STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 10, 2019
[redacted]
AGENCY: MAP
FH #: 7993061R

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 August 6, 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 Specialist

ISSUE

Was the determination of Appellant's Managed Long Term Care Plan not to provide Personal Care Services in the amount of twenty-four hour continuous care by more than one aide 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 95, is enrolled in Medicaid and is in a Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living. Appellant resides with his wife, age 88 as of the hearing date.

2. The Appellant has been in receipt of a Personal Care Services Authorization in the amount of 59.5 hours a week, 8 1/2 hours a day, 7 days weekly. The Appellant's wife also is in receipt of a Personal Care Services Authorization.

3. Appellant's representative has requested Personal Care Services in the amount of 24 hour continuous care by more than one aide from the MLTCP.

4. On January 24, 2019 and on June 19, 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 June 25, 2019, the Appellant's request for 24 hour continuous care by more than one aide was denied as not medically necessary. The MLTCP did agree to increase hours of Personal Care Services somewhat—to 66.5 hours a week, 9 ½ hours a day, 7 days a week.

6. An internal appeal was immediately requested on behalf of Appellant.

7. By final adverse determination notice dated June 27, 2019, the Appellant's request for 24 hour continuous care by more than one aide was again denied as not medically necessary.

8. On July 10, 2019, this fair hearing was requested on behalf of Appellant.

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.

(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 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the

enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department’s satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor’s network for as long as the Contractor is unable to provide them within the network.

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...

Section 505.14(a)(4)(iii) of the regulations 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.

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. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies, as specified in subclauses (a)(1) through (a)(3) of this subparagraph.

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.

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.

Administrative Directive 92 ADM-49 provides in pertinent part:

A. Medical Necessity

The district may only consider authorizing personal care services when such services are medically necessary. Determination of medical necessity is the responsibility of the assessing nurse and is based upon his/her professional judgment in consultation with the physician and/or physician's order, the social assessment, and any other information deemed relevant in making that determination.

Recipients whose needs require supervision only cannot receive personal care services. Such recipients should be referred to alternative services including, where indicated, protective services for adults, other Title XX funded adult services or supportive living arrangements within the community such as Office of Mental Retardation and Developmental Disabilities (OMRDD) and Office of Mental Health (OMH) family care homes or Department of Social Services (DSS) family-type homes. Services which may be available from informal support groups or other formal agencies in the community, such as companion and respite services, should also be considered.

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….

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….

> 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. Part-time or interim means the recipient has periods of time during the day or night when it is necessary for his/her actions to be supervised or directed by someone else. Supervision or direction as used in this context means someone assumes decision-making for the recipient and exercises independent judgments about the recipient's functioning.
>
> **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.
>
> **… Denial or termination of personal care services may be required if the recipient's health and safety cannot be assured by involvement of other individuals, outside formal agencies or the protective services for adults (PSA) program….**

GIS 03/MA/03, states as follows:

…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, such as transferring, toileting, or walking, to assure the task is being safely completed.

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

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2)voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

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

The intent of the regulation is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping**.** The Department is considering changes to the regulations to better achieve this goal. In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.
2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour splitshift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.
3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.
4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

- The existence of a medical condition that directly causes the person to need frequent assistance with personal care services tasks during the night;

- The specific task or tasks with which the person requires frequent assistance during the night;

- The frequency at which the person requires assistance with these tasks during the night;

- Whether the person requires similar assistance with these tasks during the daylight hours and, if not, why not;

- The informal supports or formal services that are willing, able and available to provide assistance with the person's nighttime tasks;

- The person's ability to use adaptive or specialized equipment or supplies to meet his or her documented medical need for assistance with nighttime tasks; and whether the person's physician has documented that, due to the person's medical condition, he or she could not safely use the equipment or supplies; and

• Whether a live-in aide would likely be able to obtain an uninterrupted five hours of sleep were live-in services to be authorized.

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:

(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, 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 record discloses the Appellant, age 95, is enrolled in Medicaid and is in a Managed Long Term Care Plan ("MLTCP") operated by Centers Plan for Healthy Living. Appellant's representative has requested Personal Care Services in the amount of 24 hour continuous care by more than one aide from the MLTCP for Appellant. By initial adverse determination notice dated June 25, 2019, the Appellant's request for Personal Care Services consisting of 24 hour continuous care by more than one aide was denied as not medically necessary. The MLTCP did agree to increase hours of Personal Care Services somewhat—to 66.5 hours a week, 9 ½ hours a day, 7 days a week. An internal appeal was immediately requested on behalf of Appellant. By final adverse determination notice dated June 27, 2019, the Appellant's request for 24 hour continuous care by more than one aide was again denied as not medically necessary. This hearing was requested on behalf of Appellant for review.

According to the June, 2019 UAS-NY evaluation, Appellant was only found to be alert and oriented x 1—"oriented to person only. Members daughter reports he is increasingly more confused and that he tries to get out of bed but is unable to bear weight. Reports member is removing diaper in the middle of the night and urinating on bed and floor…." The June evaluation further reports Appellant's self-sufficiency has deteriorated and his ADL status (activities of daily living) has declined in the preceding 90 days.

It was also uncontested that Appellant's wife, age 88 as of the hearing date, receives Personal Care Services as well—84 hours a week, 12 hours a day, 7 days a week. Unlike many

couples with Medicaid where both share the same home attendants and the hours allotted, Appellant and wife have been deemed to have strong need to each have separate attendants simultaneously.

Appellant's children present testified that two of Appellant's four children currently take turns at night with their parents. However, assisting is intensive and exhausting and does not allow them to have their own lives, working, etc. Appellant's wife is bed-ridden and in worse condition than Appellant, who actually was her caretaker until January. As per the testimony, no one else is available to help.

Appellant has been diagnosed with anxiety, depression, coronary heart disease, heart failure, age related cognitive decline, drug allergies, angina pectoris, benign prostate hyperplasia, cardiac arrest, cataracts, hearing loss, difficulty in walking, dizziness and giddiness, edema, hypertension, GERD, fecal and urinary incontinence, history of falling, hyperlipidemia, insomnia, unspecified pain, malignant melanoma, shortness of breath, osteoarthritis, and vertigo.

The June, 2019 evaluation discloses that Appellant needs total assistance with meal preparation, housework, bathing, toilet use, finances, dressing lower body, locomotion, and shopping, maximal assistance with managing medications, stairs, transportation, personal hygiene, dressing upper body, walking, and transfer toilet, and extensive assistance with bed mobility and eating. Appellant's ADL (activities of daily living) status was found to have declined and his self-sufficiency was found to have deteriorated in the prior 90 days.

Appellant's children indicated safety supervision is a major concern. The daughter testified that a month ago at night, while she was in her parents' living room, Appellant suddenly got up from his bed, but then fell, necessitating an emergency room visit. The daughter stated Appellant "slides down and puts his legs out to get out of bed." Also, according to Appellant's daughter, "one time he got dressed to go out in the middle of the night." Appellant additionally wants to get up to help his wife, although no longer in a position to be much assistance. The daughter states that when she is there at night she has to sit in the bedroom the entire time with her parents.

Regulations are clear that safety supervision is not allowable as a task by itself. Regulations also state "Personal care services may only be authorized when the district [or the MLTCP acting on behalf of the government] reasonably expects that the recipient's health and safety can be maintained in the home." With Appellant wanting to get up and out, but risking injury each time he does so, and with his wife in terrible shape, it is unfortunately clear a higher level of care is needed in this household.

Appellant's daughter explained why she does not want a nursing home for her parents. The daughter testified her mother was previously in a nursing home and the experience was disastrous, with workers not catching that she suffered a stroke while there. While care givers at any level can and do drop the ball, the record still supports the conclusion that Personal Care Services are not sufficient and proper here.

The burden is on Appellant to show that the denial of services or coverage was not correct. The Appellant's representatives did not meet the burden of proof here. Centers Plan's final adverse determination is therefore upheld.

Under other circumstances, a home hearing could be appropriate under *Varshavsky v. Perales*. However, with Appellant's serious cognitive impairment (being only alert and oriented x 1), Appellant would gain no benefit from a home hearing.

DECISION

The Managed Long Term Care Plan's determination denying Personal Care Services in the amount of 24 hour continuous care by more than one aide for Appellant is correct.

DATED: Albany, New York
08/20/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee