STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: April 15, 2019
[redacted]
AGENCY: MAP
FH #: 7944794H

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 May 8, 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

Deborah Ferguson, Fair Hearing Representative

ISSUES

Was the Appellant's request for a hearing as to Appellant's Managed Long Term Care Plan's denial of an increase of Personal Care Services timely?

If so, was the determination of Appellant's Managed Long Term Care Plan not to approve an increase from 49 hours a week, 7 hours a day, 7 days a week, to 77 hours a week, 11 hours a day, 7 days a week correct?

Was the Appellant's Managed Long Term Care Plan's determination to reduce coverage from 77 hours a week, 11 hours a day, 7 days a week, to 49 hours a week, 7 hours a day, 7 days a week, upon expiration of the aid continuing directive from a different fair hearing in April, 2019 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 83, is enrolled in a Medicaid Managed Long Term Care plan operated by Centers Plan for Healthy Living.

2. The MLTCP has authorized Appellant to receive Personal Care Services Authorization in the amount of 49 hours per week, 7 hours a day, 7 days weekly, under a task-based plan of care.

3. Appellant requested an increase in covered Personal Care Services to 77 hours per week, 11 hours a day, 7 days weekly.

4. On April 13, 2018, September 10, 2018, and subsequently on January 23, 2019, the MLTCP prepared Uniform Assessment System-NY evaluations, using the standard forms, regarding the Appellant's personal care needs.

5. By initial adverse determination notice dated September 28, 2018, the Appellant's request for increased hours was denied.

6. On or about September 28, 2018, an internal appeal was requested on Appellant's behalf.

7. By final adverse determination dated October 2, 2018, the MLTCP informed Appellant, "…we decided we are not changing our decision…."

8. On October 30, 2018, the Appellant requested a fair hearing to review the Agency's determination and a hearing, number 7853185R, was scheduled for November 27, 2018 at 9 AM. The determination was mistakenly listed in OAH records as a reduction and aid continuing was granted.

9. The Appellant did not attend the fair hearing that was scheduled for November 27, 2018, either in person or by representative, and at no time before the hearing did the Appellant request that such hearing be rescheduled.

10. Upon the Appellant's failure to appear at the scheduled fair hearing, either in person or by representative, the Office of Administrative Hearings of the New York State Office of Temporary and Disability Assistance issued a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing.

11. After Appellant's representative contacted the Office of Administrative Hearings, OAH did not find Appellant had good cause for failing to appear at the prior hearing. As a result, the present, new fair hearing number was assigned, and the date of Appellant's contacting the Office of Administrative Hearings, April 15, 2019 was listed as the date of Appellant's request for this hearing. The issues were corrected on the hearing date to reflect the Appellant's and her representative's actual concerns.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Public Assistance, Emergency Assistance to Needy Families with Children, Emergency Assistance for Aged, Blind and Disabled Persons, Veteran Assistance, Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of. In addition, any person aggrieved by the decision of a social services official to remove a child from an institution or family home may request a hearing within sixty days.

As per Matter of Bryant v. Perales, 161 A.D.2d 1186 (4th Dept.1990), the 60 day Statute of Limitations starts from the Appellant's receipt of the pertinent notice.

42 CFR 438.408(f) provides that Appellants who have received a final adverse determination from their Managed Care or MLTC plan shall have 120 days to request a fair hearing.

* Section 358-5.5.* Abandonment of a request for a fair hearing.

(a) OAH will consider a fair hearing request abandoned if neither the appellant nor appellant's authorized representative appears at the fair hearing unless either the appellant or appellant's authorized representative has:

(1) contacted OAH to request that the fair hearing be rescheduled; and

(2) provided OAH with a good cause reason for failing to appear at the fair hearing on the scheduled date.

(b) OAH will restore a fair hearing to the calendar if the appellant or appellant's authorized representative has met the requirements of subdivision (a) of this section.

(c) If the appellant defaults a fair hearing that is subject to aid-continuing, the right to aid-continuing ends upon default.

(1) If the fair hearing is restored to the calendar based upon a request to do so made within 60 days from the date of the default, aid-continuing will be restored retroactively.

(2) If the fair hearing is restored to the calendar based upon a request to do so made 60 days or more from the date of the default, aid-continuing will be restored prospectively only from the date of the request to restore the fair hearing to the calendar.

(d) In no event will a defaulted fair hearing be restored to the calendar if the request to do so is made one year or more from the date of the defaulted fair hearing.

Pursuant to the terms of a preliminary injunction in the federal class action entitled Fishman v. Daines (EDNY, 09CV5248, Bianco, J., March 6, 2016), if an applicant for or recipient of Medical Assistance requested a fair hearing to contest the adequacy, denial, reduction, restriction or termination of Medicaid benefits and fails to appear, either in person or by representative, at a fair hearing defaulted on or after April 11, 2016, the Office of Administrative Hearings had to issue a "default letter" to the applicant or recipient's address of record asking if the fair hearing request has been abandoned. This letter advised the applicant or recipient that if he or she is requesting a rescheduled hearing date, he or she must provide a good cause reason for defaulting the hearing. The default letter also advised the applicant or recipient that if the Office of Administrative Hearings did not receive a response to such letter postmarked within ten days of the mailing date, the hearing request would be deemed abandoned.

The order further provided that, if the Office of Administrative Hearings received a response from the applicant or recipient within ten days of the mailing date of the default letter and postmarked within ten days of the mailing date of such letter, requesting a rescheduled hearing date, the hearing would be rescheduled. At the rescheduled hearing, the good cause explanation for the failure to appear on the original hearing date would be addressed by the administrative law judge and, if necessary, the merits of the subject hearing request would thereafter be addressed by the administrative law judge. In 2013, policy was amended to permit a response by telephone, computer, or telefax, in addition to the possibility of making use of the United States mail.

By Proposed Judgment and by Stipulation, two documents executed on November 7, 2017, the Fishman litigation was settled. Pursuant to the just-mentioned documents, the Office of Administrative Hearings must continue to issue default reminder letters to Appellants who fail to appear at fair hearings. and must take other delineated action, but the Office will do so under its own amended policies (and soon-to-be-amended Regulations), rather than under a preliminary injunction.

Policies were not, however, promulgated to replace the preliminary injunction until March 5, 2018. On that date, Office of Administrative Hearings Transmittal 18-02 was promulgated, stating, in part, that, if the Appellant responds to the default reminder letter in a timely fashion, Office of Administrative Hearings ("OAH") staff will review the proffered reason and decide if it constituted good cause. If OAH staff find good cause, said staff will place the hearing back on the calendar, assigning a new hearing date.

If Appellant or an Appellant representative contact OAH after the required 10 day deadline, but prior to the expiration of the one year limit set forth at 18 NYCRR section 358-5.5,

OAH staff will also in such case review the proffered reason to determine whether it constitutes good cause. In this situation, the hearing will also be restored to the calendar if a good cause reason had been provided.

If during the initial 10 day period or thereafter (subject to a one year limit), Appellant or a representative ask for reopening without providing a reason determined by OAH to constitute good cause, the original hearing will remain in default status, and a new hearing will be scheduled, using the date of contact by Appellant or Appellant's representative as the request date for the new fair hearing.

It is noted that, although it is not mentioned in Transmittal 18-02, if a request for reopening is made more than one year following the date of default, the original fair hearing cannot be restored to the calendar. A new fair hearing can, however, be scheduled, making use of the date of contact with OAH as the date of request for the new hearing.

Section 358-3.6 Right to aid continuing.
In certain situations, you have the right to have your public assistance, medical assistance, SNAP benefits, and services continued unchanged until your fair hearing decision is issued. OAH will determine whether you are entitled to aid continuing and advise the appropriate social services agency and you of its decision.
(a) Public assistance, medical assistance and services.
For public assistance, medical assistance and services, the right to aid continuing exists as follows:
(i) Except as provided in paragraph (2) of this subdivision, where the social services agency is required to give you timely notice before it can take any action in your case, you have the right to aid continuing for your public assistance and medical assistance and services until the fair hearing decision is issued if you request a fair hearing before the effective date of a proposed action as contained in the notice of action. In the Medical Assistance Program, if you have been receiving assistance based on a spenddown of excess income, the right to aid continuing includes the right to have your spenddown liability continue unchanged.
(ii) If your assistance or services have been reduced or discontinued, restricted or suspended by the social services agency and you requested a hearing before the effective date contained in the notice, your assistance or services must be restored by the social services agency as soon as possible but no later than five business days after notification from OAH that you were entitled to have your public assistance, medical assistance or services continue uninterrupted pursuant to this paragraph.
(iii) In cases where the action is an automatic public assistance grant adjustment based on a change in State or Federal law, the effective date for determining the right to continued public assistance, medical assistance and SNAP benefits will be deemed to be 10 days after the date the changed grant becomes available to you.
(iv) If the effective date of the proposed action falls on a weekend or holiday, a hearing request postmarked or received by OAH on the day after the weekend or holiday will be considered timely for the purposes of aid continuing.
(2) There is no right to aid continuing of:

(i) public assistance where OAH has determined that the sole issue is one of State or Federal law or policy, or change in State or Federal law and not one of incorrect grant computation; or
(ii) medical assistance or services where OAH has determined that the sole issue is one of State or Federal law or policy; or
(iii) medical assistance when you have been determined presumptively eligible for medical assistance and have subsequently been denied eligibility for medical assistance; or
(iv) medical assistance if you are a recipient in a general hospital, not receiving chronic care services, and you are in short-term hospitalization and a utilization review committee determines that such level of care is no longer required….
(v) public assistance, medical assistance or services when the social services official determines to discontinue your benefits because you are receiving concurrent benefits as described in section 351.9 of this Title in the same social services district or in another social services district within the State.
(i) Where the social services agency is required only to give you adequate notice but not timely notice and has discontinued, reduced, restricted or suspended your public assistance, medical assistance or services, you have the right to have your public assistance, medical assistance or services reinstated and continued until a fair hearing decision is issued only if you request a fair hearing within 10 days of the mailing of the agency's notice of the action and if OAH determines that the action on your public assistance or medical assistance benefits or services did not result from the application of or change in State or Federal law or policy. If OAH determines that you are entitled to have your public assistance, medical assistance or services reinstated and continued in accordance with this paragraph, the social services agency must restore your public assistance, medical assistance or services as soon as possible but not later than five business days after being advised by OAH of such determination. With the exception of child care services, there is no right to reinstatement for supportive services provided to enable you to participate in work activities pursuant to Part 385 of this Title.
(ii) If the 10th day of the mailing of the agency's notice of the action falls on a weekend or holiday, a hearing request postmarked or received by OAH on the day after the weekend or holiday will be considered timely for the purposes of reinstatement pursuant to subparagraph (i) of this paragraph….
(
(b) Public assistance, medical assistance, and services will not be continued pending the issuance of a fair hearing decision when:
(1) you have voluntarily waived your right to the continuation of such assistance, benefits or services in writing; or
(2) you do not appear at the fair hearing and do not have a good reason for not appearing; or
(3) prior to the issuance of your fair hearing decision, a social services agency proposes to take or takes an action which affects your entitlement to public assistance, medical assistance, or services, and you do not make a request for a fair hearing regarding the subsequent notice….

(d) If your public assistance grant, child care services, or SNAP benefits are continued until a fair hearing decision is issued and you lose the fair hearing, the social services agency may recover the benefits or services which you should not have received. This subdivision does not apply to fair hearings to review the imposition of a work sanction under sections 351.2(i)(2), 385.12 and 385.13 of this Title.

(e) If you are involuntarily discharged from a tier II facility after requesting and participating in a hearing, held by the facility or the social services district in which the facility is located, and you request a fair hearing to review this determination, you do not have the right to remain at the facility pending the outcome of your fair hearing.

Section 385.3 of the Regulations provides:
(f) As an applicant or recipient you do not have the right to a fair hearing in all situations.

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

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

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or
(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

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

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

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

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

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

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

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

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

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

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

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

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

(1) Are based on valid and reliable clinical evidence or a consensus of

health care professionals in the particular field.

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-“Action” means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 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.

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, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home...".

Section 505.14(a) of the Regulations provides in part that:

> (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.
>
> (4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.
>
> (5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:
>
> (i) Level I shall be limited to the performance of nutritional and environmental support functions.
>
> (a) Nutritional and environmental support functions include assistance with the following:
>
> (1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

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

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

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

(9) feeding;

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

(11) providing routine skin care;

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

(13) changing of simple dressings.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

arranging for the delivery of personal care services according to subdivision (c) of this section….
monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

Subsection (b) of the just-cited section of Regulations provides, in part:

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….

Section 505.14(a)(4)(iii) of the regulations further provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

18 NYCRR section 505.14(b)(v)(d), meanwhile states:

> The social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

General Information Services Message 96 MA/019 advised, in part:

> The Mayer preliminary injunction order prohibits social services districts from applying task-based assessment plans to reduce the hours of any recipient whom the district has determined needs 24 hour care, including continuous 24 hour services (split-shift); 24 hour live-in services; or the equivalent provided by formal or informal caregivers.

GIS 03 MA/03 states ““. . . a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs.”

Under Section 505.14(a)(4) of the Regulations, personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

Section 505.14(b) of the Regulations provides that reauthorization for personal care services requires similar assessments as for the initial authorization; however a nursing assessment is not required for Level I services if the physician's order indicates that the patient's medical condition is unchanged. Reauthorization of Level II services must include an evaluation of the services provided during the previous authorization period and must include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

NYS DEPARTMENT OF HEALTH

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

I. Scope of the Personal Care Benefit

(a) vii. Personal care services includes some or total assistance with:

1. Level I functions as follows:
    a. Making and changing beds ;
    b. Dusting and vacuuming the rooms which the member uses;
    c. Light cleaning of the kitchen, bedroom and bathroom;
    d. Dishwashing;

e. Listing needed supplies;
f. Shopping for the member if no other arrangements are possible;
g. Member's laundering, including necessary ironing and mending;
h. Payment of bills and other essential errands; and
i. Preparing meals, including simple modified diets.

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

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;
- Visual function;
- Communication;

- Activities of daily living functional potential;

- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);

- Urinary incontinence and indwelling catheter;

- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);

- Activities;

- Falls;

- Nutritional status;

- Feeding tubes;

- Dehydration/fluid maintenance;

- Dental Care;

- Pressure ulcers;

- Psychotropic drug use; and

- Physical restraints.

*****

4480. PERSONAL CARE SERVICES

C. Scope of Services – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

1. Cognitive Impairments.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

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.

Section 358-5.9 of the Regulations provide in part:

> 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.

DISCUSSION

The Appellant, age 83, is enrolled in a Medicaid Managed Long Term Care plan operated by Centers Plan for Healthy Living. The MLTCP has authorized Appellant to receive Personal Care Services Authorization in the amount of 49 hours per week, 7 hours a day, 7 days weekly, under a task-based plan of care. Appellant requested an increase in covered Personal Care Services to 77 hours per week, 11 hours a day, 7 days weekly. By initial adverse determination notice dated September 28, 2018, the Appellant's request for increased hours was denied. On or about September 28, 2018, an internal appeal was requested on Appellant's behalf. By final adverse determination dated October 2, 2018, the MLTCP informed Appellant, "…we decided we are not changing our decision…." A hearing was initially requested on October 30, 2018 to challenge Centers Plan's determination.

In response to the October 30 request, Hearing# 7853185R, was scheduled for November 27, 2018 at 9 AM. The determination was mistakenly listed in OAH records as a reduction and aid continuing was granted as a result. However, there was no appearance by Appellant or any representative on her behalf that day. No adjournment request was made at the time. The initial issue for the Commissioner to decide was whether there was a valid excuse for missing that hearing date.

Appellant's daughter acknowledged prompt receipt of the hearing notice for November 27. The daughter stated she and Appellant did not appear because a call informing about receiving aid continuing confused the daughter. The daughter said she mistakenly believed the matter was resolved. The daughter was unable to give details about who made the call, from what organization they were with, and when. The daughter's explanation is found to be

insufficient. Nevertheless, in the September, 2018 and January, 2019 nurse reports from Centers, Appellant is listed as having a history of dementia and only being alert and oriented x 1. Appellant thus is completely reliant on others to handle her affairs. If others drop the ball on Appellant's behalf, Appellant is incapable of taking care of things properly herself. Accordingly, with her dementia, Appellant is found to have sufficient excuse to miss the prior hearing. Appellant may still proceed with the desired issues of concern.

The Appellant and her representative requested this hearing in part to challenge the expiration of her aid continuing directive. Unfortunately for Appellant, expiration of aid continuing is not a hearable issue under applicable policy. Moreover, with a denial of an increase involved, not a reduction, aid continuing should not have been provided in the first place, absent a finding that Appellant was "homebound," a finding that did not occur. Accordingly, there is no issue for the Commissioner to decide as to aid continuing.

As noted above, in the September, 2018 nurse evaluation, the last before Centers' determinations, Appellant was found to be alert and oriented x 1, to person, with a diagnosis of dementia. The September, 2018 evaluation found that the Appellant needed total assistance with meal preparation, housework, finances, and shopping, maximal assistance with medications, stairs, transportation, bathing, and dressing lower body, and extensive assistance with hygiene, dressing upper body, walking, locomotion, transfer toilet, toilet use, bed mobility, and eating. The January, 2019 evaluation, which came after the final adverse determination, stated there has been no change as to Appellant's ADL (activities of daily living) status and her self-sufficiency.

The September, 2018 nurse evaluation noted that Appellant suffered from health conditions which can significantly impair her ability to function---acute [redacted].

The September, 2018 nurse evaluation stated Appellant needs extensive assistance or more with toileting and dressing her lower body. hygiene, transfer toilet, walking, and locomotion. All of those are recognized round the clock needs. Regulations specify that individuals with round the clock needs should not have their hours calculated using a task-based assessment. {See 18 NYCRR 505.14(b)(v)(d) and GIS 96 MA/019.}

Appellant's daughter testified she makes herself available at night to assist Appellant, but can not during the day. According to the daughter, no one else, besides the home attendant, is currently available to help Appellant during the day.

In light of the evidence and testimony presented at the hearing, Appellant's requested increase to 77 hours a week is found to be reasonable. By pointing to evidence of record, Appellant and her family member(s) established a medical need for additional Personal Care Services hours. The determination by Centers Plan is not sustained.

DECISION AND ORDER

With regard to the determination by a relevant governmental agency to cease an order of fair hearing aid-to-continue given in connection with a prior fair hearing, there is no issue to be decided by the Commissioner of the New York State Department of Health.

The Appellant's Managed Long Term Care Provider's determination to deny Appellant's request for an increase in the hours of Personal Care Services received was not correct and is reversed.

1. , The MLTCP is directed to authorize Personal Care Services to the Appellant in the amount of 77 hours per week; 11 hours per day, 7 days a week.

2. The MLTCP is directed to notify Appellant, upon compliance with this fair hearing decision.

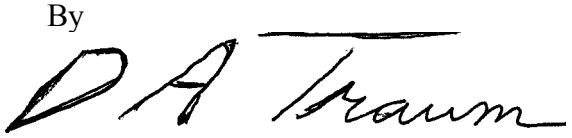
Should the MLTCP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's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

As required by Section 358-6.4 of the Regulations, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
06/10/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee