STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 6, 2018
[redacted]
AGENCY: MAP
FH #: 7716826Y

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

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 April 27, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Julia Rolffott, Fair Hearing Representative

ISSUE

Was the Managed Long-Term Care Plan's determination dated February 14, 2018, to deny the Appellant's request for an increase in Personal Care Assistance (PCA) hours from 84 hours weekly (12 hours daily, 7 days weekly) to an increase of 168 hours weekly (two 12-hour split shift personal care services by more than one personal care services aid, 7 days weekly) and to continue to authorize; remain the same, personal care services authorization in the amount of 84 hours weekly (12 hours daily, 7 days a week) correct?

Was the Managed Long-Term Care Plan's determination dated March 28, 2018, to deny the Appellant's request for an Expedited Appeal and will process the Appellant's request as a standard action appeal 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 82, has been in receipt of Medical Assistance benefits provided through Centers Plan for Healthy Living, a Medical Assistance managed long term care plan.

2. The Appellant has been in receipt of personal care services Level 2 in the amount of 12 hours daily, 7 days weekly (84 hours weekly).

3. On January 15, 2018 Centers Plan for Healthy Living completed a "Client Task Sheet: PCW/PCA level II" for the Appellant.

4. On January 15, 2018, Centers Plan For Healthy Living completed a "Uniform Assessment System" assessment for the Appellant.

5. By notice dated February 16, 2018, the Managed Long-Term Care Plan determined to deny the Appellant's request for an increase in Personal Care Assistance hours from 84 hours weekly (12 hours daily, 7 days weekly) to 168 hours weekly (two 12-hour split shift, 7 days weekly) and continue to provide to the Appellant with a Personal Care Services authorization remaining the same in the amount of 84 hours weekly (12 hours daily, 7 days a week).

6. The Medical Plan's February 16, 2018 notice also informed the Appellant that the request for two 12-hour split shift was denied because: "(84) hours weekly is enough time of PCA services to adequately meet your needs".

7. By notice dated March 28, 2018, the Managed Long-Term Care Plan determined to deny the Appellant's request for an Expedited Appeal and will process the Appellant's request as a standard action appeal.

8. On March 6, 2018, this hearing was requested.

APPLICABLE LAW

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

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

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

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

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

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

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

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

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

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

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

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

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

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

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

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

(b) Content of notice. The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) The reasons for the action...

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home."

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

(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

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

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

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

(8) feeding;

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

(10) providing routine skin care;

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

(12) changing of simple dressings.

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.

MLTC Policy 16.07 provides, in part, that:

All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance.

Pursuant to the New York State Department of Health Guidelines for Consumer Directed Personal Assistance Services, published June 30, 2013, the scope of services regarding Consumer Directed Personal Assistance Services includes the following:

a. Purpose: Consumer Directed Personal Assistance Services is intended to permit chronically ill or physically disabled individuals receiving home care services greater flexibility and freedom of choice in obtaining such services.

b. An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative. Personal care services, home health aide services, and skilled nursing tasks shall have the same meaning as 18 NYCRR § 505.28 (b)(9), (7), & (11) respectively.

c. The terms consumer directed personal assistant and designated representative shall have the same meaning as 18 NYCRR § 505.28(b)(3) & (5).

e. Level of Service:

. The assessment for home-based services identifies the tasks necessary to keep the enrollee safely in the home. The plan of care is developed by the enrollee with the assistance of the MCO, provider and any individuals the enrollee chooses to include.

ii. The plan of care is developed in conjunction with the enrollee based on the assessment and considers the number of hours authorized to accomplish the tasks. These tasks may include level 1 and level 2 PCS, home health aide services and/or skilled nursing tasks.

iii. The MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e).

iv. CDPAS services are managed by the enrollee in accordance with the enrollee's plan of care. The authorization should provide the number of hours authorized however, it is the enrollee who decides how those hours are arranged over the week. The MCO does maintain the right to determine whether the number of hours is appropriate to the plan of care. The FI is not responsible for assuring that the member is managing the plan of care.

18 NYCRR 505.28(b)(3) provides that "a consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer". However, a consumer directed personal assistant may include "any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary."

When the change in service needs results from a change in the consumer's medical condition, "including the consumer's loss of the ability to instruct, supervise or direct the consumer directed personal assistant", the district must obtain a new physician's order and nursing assessment. 18 NYCRR 505.28(f)(2)(ii).

Pursuant to GIS 03 MA/003, task based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

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

GIS 12/MA/026

"The Department has directed by the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, to clarify the proper interpretation and application of 18 NYCRR 505.14 with respect to the availability of 24-hour, split-shift personal care services for needs that are predicated and for Medicaid recipients whose only nighttime need is turning and positioning.

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a life-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 determined that such equipment or supplies can be provided safely and cost-effectively; and (2) voluntary assistance available form informal caregivers or formal services provided by an entity or agency.

When a person's night time 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 persons medical condition, he or she could not safely use the equipment or supplies; and
   Whether a live-in aid would likely be able to obtain an uninterrupted five hours of sleep where live-in services to be authorized." GIS 12 MA/026 dated 10/3/12

DISCUSSION

The record established that the Appellant, 82 years of age, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Long Term Care Plan Health First. On January 15, 2018, a nursing assessor completed a uniform assessment system evaluation of the Appellant's personal care needs. On January 15, 2018, a Client Task Sheet: PCW/PCA Level II was conducted by the Managed Long-Term Care Plan of the Appellant's personal care needs.

The record also establishes that the Appellant is diagnosed with: [redacted].

By notice dated February 14, 2018, the Managed Long-Term Care Plan determined to deny the Appellant's request for an increase in Personal Care Assistance hours from 84 hours weekly (12 hours daily, 7 days weekly) to 168 hours weekly (two 12-hour split shifts by different personal care attendants, 7 days weekly and to continue to provide, remain the same to the Appellant with a Personal Care Services authorization in the amount of 84 hours weekly (12 hours daily, 7 days a week). The Medical Plan's February 14, 2018 notice also informed the Appellant that the request for 2 X 12-hour split shift was denied because Center Plan for Healthy Living has determined that services twelve (12) hours daily/ seven (7) days a week (totaling eighty-four (84) hours weekly is enough time of PCA services to adequately meet your needs."

On January 15, 2018, a nursing assessor completed a uniform assessment system evaluation of the Appellant's personal care needs. On January 15, 2018, an assessor completed a Client Task Sheet: PCW/PCA Level II evaluation of the Appellant's personal care needs.

By notice dated March 28, 2018, the Managed Long-Term Care Plan determined by notice of MLTC Denial of Request for Expedited Appeal, to deny the Appellant's request to expedite and will process the Appellant's request as a standard action appeal. On March 6, 2018, this hearing was requested.

18 NYCRR 505.14(a)(2) provides a definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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.

The credible evidence establishes that on January 15, 2018, a nursing assessor completed a routine uniform assessment system evaluation of the Appellant's personal care needs marked *Managed Long-Term Care Medical Plan Health First Exhibit 6*. This assessment was carefully reviewed.

With regards to meal preparation, the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Total dependence- full performance by others during the entire period.

With regards to Ordinary housework, the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Total dependence- full performance by others during the entire period.

With regards to managing finances, the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Total dependence- full performance by others during the entire period.

With regards to managing medications, the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Maximal assistance – help throughout task, but performs less than 50% of task on own.

With regards to phone use, shopping, stairs and equipment management, the uniform assessment system evaluation of the Appellant's personal care needs indicates that – activity did not occur during entire period: Total dependence – full performance by others during entire period.

With regards to bathing, personal hygiene, dressing upper and lower body, the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Total dependence- full performance by others during the entire period.

With regards to walking, how walks between location on same floor indoors, the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Maximal assistance – weight bearing support (including lifting limbs) by 2+ helpers – OR – weight bearing support for more than 50% of subtasks.

With regards to locomotion – how moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair – the uniform assessment system evaluation of the Appellant's personal care needs indicates that the Appellant needs: Total dependence – full performance by others during all episodes.

With regard to toilet transfers, the uniform assessment system evaluation of the Appellant's personal care needs indicates a need for: Total dependence – full performance by others during all episodes.

With regard to toilet use, the uniform assessment system evaluation of the Appellant's personal care needs indicates a need for: Total dependence – full performance by others during all episodes.

With regard to bed mobility, the uniform assessment system evaluation of the Appellant's personal care needs indicates a need for: Maximal assistance (weight-bearing support, including lifting of limbs, by 2+ helpers – OR - weight-bearing support for more than 50% or more of subtasks).

With regard to eating, the uniform assessment system evaluation of the Appellant's personal care needs indicates a need for: Maximal assistance (weight-bearing support, including lifting of limbs, by 2+ helpers – OR - weight-bearing support for more than 50% or more of subtasks).

Activity Level, total hours of exercise or physical activity level in the Last 3 days = Less than 1 hour – No days out. ….. Overall self-sufficiency has changed significantly as compared to status 90 days ago, or since last assessment if less than 90 days = No change.

Managed Long Term Care Medical Plan Health First Exhibit 6 page 3- 5 of 22.

The Representative for the Medical Plan Health First also presented a copy of the Plan's notice dated February 14, 2018, wherein the Managed Long Term Care Plan determined to deny the Appellant's request for an increase in Personal Care Assistance hours from 84 hours weekly (12 hours daily times 7 days weekly) to and increase of 168 hours weekly (2 times 12 hour split shift by more than one personal care aid, times 7 days weekly) and to continue to provide the Appellant, remain the same authorization with a Personal Care Services authorization in the amount of 84 hours weekly (12 hours daily, 7 days a week) Level II marked *Managed Long Term Care Medical Plan Health First Exhibit 1* which indicated in pertinent part:

"Managed Long Term Care Action Taken, Denial, Reduction or Termination of Benefits (211), Notice Date: 02/14/2018, This Action will take effect on 2/15/2018, … Centers Plan for Healthy Living has made a decision about your health care services.

X. Will not be increased

Before this action, from 2/2/2018 to 7/31/2018, the plan approved:
12 Hours/Day Personal Care Aide Level 2, 7 day(s) weekly, 84 Hours weekly
You requested approval for:
12 Hours/Day Personal Care Aide Level 2, 7 day(s) weekly, 12 Hours/Day Personal Care Aide Level 2, 7 day(s) weekly, 168 Hours weekly
Starting 2/15/2018, the plan approval stays at:
12 Hours/Day Personal Care Aide Level 2, 7 day(s) weekly, 84 Hours weekly
This means from 2/15/2018 to 7/31/2018, your health care is approved for:

12 Hours/Day Personal Care Aide Level 2, 7 day(s) weekly, 84 Hours weekly = Total 2016 Hours

Centers Plan for Healthy Living is taking this Action because:

A comprehensive NYS Department of Health Uniform Assessment System (UAS-NY) was conducted on 01/15/2018. The UAS-NY produces a Nursing Facility Level of Care (NFLOC) Score. Your NFLOC score is 33. The UAS-NY assessments showed that you have demonstrated the following abilities in your abilities to perform your Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs):

Dressing upper and lower body, locomotion, toilet use, personal hygiene, Bathing, Meal preparation, ordinary housework showed Total Assistance, where you depend completely upon someone else to complete all parts of this task. You do not participate in this task at all;

Walking, Transfer toilet, Bed mobility, Eating and Medication Management showed Maximal Assistance where you require more assistance from someone else to complete most parts of this task. You provide limited participation in this task.

Cognition: Severely Impaired

Urinary Incontinence: Frequently incontinent

Bowel Incontinence: Continent

Falls: 2 or more falls within the last 30 days

Hospitalization: No Hospitalization in the last 90 days.

You have been receiving Personal Care Aide (PCA) services twelve (12) hours daily/seven (7) days a week (totaling eighty-four (84) hours weekly). You requested to increase your PCA services from twelve (12) hours daily/seven (7) days a week (totaling eighty-four (84) hours weekly) to twelve (12) hours during the day and twelve (12) hours during the night (split twelve (12) shifts), seven (7) days weekly. Your request has been reviewed and Center Plan for Healthy Living has determined that services twelve (12) hours daily/seven (7) days a week (totaling eighty-four (84) hours weekly) is enough time of PCA services to adequately meet your needs. Therefore, your services will remain the same of (12) hours daily/seven (7) days a week (totaling eight-four (84) hours weekly). Your services will be reassessed in July 2018 or sooner if any significant change is reported."

Managed Long Term Care Medical Plan Health First Exhibit 1 page 1 and 2.

The Representative for the Medical Plan Health First stated at the fair hearing that based upon the January 15, 2018 assessment, the medical plan also determined that the Appellant has a wife who can give weight bearing assistance in the household which led to the Medical plan providing the 84 hours (12 hours daily 7 days a week) to meet the Appellant's increased daily living tasks needs and night time needs.

The Appellant's wife testified at the fair hearing, that she is 70 years old; requires a walker for ambulating and is not able physically to meet the Appellant's daily living tasks needs which are all basic daily living task needs and that she is unable to meet the Appellant's night time needs to include his ambulating and his incontinence. The Appellant's wife stated that the Appellant is unable to perform any basic daily living task need and has urinary incontinence as well as unable to transfer himself out of bed without total assistance since the Appellant has dementia; Parkinson's disease and abnormalities of mobility and gait. She testified that the Appellant has unscheduled nighttime needs regarding his urinary incontinence. The Appellant's Representative added that the Appellant's medical condition has steadily and rapidly deteriorated. In support of the Appellant's positions, the Appellant Representative pointed out at the fair hearing, the Appellant's previously submitted to the Managed Long-Term Care Plan, Appellant's Doctor letter, dated January 8, 2018, which the Managed Long Term Care Plan did submit into evidence at the fair hearing. The Appellant's doctor's letter dated January 8, 2018 states:

"[redacted],

January 8, 2018,

Re[redacted]

To Whom It May Concern,

[redacted] is a patient under my care for advanced Parkinson's Disease associated with dementia and severe orthostatic hypotension. As a result of his poor balance, low blood pressure, and cognitive impairments he has fallen many times and will continue to be at high risk of falls with injury. He does try to get out of bed at night as well. He is in need of constant supervision for his safety and needs assistance any time he tries to ambulate or he will fall. I am recommending you approve him for home health attendant care for 24 hours a day in split shifts due to his risk of falls both during the day and at night.

Sincerely,

[redacted]"

See MLTC Exhibit 8, dated January 8, 2018 Dr. [redacted]

At the hearing, the Appellant's wife further testified that the Appellant is bedbound and he typically wakes up four or more times during the night where he requires total assistance with walking and/or toileting before he wakes up in the morning. The Appellant's wife testified that she cannot manage any of the Appellant's day or nighttime needs. The Appellant's wife further testified that the Appellant is not able to perform any daily living tasks without total assistance from others nor can the Appellant perform any aspect of taking care of his night time needs without total assistance from others to include transfer to toilet, toilet use or transfer back to bed.

The Appellant's Representative testified at the fair hearing, and added that the Appellant is incontinent of bladder; just recently the Appellant has become incontinent of bowel and the Appellant cannot ambulate at all during the day or night without total assistance from others. The Appellant's Representative testified that the Appellant's condition rapidly deteriorated. In support of these contentions, the Appellant Representative – Appellant's daughter submitted into evidence nighttime logs indicating multiple needs in the night for toileting, every night from February 10, 2018 to April 18, 2018.

See Appellant Exhibit B Logs.

The Appellant's Representative's hearing presentation regarding the Appellant's need for total assistance with all daily living tasks to include walking and/or toileting was found to be credible based on the Appellant's wife's testimony since it was detailed and consistent as well as supported by the Appellant's treating physician's documentation indicating; that the Appellant cannot perform any daily living tasks needs, is incontinent, and because the Appellant's wife's testimony was bolstered by the Managed Long Term Care Plan's uniform assessment system evaluation and the Medical Plan's evaluation dated February 15, 2018.

The evidence has been carefully considered. The credible evidence establishes that the Appellant needs total assistance during such calendar day with all daily living tasks and is totally dependent on others to perform the tasks, to include walking and/or toileting 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 and the credible evidence also shows that the Appellant does not have any other support that can be provided by family or by others to meet the Appellant's daily living task personal care needs in the day (or night time). The credible evidence establishes that the Appellant is entitled to a Personal Care Services authorization in the amount of continuous personal care services (split-shift care).

The Appellant further sought review of the Managed Long Term Care Plan, Centers Plan for Healthy Living MLTC Denial Request for Expedited Appeal notice dated March 28, 2018, denying the Appellant's request for an expedited action appeal and will process the Appellant's request as a standard action appeal. That issue is moot, however, based upon the above discussion.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination dated February 14, 2018, to provide the Appellant with a Personal Care Services authorization in the amount of 84 hours weekly (12 hours daily, 7 days a week) cannot be sustained and is reversed.

1. The Managed Long-Term Care Plan is directed to provide the Appellant with an increased Personal Care Services authorization in the amount of continuous personal care services (split-shift care).

Should the Managed Long-Term Care Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant 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 to the Managed Long-Term Care Plan promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, the Managed Long-Term Care Plan must comply immediately with the directives set forth above.

DATED: Albany, New York
05/09/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee