STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 24, 2019
[redacted]
AGENCY: MAP
FH #: 7983801Z

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 19, 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, by: Debra Ferguson, Fair Hearing Representative

ISSUE

Was the Managed Long-Term Care Plan's determination authorizing Appellant to receive Personal Care Services of 63 hours weekly, provided 9 hours daily, 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, [redacted], and has been in receipt of a Medical Assistance authorization for Personal Care Services provided 63 hours weekly, 9 hours daily, 7 days weekly, through Centers Plan for Healthy Living, a Managed Long-Term Care, partially capitated plan, hereinafter, "MLTCP."

2. On May 2, 2019, the Appellant and/or her representative requested an increase in Personal Care Service hours from 63 hours weekly, 9 hours daily, 7 days weekly, to "live-in" 24 hour Personal Care Services.

3. On October 29, 2018, the MLTCP obtained a "UAS Assessment System – New York Comprehensive Community Assessment Report for Appellant, hereinafter, "UAS of October 29, 2018."

4. On October 29, 2018, the MLTCP obtained a "UAS Assessment System – New York Community Assessment Comparison Report for Appellant, hereinafter, "UAS of October 29, 2018."

5. On October 29, 2018, the MLTCP obtained a Person-Centered Service Plan Outcome and Summary.

6. On October 29, 2018, the MLTCP obtained a Client Task Sheet.

7. On April 22, 2019, the MLTCP obtained [redacted] of [redacted], hereinafter, "Progress Notes."

8. On April 26, 2019, the MLTCP obtained the "PT – Therapist Progress & Discharge Summary."

9. On May 1, 2019, the MLTCP obtained a "UAS Assessment System – New York Comprehensive Community Assessment Report for Appellant, hereinafter, "UAS of May 1, 2019."

10. On May 1, 2019, the MLTCP obtained a "Client Task Sheet: PCW/PCA Level II."

11. On May 2, 2019, the Appellant and/or her representative requested an increase in Personal Care Service hours from 63 hours weekly, 9 hours daily, 7 days weekly to "live-in" 24-hour Personal Care Services.

12. On May 9, 2019, the MLTCP issued an "Initial Adverse Determination Denial Notice," hereinafter, the "Determination," denying Appellant's request for an increase in Personal Care Service hours to "live-in" 24-hour Personal Care Services.

13.. On May 31, 2019, Appellant's representative appealed the Determination.

14. On June 3, 2019, the MLTCP issued a "Final Adverse Determination Denial Notice," hereinafter, the "Final Adverse Determination," upholding the Determination.

15. On June 24, 2019, Appellant and/or her representative requested this fair hearing on the adequacy of her Personal Care Services.

APPLICABLE LAW

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

Section 438.210 of 42 CFR Subpart D provides, in 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.

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 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

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 Plan Enrollees dated July 2, 2015, provides:

For all MLTC partial capitation plan 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 plan'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 plan'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 plans. Enrollees in other MLTC products, such as MAP and PACE plans, must continue to exhaust their plan'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 plan 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 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.

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.

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 Plan 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 Plans (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 Plans 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 Plan 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) Plans 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 Plan within 30 days from the date of the assessment. In these situations, the MLTC Plan must review the UAS-NY Community Assessment with the applicant and verify the information is unchanged.

If there are no changes, the MLTC Plan 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 planning and the delivery of services, the MLTC Plan will conduct a new UAS-NY Community Assessment.
If the individual does not enroll in an MLTC Plan 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 plan 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 Plan (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 plan, but is not yet an Enrollee of a Managed Long-Term Care Plan.
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 Plan of Care; discharge plan; 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 Plan 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 Plan of Care

established, and MLTCP services must be in place for the consumer on day of discharge to the community setting.

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, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations, they would be in receipt of inadequate service not meeting legal requirements. 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.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

Administrative Directive 92 ADM-49 provides in pertinent part:

B. Health and Safety of Recipient

Personal care services may only be authorized when the district reasonably expects that the recipient's health and safety can be maintained in the home. This determination must consider the following:

1. Stability of the Recipient's Medical Condition

The assessing nurse has primary responsibility for determining stability of the recipient's medical condition. The recipient and/or any informal caregiver should be given the opportunity to be involved in this determination. The determination should be based on information included in the nursing assessment and a review of the physician's order. In situations where there is a question about this determination, the assessing nurse may wish to involve the case manager or obtain consultation from the local professional director or his/her designee.

A stable medical condition is defined as follows:

a. the condition is not expected to exhibit sudden deterioration or

improvement; and

b. the condition does not require frequent medical or nursing judgment to determine changes in the recipient's plan of care; and

c. the condition is such that a physically disabled individual is in need of routine supportive assistance to maintain his or her level of functioning and does not need skilled professional care in the home; or

d. the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

If the recipient's medical condition is not stable, the provision of personal care services is inappropriate unless a determination is made that the provision of personal care services in combination with the intervention of appropriate skilled nursing services, home health aide and/or therapy can adequately meet the recipient's needs.

2. Ability of the Recipient to be Self-Directing

The case manager has primary responsibility for determining the recipient's self-directing capability. The determination should be based on a review of available information in the physician's order and the social and nursing assessments. The case manager must be sensitive to the recipient's habits, factors in the recipient's physical environment and relationships with informal caregivers that might impede the recipient's ability to consistently be self-directing. In situations where there is a question about the final determination, the case manager should consult with the assessing nurse, the local professional director or his/her designee or protective services for adults case managers. The case manager may also wish to obtain a psychiatric evaluation.

Self-directing means that the recipient has the capability to make choices about activities of daily living, understand the impact of these choices and assume responsibility for the results of these choices...

A non-self-directing recipient lacks the capability to make choices about the activities of daily living, understand the implications of these choices, and assume responsibility for the results of these choices. Characteristics of a non-self-directing recipient include:

a. the recipient may be delusional, disoriented at times, have periods of

agitation, or demonstrate other behavior which is inconsistent and unpredictable; or

b. the recipient may have a tendency to wander during the day or night and to endanger his or her physical safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home; or

c. the recipient may exhibit other behaviors which are harmful to himself or herself or to others such as hiding medications, taking medications without his or her physician's knowledge, refusing to seek assistance in a medical emergency, or leaving lit cigarettes unattended. The recipient may not understand what to do in an emergency situation or know how to summon emergency assistance.

Personal care services may only be provided to non-self-directing recipients if the responsibility for direction is assumed by another individual or an outside agency and any needed supervision or direction is provided on a part-time or interim basis by that individual or agency....

Responsibility for part-time or interim supervision may be assumed by:

- a self-directing individual who resides in the recipient's household; or
- a legally or non-legally responsible relative, friend, neighbor, or other informal caregiver who is self-directing; or
- a formal agency such as an area office for the aging; or
- a self-directing individual who lives in another household.

If the individual assuming part-time or interim supervision resides outside of the recipient's home, consideration should be made as to whether that individual has substantial daily contact with the recipient in the recipient's home.

Factors used to determine whether substantial daily contact in the recipient's home is being made include:

- the individual is physically present in the home at times throughout the day or night as necessary to assure the safety of the recipient; and
- any discretionary decisions or choices involved in carrying out the

functions and tasks identified in the recipient's plan of care are conveyed to the person providing personal care services.

Substantial daily contact does not mean the individual must be physically present in the home for a specified amount of time. The frequency of contact needed to assure a safe situation and provide discretionary direction should be based on each recipient's case situation as reflected in the social and nursing assessments and in the recipient's plan of care.

Supervision and direction of non-self-directing recipients is not an appropriate role for individuals providing personal care services. Such individuals can perform the functions or tasks specified in the recipient's plan of care as instructed by another person. They can also observe and monitor the recipient for possible changes in his/her functioning. However, when changes are noted, the individual is responsible for reporting his/her observations to the appropriate professional for review and decisions about the recipient's plan of care.

* Section 358-5.9* Fair hearing procedures.

(a) 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 was not correct or that the appellant is eligible for a greater amount of assistance or benefits or is exempt from work requirements pursuant to Part 385 of this Title. 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.

DISCUSSION

The record establishes that the Appellant, [redacted], resides alone, and has been in receipt of a Medical Assistance authorization for Personal Care Services provided 63 hours weekly, 9 hours daily, 7 days weekly, through the MLTCP.

The record establishes that on May 2, 2019, the Appellant and/or her representative requested an increase in Personal Care Service hours from 63 hours weekly, 9 hours daily, 7 days weekly to live-in 24-hour personal care services.

The record establishes that on October 29, 2018, the MLTCP obtained a "UAS Assessment System – New York Comprehensive Community Assessment Report for Appellant, hereinafter, "UAS of October 29, 2018."

The record establishes that on October 29, 2018, the MLTCP obtained a "UAS Assessment System – New York Community Assessment Comparison Report for Appellant, hereinafter, "UAS of October 29, 2018."

The record establishes that on October 29, 2018, the MLTCP obtained a Person-Centered Service Plan Outcome and Summary.

The record establishes that on October 29, 2018, the MLTCP obtained a Client Task Sheet.

The record establishes that on April 22, 2019, the MLTCP obtained [redacted] of [redacted], hereinafter, "Progress Notes."

The record establishes that on April 26, 2019, the MLTCP obtained the "PT – Therapist Progress & Discharge Summary."

The record establishes that on May 2, 2019, the Appellant and/or her representative requested an increase in Personal Care Service hours from 63 hours weekly, 9 hours daily, 7 days weekly to "live-in", 24-hour Personal Care Services.

The record establishes that on May 1, 2019, the MLTCP obtained the UAS of May 1, 2019.

The record establishes that on May 1, 2019, the MLTCP obtained a "Client Task Sheet: PCW/PCA Level II."

The record establishes that on May 9, 2019, the MLTCP issued the Determination, denying Appellant's request for an increase in services to "live-in," 24-hour Personal Care Services daily, stating in pertinent part:

> "…the health care service is not medically necessary…Based on this assessment (UAS of May 1, 2019), it was identified that:
> You are able to use a walker for walking indoor and wheelchair for outdoor activities with assistance.
> You can transfer on and off the toilet and take care of your toileting needs with assistance.
> You are able to use a bedside commode with some assistance.
> You are able to move from lying position and turn from side to side when in bed.
> You are able to feed yourself once your meals are prepared by your Personal Care Aide.
> You require safety monitoring and supervision as a standalone task.
> You can activate a Personal Emergency Response if necessary.
> No unscheduled daytime or nighttime needs have been identified.
> To best meet your needs, your Care Management Team has: co-ordinated with [redacted] on 05/06/2019 to expedite your Personal Emergency system (PERS) re-installation…"

The record establishes that on May 31, 2019, Appellant's representative appealed the Determination.

The record establishes that on June 3, 2019, the MLTCP issued the Final Adverse Determination upholding the Determination, stating in pertinent part:

> "…the service (increase) is not medically necessary. The request for an increase of Personal Care Aide (PCA) services was denied because [redacted] does not meet the criteria… [redacted] recently underwent a follow-up face-to-face clinical assessment on May 1, 2019 utilizing the New York State Department of Health's Uniform Assessment System (UAS) Tool that showed most of [redacted]'s abilities to perform physical functioning stayed the same since her prior assessment that was completed by Centers Plan for Healthy Living on October 29, 2018. [redacted]'s abilities to perform physical functioning (daily activities) stayed the same for dressing upper and lower body, personal hygiene (cleaning yourself), bed mobility (moving around the bed), walking, bathing, transfer toilet (getting on and off the toilet), eating, meal preparation, medication management and ordinary housework… In summary, most of [redacted]'s abilities to perform physical functioning (daily activities) stayed the same; therefore, her hours stay the same…"

It is noted that Appellant's ability to "transfer toilet" decreased to requiring "maximal assistance" contrary to the statement above. (See UAS of May 1, 2019, p. 5.)

The record establishes that on June 24, 2019, Appellant and/or her representative requested this fair hearing on the adequacy of her Personal Care Services.

The record establishes that Appellant's diagnoses, as stated in the UAS of May 1, 2019 are as follows:

Anxiety
Cancer
Depression
Parkinson's Disease
Age related cognitive decline
Age-related osteoporosis without current
Pathological fracture
Anxiety disorder, unspecified
Atopic Dermatitis, unspecified
Auditory hallucinations
Constipation unspecified
Delirium due to known physiological
Condition
Dizziness and giddiness
Edema unspecified
Essential (primary) hypertension

Gastro-esophageal reflux disease without
Esophagitis
History of Falling
Muscle weakness (generalized)
Other fatigue
Other recurrent depressive disorders
Pain, unspecified
Personal history of malignant neoplasm of breast
Presence of left artificial knee joint
Primary generalized (osteo) arthritis
Repeated falls
Shortness of breath
Sleep disorder, unspecified
Spontaneous ecchymoses
Tremor, unspecified
Unspecified abnormalities of gait and mobility
Unspecified age-related cataract
Unspecified macular degeneration
Unspecified urinary incontinence
Vitamin deficiency, unspecified

(See UAS of May 1, 2019, pgs. 19, 20 and 21.)

The assessing nurse added "Comments, Section F" to the UAS of May 1, 2019, as follows:

"Member requires assistance with ADL's and IADL's due to Parkinson's, OA, Sundowning syndrome. Tremor, fatigue and pain. Member requires significant weight bearing assistance with bathing, dressing, lower body, ambulation and transfers due to gait abnormality, pain and Parkinson's. Member daughter reports member requires significant weight bearing assistance with her upper body for grooming and dressing upper body due to tremor and pain. Member PCA provides setup help with reminders to ensure medication compliance. Member uses a seated walker and human assistance indoor and a wheelchair pushed by others outdoors. FA educated member and daughter on fall prevention."

(See UAS of May 1, 2019, p. 6)

It is noted that the UAS of May 1, 2019 reports that Appellant requires "maximal assistance" with bathing, personal hygiene, dressing, walking and toileting and has "total dependence" for locomotion. Appellant's overall self-sufficiency as compared to status 90 days ago, or since last assessment if less than 90 days is reported as "deteriorated."

(See UAS of May 1, 2019, p. 5.)

Appellant's physician had the following additional diagnoses for the Appellant:

Dementia
Hypertension
Degenerative Osteoarthritis
Unstable gait

(See letter of [redacted], M.D. dated June 21, 2019.)

Appellant's representative reported that the Appellant fell and was admitted to [redacted] on [redacted], having a laceration to her right leg. She stated that the Appellant was discharged to [redacted] for rehabilitation on March 31, 2019, and was released to go home on April 27, 2019.

[redacted] of [redacted] had the following additional diagnoses for Appellant:

Repeated falls
Urinary tract infection
Metabolic encephalopathy
Peripheral Vascular Disease
Urinary Tract Infection
Ataxic gait
Constipation
Incontinent of bowel

(See [redacted] Progress Notes "New", page 1.) It is noted that the Appellant fell out of bed at the skilled nursing facility attempting to go to the bathroom on her own and on other occasions.

There was a brief mention by Appellant's representative that Appellant's daughter assessed that although she requested "live-in" 24-hour Personal Care Services for the Appellant, services of 84 hours weekly, 12 hours daily would suffice, for now, while she is able to assist her mother during the night. She stated that the [redacted] Appellant's condition has deteriorated since the last assessment, that she is unable to stand on her own, due to muscle weakness, cannot change her pull-ups and that she is incontinent of bladder. She stated that Appellant has loss of vision in one eye and that she needs assistance with all ADLs. She stated that Appellant's daughter is unable to assist her until 8:30pm and that she has to leave for work in the morning. She stated that Appellant has no informal help from anyone but her daughter. She directed attention to the "UAS-NY Assessment Information," Section 3: Care Management Report which essentially states, inter alia, that Appellant's condition has deteriorated physically and cognitively and that her decision-making ability has declined from minimally impaired to moderately impaired. It is noted that Appellant's NFLOC increased from 25 in the UAS of October 29, 2018 to 27 in the UAS of May 1, 2019. It is also noted that the Appellant suffers from Parkinson's, dementia and Sundowning Syndrome.

As it is undisputed that the Appellant is incontinent of bladder, "totally dependent" for locomotion (See UAS of May 1, 2019, p. 5,) and requiring "maximal assistance" for most ADLs, including toileting, and as the credible evidence at the hearing is that she requires Personal Care

Services from 9am, when her daughter leaves for work, until 8:30pm, when she returns to her, the Appellant requires an increase in Personal Care Services to 80 ½ hours weekly, 11 ½ hours daily, 7 days weekly. The MLTCP's contention that Appellant's Personal Care needs are met with the provision of 63 hours of Personal Care Services weekly is not supported by the evidence at the hearing and is not sustained.

DECISION AND ORDER

The MLTCP's determination authorizing the Appellant to receive 63 hours of Personal Care Services, provided 9 hours daily, 7 days weekly is not correct and is reversed.

1. The MLTCP is directed to increase Appellant's Personal Care Services to 80 ½ hours weekly, 11 ½ hours daily, 7 days weekly.

Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant, and her representative, promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the MLTCP promptly to facilitate such compliance.

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

DATED: Albany, New York
08/15/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By
H Cooper Gregory

Commissioner's Designee