 24-hour split-shift care (included within the regulatory definition of "continuous personal care services") or live-in 24-hour personal care services. Under Section 505.14, this depends on whether the person needs "some" or "total" assistance with toileting, walking, transferring, or feeding, and whether these needs are "frequent" or "infrequent", and able to be "scheduled" or "predicted".

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.

Section 358-5.9 of the Regulations provides in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of medical assistance, 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.

DISCUSSION

The uncontroverted evidence establishes that the Appellant, who is 72 years old, has been in receipt of Medical Assistance benefits through a Managed Long Term Care Plan known as Centers Plan for Healthy Living ("Centers Plan" or "the Plan") and receives a personal care services ("PCS") authorization in the amount of 49 hours weekly (7 hours daily, 7 days weekly). The record further establishes that on November 7, 2018, a request was made on the Appellant's behalf to increase the Appellant's PCS authorization from 49 hours weekly to 70 hours weekly (10 hours daily, 7 days per week). In response, the Plan issued an Initial Adverse Determination on November 20, 2018, wherein the Plan determined to deny the request for an increase of the Appellant's PCS authorization because the service was not medically necessary. Thereafter, on December 5, 2018, following an internal appeal request, the Plan issued a Final Adverse Determination advising the Appellant of its determination to uphold its initial adverse determination to deny the request for an increase in PCS services.

The Appellant's daughter-in-law confirmed that the Appellant receives 49 total PCS hours weekly, allocated into 7 hours per day, but argued that the hours authorized are insufficient to meet all of the Appellant's personal care needs on a daily basis.

The hearing record establishes that the Appellant is currently suffers from various physical impairments, including bladder and bowel incontinence and osteoarthritis in both knees, which has resulted in difficulty walking and pain. The current Uniform Assessment System New York (UASNY) Community Assessment Comments Report of the Appellant's personal care needs conducted on November 13, 2018 further indicated that the Appellant has reported dizziness, unsteady balance, and occasional forgetfulness. Based on the most recent assessment, the Plan determined that the Appellant requires extensive assistance with bathing, dressing, walking, and toilet transferring, is totally dependent for meal preparation and ordinary housework, and needs setup help only for eating her meals.

The Regulations above require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. At the hearing, with respect to the Appellant's needs, the Appellant's daughter-in-law argued that the Appellant has arthritis in her hands and she is therefore unable to feed herself. The Appellant's daughter-in-law further claimed that additional

hours are needed because the Appellant is home alone at night as she goes to bed around 10:00 p.m., and an aide needs to be present in order to take care of any needs that may arise. She further contended that the aides do not come in to assist the Appellant until 12:00 p.m., therefore the Appellant's morning needs are not being met.

In support of her claims, the Appellant's daughter-in-law presented several medical treatment notes and physician letters. The November 6, 2018 letter, written by Dr. [redacted], confirms that the Appellant is suffering from "severe osteoarthritis which is getting worse day by day and her ambulation is getting difficult to manage by herself. She needs more help at least 3 (three) more hours/day to overcome the situation of her disability." In addition, the December 19, 2018 letter, written by [redacted], states that the "PATIENT HAS SEVERE PAIN AND ARTHRITIS IN BOTH HER RIGHT AND LEFT KNEE. SHE IS STILL RECOVERING." Lastly, a progress note dated December 19, 2018, and signed by [redacted], indicates that the Appellant requires a left total knee replacement, and states that the Appellant was instructed that she must strengthen her knees and undergo physical therapy.

The Appellant's representative's testimony and supporting documentation have been considered, but were found not persuasive. The evidence presented at the hearing does not provide a sufficiently documented medical need for the tasks to be performed with a frequency that would warrant an increased PCS authorization to 70 hours weekly. There was no evidence indicating that the Appellant has difficulty eating due to arthritis in her hands, nor was there evidence presented suggesting that there were needs which the Plan has failed to consider.

In the present case, the record established that all of the Appellant's task needs requirement can be safely provided within the 49 hours authorized per week. It is noted that the Appellant's hours are provided as Consumer Directed Personal Assistance Program (CDPAP) services, and she can direct how and when to utilize the authorized hours each day to maximize the authorization.

Based on the foregoing, the Appellant's representative has failed to establish that the Plan's determination was not proper. The Plan established that it evaluated the Appellant's entitlement to a Personal Care Services authorization in accordance with the Regulations. At this hearing, the Appellant's representative has not submitted, nor pointed to evidence sufficient to require the conclusion that the Plan determination was not proper.

For the above stated reasons, Centers Plan's determination is affirmed.

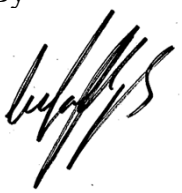
DECISION

The December 3, 2018 Final Adverse Determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Personal Care Services from 49 hours weekly to 70 hours weekly was correct.

DATED: Albany, New York
02/28/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee