**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** May 17, 2016
[redacted]
**AGENCY:** MAP
**FH #:** 7303628J

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

**AMENDED 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 June 10, 2016, 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

Nurzit Arzi, Grievances and Appeals

## ISSUE

Was the Managed Long-Term Care Plan's determination to deny the Appellant's representative's request to increase the Appellant's Personal Care Services Authorization from the amount of 24 hours daily, 7 days weekly, continuous care, sleep-in care to 24 hours per day, 7 days per week, continuous ("split-shift") care 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 partially capitated managed long term care plan operated by Centers Plan for Healthy Living (hereinafter, the "MLTC Plan"), and has been in receipt of an authorization for personal care services in the amount of 24 hours per day, 7 days

per week, sleep-in care. She resides in a separate apartment in a house owned by her daughter and son-in-law. Although he daughter and son-in-law reside above the Appellant's apartment, they are physically incapable of consistently assisting the Appellant with her activities of daily living.

2. On January 5, 2016, the Appellant was admitted to [redacted] after falling down and exhibiting altered mental status.

3. On January 8, 2016, the Appellant was transferred from [redacted] to a Skilled Nursing Facility for short-term rehabilitation purposes.

4. On March 15, 2016, the Appellant was discharged from the Skilled Nursing Facility to her home.

5. On March 15, 2016, the Appellant's internist evaluated the Appellant's health condition.

6. On March 15, 2016, a registered nurse employed by the MLTC Plan conducted an assessment of the Appellant's personal care services needs for the current certification period, during which the reviewing nurse determined that the Appellant exhibited total dependence upon others for the performance of her activities of daily living, except for walking and bed mobility (for which she required extensive assistance), and eating and toilet transfers (for which she required maximal assistance). Upon concluding the review of the Appellant's personal care services needs, the reviewing nurse recommended that the Appellant receive personal care services in the amount of 24 hours per day, 7 days per week, sleep-in care. Split-shift, or continuous care was not recommended because the Appellant's daughter "reported that the member is able to get up by herself to toilet, but not cleaning herself. **Requires max. assist[ance] w[ith] toileting."

7. On the morning of March 21, 2016, the Appellant's daughter discovered the Appellant on the floor with a small bruise.

8. On March 23, 2016, the Appellant was evaluated by her internist, during which a CT scan of her brain was completed in order to assess the severity of any injuries to the Appellant's head sustained as a result of her falling down on March 21, 2016.

9. On March 25, 2016, an employee of the MLTC Plan communicated with the Appellant's internist. During the conversation, the Appellant's physician requested an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, "sleep-in" care to 24 hours per day, 7 days per week, continuous ("split-shift") care due to the Appellant's deteriorating health. He advised the Plan that the Appellant "did have a change to health since he last saw her." He stated that the Appellant was "nearly nonresponsive, hardly speaking" and "barely walking" when he evaluated her on March 23, 2016.

10. On March 29, 2016, a registered nurse employed by the MLTC Plan conducted a new

assessment of the Appellant's personal care services needs for the current certification period, in which the reviewing nurse noted that the Appellant has "advanced Alzheimer's disease", which renders her unable to "participate during dressing, bathing, personal hygiene, and toilet use", and that she requires another person to completely perform activities of daily living, including transfers. A new diagnosis of "Urinary Tract Infection" was inserted in the Functional Supplement component of the assessment. The reviewing nurse commented in the assessment that the Appellant is unable to sleep during the night, and wakes up between 3 and 4 times each night. When she is awake, she tries to get out of bed. The assessment notes that the Appellant has difficulty falling asleep or staying asleep, and that the Appellant's ADL status has declined, and that her overall self-sufficiency has "deteriorated" since her previous assessment on March 15, 2016. In the Service Approval Form prepared by the reviewing nurse, the nurse determined that the Appellants meets the criteria for split-shift care, and not for 24 hour live-in care because the Appellant wakes up frequently, between 3-4 times, tries to get out of bed, and is totally dependent upon others for toileting/incontinent care, and bed mobility. However, upon review by the Plan's Medical Director, the Plan determined to continue to authorize the Appellant to receive Personal Care Services in the amount of 24 hours per day, 7 days per week, live-in care.

11. By notice dated April 11, 2016, the MLTC Plan advised the Appellant of its determination to deny the Appellant's representatives' request for an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, sleep-in care to 24 hours per day, 7 days per week, continuous ("split-shift") care because the requested increase is not "medically necessary". The notice advises further, that "[b]ased on the comprehensive [assessment] conducted on 3/29/2016[,] you have demonstrated decline in some areas of Activities of Daily Living and Instrumental Activities of Daily Living and no change in all other areas of Activities of Daily Living and Instrumental Activities of Daily Living. Comparison of the two comprehensive [assessment] conducted on 3/15/2016 and 3/29/2016 showed a decrease in participation in the following Activities of Daily Living and Instrumental Activities of Daily Living…Bed Mobility: declined from Extensive Assistance…to Total Dependence…to complete this task…Transfer Toileting: declined from Maximal Assistance…to Total Dependence…to complete this task. The current assessment on 3/29/2016 showed no change in all other areas of Activities of Daily Living and Instrumental Activities of Daily [Living] from your previous assessment…twenty-four (24) hour[s] per day, seven (7) days a week (live-in service)…is sufficient time of Personal Care Aide services to assist you…"

12. The Appellant's daughter requested an internal appeal on the Appellant's behalf to contest the Plan's initial adverse determination.

13. By notice dated April 18, 2016, the MLTC Plan advised the Appellant of its determination to uphold its initial adverse determination to deny the Appellant's representatives' request for an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, sleep-in care to 24 hours per day, 7 days per week, continuous ("split-shift") care for the following stated reason: "Ms. [redacted], you are an 82[-]year[-]old woman with advanced Alzheimer's disease living in a basement apartment. Your daughter lives upstairs, but is unable to serve as backup during off-hours when the PCA might not be present. According to the NYS Uniform Assessment done on March 29, 2016, you are totally dependent for all ADLs

except ambulation and locomotion, for which you require extensive assistance and cannot be left alone…[Y]ou have had a number of falls, are Alert and Oriented x 0, and unable to communicate your needs. According to the assessment, you exhibited sleep problems on one of the previous three days…"

14. On May 17, 2016, the Appellant's representative requested this fair hearing on the Appellant's behalf.

15. On June 29, 2016, a prior Decision After Fair Hearing was issued which reversed the Agency's April 11, 2016 determination to deny the Appellant's representatives' request for an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, sleep-in care to 24 hours per day, 7 days per week, continuous ("split-shift") care. Subsequently, the Appellant requested reconsideration of the Decision on the grounds that the fair hearing addressed the Agency's denial of an increase in personal care hours to "24 hours per day, 7 days per week, continuous ("split-shift") care," however, the Decision directed the Agency to increase the Appellant's Personal Care Services authorization to the amount of "24 hours per day, 7 days per week, continuous care," the same level of care the Agency currently provides. The Office of Administrative Hearings has reviewed the fair hearing record and the digital recording and concurs that the directive should state "24 hours per day, 7 days per week, continuous ("split-shift") care" and not "24 hours per day, 7 days per week, continuous care." Accordingly, the June 29, 2016 Decision has been vacated and this Amended Decision is being substituted therefor.

## 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.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--
(i) The enrollee and his or her representative;

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.

The partial capitation Managed Long-Term Care Model Contract provides, in part:

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.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.
Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

*State Fair Hearings*

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

Pursuant to the New York State Department of Health Office of Health Insurance Programs MLTC Policy 15.03, for all MLTC partial capitation plan decisions made on or after July 1, 2015 that deny, reduce or discontinue enrollees' services, enrollees may request a State fair hearing from the NYS Office of Temporary and Disability Assistance ("OTDA") immediately without first requesting an internal appeal of the determination.

The model contract for partially capitated MLTC plans advises that Social and environmental supports are services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Pursuant to Appendix G, Social and environmental supports may be provided through care management. Care management is a process that assists Enrollees to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered under the capitation payment of this Agreement.

Person Centered Service Plan (or plan of care) is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the Enrollee, as well as the person's functional level and support systems. Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports

necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person centered service plan or elsewhere in the care management record.

MLTC policy memo 13.09(a) reminds Plans of MLTC Policy 13.09: *Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York* which indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM).

As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013;** the SAAM assessment must **not** be used for these new enrollees. Additionally, the UAS-NY must be used for *all* reassessments beginning **October 1, 2013**.

All SAAM assessments conducted from June 16, 2013 through September 30, 2013 must be submitted to the Department of Health by October 31, 2013 via the regular SAAM submission process.

MLTC policy memo 13.09(b) advises in part:

**1. Is it permissible for an MLTC Plan to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.**

No. All MLTC Plans (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC Plans to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

Section 505.14(a)(1) of the Regulations, as amended effective December 23, 2015, 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.

Section 505.14(a)(3)(iii)(a) 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:

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

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

medical assistance program; or

(3) 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.

General Information Service message 97 MA 033 includes a reminder concerning "statements of understanding". The GIS Message advises that the contribution of family members or friends to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.) In New York City, the form statement of understanding is entitled "Agreement of Friend or Relative."

12 OHIP/ADM-1 states, in part:

With regard to informal caregivers, such support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.

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...

A GIS message 99/MA/036 dated December 16, 1999, advises that on October 6, 1999, the U.S. Court of Appeals for the second circuit in Rodriguez et al v. City of New York et al (197 F.3d 611) reversed the lower court's April 19, 1999, decision in Rodriguez et al v. DeBuono et al (44 F. Supp.2d 601) that safety monitoring should be an included task in task based assessments. Therefore, safety monitoring is not an included task in task based assessments.

General Information Service Message GIS 03/MA/03, released on January 24, 2003 by the New York State Department of Health, reads as follows:

The purpose of this GIS is 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.

Social services districts, including those using locally developed task based assessment (TBA) instruments, must complete a comprehensive assessment of the patient's health care needs in order to determine the patients appropriateness for services and the amount, frequency and duration of a service authorization. Department regulations (18 N.Y.C.R.R. 505.14) require both a social and nursing assessment in the Personal Care Services patient assessment process.

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. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patients day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

When the district, in accordance with 505.14 (a)(4), has determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patients scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physicians order and the nursing and social assessments to assure that the authorization and scheduling of hours in combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patients personal care needs.

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.

Completion of accurate and comprehensive assessments are essential to safe and adequate care plan development and appropriate service authorization. Adherence to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

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

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

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

In the meantime, the Department provides the following clarifications:

1. The fact that a person's needs are predictable does not preclude the receipt of 24-hour split-shift care, if the person has a documented medical need for the tasks to be performed with a frequency that would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep.

2. The need for turning and positioning and/or the need for diaper changes, by themselves, neither preclude nor justify the receipt of 24-hour split-shift care. In order to receive 24-hour split-shift care, the person must have a documented medical need for those tasks to be performed so frequently that a live-in aide cannot provide them and still obtain an uninterrupted five hours of sleep.

3. A person with a documented medical need for turning and positioning may, if otherwise appropriate, qualify for either 24-hour split-shift care or live-in care depending on the frequency at which turning and positioning is required at night, regardless of whether the person has a nighttime need for transferring.

4. When determining whether a person requires 24-hour split-shift care or live-in care, the local professional director must consider whether the physician's order and other required assessments document the following:

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

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

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

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

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

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

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

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.

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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.

Pursuant to MLTC Policies 13.09 and 16.01, the New York State Department of Health Office of Health Insurance Programs, Division of Long-Term Care sets forth specific requirements for conducting and completing the Uniform Assessment System (UAS) Assessments. MLTC Policy 16.01, dated March 15, 2016, lends further explanation to the responses set forth in Policy 13.09 regarding the timing for completing the assessment. MLTC Policy 16.01 states unequivocally that nurses conducting the UAS-NY Assessment are expected to finalize the assessment on the same day as the assessment was conducted, and include the signature, complete legal name, license number, and official title of the assessor. If the assessor requires additional information from a collateral source who is unavailable when the assessment occurs, the assessor is required to obtain the required information, and sign and finalize the assessment no later than 2 days from the date upon which the assessment was conducted. Assessments that are not signed and/or not finalized, are deemed to be invalid.

Section 358-5.9 of the Regulations provides in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of 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 hearing record establishes that the Appellant, age 83, has several medical diagnoses including advanced Alzheimer's-related dementia, cerebral atrophy (loss of brain cells), white matter disease (a disease that disrupts neural connections, thereby preventing signals to be carried to and from cells), full incontinence of bladder and bowel, coronary heart disease, urinary tract infection, constipation, hypertension, hyperlipidemia, and major depressive disorder. The Appellant cannot walk independently, even with the use of an assistive device. As an example, although the Appellant has been repeatedly shown how to ambulate with a walker, the Appellant's dementia has completely obstructed her ability to understand the purpose of the walker, and how to use it.

The Appellant is unable to get herself in and out of her bed, and is almost completely incapable of repositioning herself in bed (*see* March 29, 2016 assessment). As her dementia has progressed, the Appellant is increasingly restless at night, and wakes up between three and four times in the overnight hours because she needs to use the toilet and/or be changed, and also because she is very disoriented. In an attempt to address the Appellant's restlessness overnight (described by the Appellant's son-in-law as a problem for the Appellant's PCS Aides because they are unable to sleep while the Appellant is awake), the Appellant was prescribed a sleeping medication which has proven ineffective. After taking the medication for just a few weeks, the Appellant is significantly groggier during the day and even less lucid than she was before taking this medication. During the hearing, the Appellant's daughter and son-in-law repeatedly emphasized that the sleep medication prescribed by a neurologist with whom the family had consulted for a second opinion regarding the Appellant's dementia is ineffective at best, but appears to be counterproductive. The Appellant's daughter and son-in-law asserted that the Appellant now shows less enthusiasm and understanding of her surroundings than before she began to take this medication.

The Appellant has been in receipt of an authorization for personal care services in the amount of 24 hours per day, 7 days per week, live-in care. The Appellant resides in a basement apartment in home owned by the Appellant's daughter and son-in-law. Both the Appellant's daughter and son-in-law, who appeared at the hearing on the Appellant's behalf, are employed full-time. The Appellant's daughter and son-in-law direct the Appellant's care; however, they are physically incapable of substituting or supplementing the personal care services required by the Appellant on a daily basis. The Appellant's daughter contends that the Appellant requires round-the-clock Personal Care Services in the amount of 24 hours per day, continuous ("split-shift") care because the Appellant does not sleep at night, requires overnight toileting assistance, and repeatedly wakes up her assigned Personal Care Services Aides by babbling loudly, and trying to get out of her bed.

On January 5, 2016, the Appellant was admitted to [redacted] after falling down and exhibiting altered mental status. On January 8, 2016, the Appellant was transferred from [redacted] to a Skilled Nursing Facility for short-term rehabilitation purposes, where she remained until she was discharged on March 15, 2016. On the date of discharge from the Skilled Nursing Facility (March 15, 2016), the Appellant's internist

evaluated the Appellant's health condition. That same day, March 15, 2016, a registered nurse employed by the MLTC Plan conducted an assessment of the Appellant's personal care services needs for the current certification period, during which the reviewing nurse determined that the Appellant exhibited total dependence upon others for the performance of her activities of daily living, except for walking and bed mobility (for which she required extensive assistance), and eating and toilet transfers (for which she required maximal assistance). Upon concluding the review of the Appellant's personal care services needs, the reviewing nurse recommended that the Appellant receive personal care services in the amount of 24 hours per day, 7 days per week, sleep-in care. Split-shift or continuous care was not recommended because the Appellant's daughter "reported that the member is able to get up by herself to toilet, but not cleaning herself. **Requires max. assist[ance] w[ith] toileting."

On the morning of March 21, 2016, the Appellant's daughter discovered the Appellant on the floor with a small bruise. The Appellant was evaluated by her internist on March 23, 2016, during which a CT scan of her brain was completed in order to assess the severity of any injuries to the Appellant's head sustained as a result of her falling down on March 21, 2016.

On March 25, 2016, an employee of the MLTC Plan communicated with the Appellant's internist. During the conversation, the Appellant's physician requested an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, "sleep-in" care to 24 hours per day, 7 days per week, continuous ("split-shift") care due to the Appellant's deteriorating health. He advised the Plan that the Appellant "did have a change to health since he last saw her" on March 15, 2016. He stated that the Appellant was "nearly nonresponsive, hardly speaking" and "barely walking" when he evaluated her on March 23, 2016.

On March 29, 2016, a registered nurse employed by the MLTC Plan conducted a new assessment of the Appellant's personal care services needs for the current certification period, in which the reviewing nurse noted that the Appellant has "advanced Alzheimer's disease", which renders her unable to "participate during dressing, bathing, personal hygiene, and toilet use", and that she requires another person to completely perform activities of daily living, including transfers. A new diagnosis of "Urinary Tract Infection" was inserted in the Functional Supplement component of the assessment.

The reviewing nurse commented in the assessment that the Appellant is unable to sleep during the night, and wakes up between 3 and 4 times each night. When she is awake, she tries to get out of bed. The assessment notes that the Appellant has difficulty falling asleep or staying asleep, and that the Appellant's ADL status has declined, and that her overall self-sufficiency has "deteriorated" since her previous assessment on March 15, 2016. In the Service Approval Form prepared by the reviewing nurse at the conclusion of the March 29, 2016 assessment, the nurse determined that the Appellants meets the criteria for split-shift care, and not for 24 hour live-in care because the Appellant wakes up frequently, between 3-4 times, tries to get out of bed, and is totally dependent upon others for toileting/incontinent care, and bed mobility. However, upon review by the Plan's Medical Director, the Plan determined to continue to authorize the Appellant to receive Personal Care Services in the amount of 24 hours per day, 7 days per week,

live-in care.

By notice dated April 11, 2016, the MLTC Plan advised the Appellant of its determination to deny the Appellant's representatives' request for an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, sleep-in care to 24 hours per day, 7 days per week, continuous ("split-shift") care because the requested increase is not "medically necessary". The notice advises further, that "[b]ased on the comprehensive [assessment] conducted on 3/29/2016[,] you have demonstrated decline in some areas of Activities of Daily Living and Instrumental Activities of Daily Living and no change in all other areas of Activities of Daily Living and Instrumental Activities of Daily Living.

Comparison of the two comprehensive [assessment] conducted on 3/15/2016 and 3/29/2016 showed a decrease in participation in the following Activities of Daily Living and Instrumental Activities of Daily Living…Bed Mobility: declined from Extensive Assistance…to Total Dependence…to complete this task…Transfer Toileting: declined from Maximal Assistance…to Total Dependence…to complete this task. The current assessment on 3/29/2016 showed no change in all other areas of Activities of Daily Living and Instrumental Activities of Daily [Living] from your previous assessment…twenty-four (24) hour[s] per day, seven (7) days a week (live-in service)…is sufficient time of Personal Care Aide services to assist you…"

By notice dated April 18, 2016, the MLTC Plan advised the Appellant of its determination to uphold its initial adverse determination to deny the Appellant's representatives' request for an increase in the Appellant's Personal Care Services Authorization from 24 hours per day, 7 days per week, sleep-in care to 24 hours per day, 7 days per week, continuous ("split-shift") care for the following stated reason: "Ms. [redacted], you are an 82[-]year[-]old woman with advanced Alzheimer's disease living in a basement apartment. Your daughter lives upstairs, but is unable to serve as backup during off-hours when the PCA might not be present. According to the NYS Uniform Assessment done on March 29, 2016, you are totally dependent for all ADLs except ambulation and locomotion, for which you require extensive assistance and cannot be left alone…[Y]ou have had a number of falls, are Alert and Oriented x 0, and unable to communicate your needs. According to the assessment, you exhibited sleep problems on one of the previous three days…"

Federal regulations require that the State's contracts with managed long term care plans must provide, among other things, that the services offered must be furnished in an "amount, duration and scope" that is no less than the "amount, duration and scope" for the same services furnished to Medicaid fee-for-service recipients. Federal regulations also provide that the managed long term care plan may place appropriate limits on services on the basis of medical necessity, but that criteria for determining medical necessity may be no more restrictive than that applicable to fee-for-service recipients.

At the hearing, the Appellant's daughter and son-in-law explained that the Appellant requires Personal Care Services in the amount of 24 hours per day, 7 days per week, continuous care because the Appellant's overnight needs regularly and consistently prevent her Personal Care Services Aides from sleeping at night. The Appellant's daughter asserted that the

Appellant blabbers incessantly and incoherently overnight because she is disoriented. Additionally, even though she is unable to move around in her bed and is unable to get herself safely out of bed, she regularly attempts to leave her bed. The Appellant's babbling becomes louder and more urgent when she needs to use the toilet. The Appellant's daughter explained that she has witnessed her mother's overnight activities because she installed a camera in her mother's apartment. In support of her statements regarding her mother's overnight needs, the Appellant's daughter submitted into evidence a letter dated May 3, 2016 from the Appellant's internist, Dr. [redacted], which provides, in pertinent part:

> To Whom It May Concern:
>
> My patient, Mrs. [redacted], is an 82[-]year[-]old woman who has had Alzheimer's disease for approximately 12 years. Mrs. [redacted] is receiving 24-hour care from [Personal Care Services Aides]; however, this does not address her present needs. Mrs. [redacted] [talks loudly] all night and often tries to get out of bed. She keeps the [Personal Care Services Aide] up[,] resulting in most of them quitting after 2 nights as they cannot function without sleep. Mrs. [redacted] gets up regularly in [the] middle of the night. At times[,] she wanders and is unsafe. At other times[,] she tries walking to the bathroom. However, because she is unsteady on her feet, she has fallen several times when getting out of bed unassisted. This has resulted in her being hospitalized due to concussion. Consequently, Mrs. [redacted] requires assistance…upon awakening…

[Appellant Exhibit 1]

The explanation provided on the Appellant's behalf at the hearing is corroborated by the findings in the assessment conducted by the MLTC Plan on March 29, 2016, the April 11, 2016 initial adverse determination, and the April 18, 2016 final adverse determination. The Plan was aware of the Appellant's cognitive decline, and the overall deterioration in her self-sufficiency. In the span of two weeks between the March 15, 2016 assessment and the March 29, 2016 assessment, the Appellant exhibited further cognitive decline, and her dependence upon others for bed mobility and toilet transfers increased from extensive assistance to total dependence. The Appellant was already determined to be totally dependent upon others for toileting and incontinent care in the March 15, 2016 assessment. While the statements in the April 11, 2016 notice are correct, inasmuch as the Appellant's need for assistance with walking, locomotion, and toilet use had not changed (she was already determined to need total assistance with toilet use, and extensive assistance with walking and locomotion) after the March 15, 2016 assessment, these assertions fail to establish that the Plan rendered a correct determination regarding the Appellant's Personal Care Services needs.

The assessments also include mention the Appellant's inability to sleep at night, which is a common symptom of individuals who suffer from dementia, and Alzheimer's-related dementia, and is referred to as "sundowning" (*see* US National Institute of Health, National Library of Medicine: https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000029.htm).

Furthermore, as explained by the Alzheimer's Association, "[t]hose who cannot sleep may wander, be unable to lie still, or yell or call out, disrupting the sleep of their caregivers." (*see* http://www.alz.org/alzheimers_disease_10429.asp).

The Appellant's most recent assessment conducted by the MLTC Plan on March 29, 2016 notes that the Appellant is completely dependent upon others for transfers to and from the toilet, toileting and incontinent care, walking, and bed mobility. Aside from her overall state of confusion, the Appellant wakes up overnight because of toileting needs. In all, it is established that the Appellant wakes up overnight at least three or four times. The Appellant's representatives have also established that the prescribed sleep medication is an ineffective solution because it has resulted in, or significantly contributed to, the Appellant's heightened confusion and disoriented state.

Two or more overnight requests for toileting assistance overnight, along with repositioning needs, the Appellant's inability to fall asleep and stay asleep and her frequent yelling would clearly prevent a Personal Care Services Aide from obtaining at least 5 hours of uninterrupted sleep overnight. The Appellant's medical conditions and related symptoms require frequent assistance with personal care services tasks during nighttime hours, specifically, toileting (including transfers to and from the wheelchair, and to and from the toilet), assistance with cleaning after toileting, turning and repositioning, and transferring the Appellant to and from her bed during periods of wakefulness overnight.

At a hearing concerning the adequacy of Medical Assistance coverage or services, the Appellant or her representative must establish that the Agency (or private entity subject to fair hearing jurisdiction) did not provide sufficient benefits or services. The evidence submitted by the Plan, along with the corroborating testimony provided on the Appellant's behalf at the hearing establish that the Appellant's medical conditions necessitate frequent assistance with personal care services tasks during the night which requires assistance of an aide, and the frequency of such needs would not allow a live-in aide to perform them and still obtain an uninterrupted five hours of sleep. For all of these reasons, the Managed Long-Term Care Plan's determination cannot be sustained.

## DECISION AND ORDER

The Managed Long-Term Care Plan's determination to deny the Appellant's representative's request to increase the Appellant's authorization for Personal Care Services from 24 hours daily, 7 days weekly, continuous care to 24 hours per day, 7 days per week, continuous ("split-shift") care is not correct and is reversed.

1. The MLTC Plan is directed to increase Appellant's Personal Care Services authorization to 24 hours per day, 7 days per week, continuous ("split-shift") care.

2. The MLTC Plan is directed to advise Appellant's daughter upon the MLTC Plan complying with this fair hearing decision.

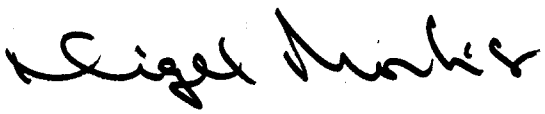
Should the MLTC Plan need additional information from the Appellant's daughter in order to comply with the above directives, it is directed to notify the Appellant's daughter promptly in writing as to what documentation is needed. If such information is requested, the Appellant's daughter must provide it to the MLTC Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
10/18/2016

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee