STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 6, 2019
[redacted]
AGENCY: MAP
FH #: 8058950Q

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

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 2, 2020, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Deborah Ferguson, Fair Hearing Representative

ISSUE

Was the Appellant's Managed Long Term Care Plan's determination to deny a request for an increase in Personal Care Services from 49 hours weekly to 70 hours weekly, correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 76, is enrolled in a managed long term care plan operated by Centers Plan for Healthy Living ("Centers Plan") and has been in receipt of Personal Care Services Authorization of 7 hours, 7 days for a total 49 hours weekly.

2. The Appellant requested an increase in Personal Care Services of 10 hours, 7 days

for a total of 70 hours weekly.

3. On January 8, 2019, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs and an Aide Task Service Plan.

4. On July 19, 2019, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs and an Aide Task Service Plan.

5. On July 25, 2019, Centers Plan advised the Appellant by an Initial Adverse Determination Letter of its intent to deny the Appellant's request for an increase of Personal Care Services Authorization from 49 hours weekly to 70 hours weekly on the ground that the "health care service is not medically necessary."

6. An Internal Plan Appeal was requested on Appellant's behalf, to review Centers Plan's determination to deny a request for an increase of Personal Care Services Authorization from 49 hours weekly to 70 hours weekly.

7. On August 12, 2019, Centers Plan advised the Appellant by Final Adverse Determination Letter, of its intent to uphold its determination to deny a request for an increase of Personal Care Services Authorization from 49 hours weekly to 70 hours weekly on the ground that the "health care service is not medically necessary."

8. On November 6, 2019, this fair hearing was requested to contest Centers Plan's determination.

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.

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.

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

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

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

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

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

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

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

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

(2) dressing;

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

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

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

(6) transferring from bed to chair or wheelchair;

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

(8) feeding;

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

(10) providing routine skin care;

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

(12) changing of simple dressings.

Administrative Directive 12 OMM/ ADM-1 advised in relevant part that new language has been incorporated defining continuous personal care services and continuous consumer directed personal assistance as constituting uninterrupted care provided by more than one person to a consumer who requires total assistance with toileting and/or walking and/or transferring and/or feeding and which involves more than 16 hours of care per day during times that cannot be predicted or scheduled. The amended regulations also provide definitions of live-in 24 hour personal care services and live-in 24 hour consumer directed personal assistance, where no such definitions previously existed in regulation.

Specifically, the new definitions of continuous personal care services or continuous consumer directed personal assistance mean the provision of uninterrupted care, by more than one person, for more than 16 hours per day, for a consumer who, because of his or her medical condition and disabilities, requires total assistance with toileting, transferring, walking or feeding at times that cannot be predicted or scheduled. As in the past, the consumer's need for assistance is not capable of being scheduled; that is, it occurs at times that cannot be predicted, which is the language used in the amended regulations.

"Total assistance" remains defined in the regulations as meaning that a specific function or task (for continuous care, the tasks of toileting, walking, transferring or feeding) is performed and completed for the patient.

In instances when continuous personal care services or continuous consumer directed personal assistance is being considered, the nursing assessment must determine and document that the consumer requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted or scheduled [§505.14 (b)(4)(i)(c)(2) and §505.28 (d)(3)(ii)(g)].

Definitions of live-in 24 hour personal care services and live-in 24 hour consumer directed personal assistance have been added to the regulations [§505.14 (a)(5) and §505.28 (b)(8)]. This level of service has existed, but is now defined in the Department's regulations. Potentially eligible individuals must have a medical condition and disabilities (functional deficits) requiring some or total assistance with one or more personal care or CDPAP functions during the day and night and have a need for such assistance during the night that is infrequent or that can be predicted or scheduled. "Some assistance" remains defined in the regulations as meaning that a specific function or task is performed and completed by the patient with help from another individual.

The regulations require that, for recipients who may be eligible for live-in 24 hour services, the social assessment must include an evaluation whether the recipient's home has adequate sleeping accommodations for a live-in aide [§505.14 (b)(3)(ii)(c) and §505.28 (d)(2)(v)]. Examples of adequate accommodations include an available spare bedroom, room partition or a

fold-out sofa. Availability of sleep-in space for the aide shall be determined on a case by case basis by the local district, taking into account the consumer's living situation. In determining the appropriateness of live-in 24 hour services, the local district should also assess whether the client can be safely left alone without care for a period of one or more hours per day.

The regulations promote the efficient use of resources designed to enhance the independence of individuals in support of their desire to remain in the community. To that end, the regulations require that personal care services and consumer directed personal assistance shall not be authorized if the patient's need for assistance can be met by:

adaptive or specialized equipment or supplies including, but not limited to, beside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely, and, by promoting the consumer's independence in the home or other location, services provided would also be cost-effective; or

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. [§§ 505.14(a)(4)(iii) and 505.28(e)(1)]

With regard to adaptive or specialized equipment (the "efficiencies"), the nursing assessment shall include a professional evaluation whether such adaptive or specialized equipment or supplies can meet the recipient's need for assistance and whether such equipment or supplies can be provided safely and cost-effectively when compared to the provision of aide services. Such adaptive or specialized equipment or supplies include, but are not limited to, bedside commodes, adult diapers, urinals, walkers and wheelchairs

[§§ 505.14(b)(3)(iii)(b)(5) and (b)(3)(iv)(a)(7)and §505.28(d)(3)(ii)(f)].
With regard to informal caregivers, such support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

GIS message GIS 12 MA/ 026 advises that 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.

Administrative Directive 92 ADM-49 clarifies State policy with regard to the requirement that an applicant for/ recipient of Personal Care Services have a stable health condition, and be able to self-direct, and be able to direct a Personal Care Services worker. The ADM reiterates that responsibility for making certain choices can be delegated to a self-directive individual, or to an organization.

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 they would be in receipt of inadequate service not meeting legal requirements,

without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. 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. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released 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. In relevant portion, this GIS Message states:

> 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**.**

18 NYCRR 358-5.9(a) provides:

MLTC Policy 16.07 provides, in part, that:

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

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption 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 76, is enrolled in a managed long term care plan operated by Centers Plan for Healthy Living ("Centers Plan") and has been in receipt of Personal Care Services Authorization of 7 hours, 7 days for a total of 49 hours weekly. The hearing record further establishes that a request was made on behalf of the Appellant, for an increase in Personal Care Services to 10 hours per day, 7 days per week for a total of 70 hours weekly. The credible evidence establishes that by notice dated July 25, 2019, Centers Plan advised the Appellant by an Initial Adverse Determination Letter of its intent to deny the Appellant's request for an increase of Personal Care Services Authorization from 49 hours weekly to 70 hours weekly on the ground that the "health care service is not medically necessary." On November 6, 2019, this fair hearing was requested to contest Centers Plan's

determination.

At the hearing, Centers Plan submitted into evidence the July 25, 2019 Initial Adverse determination that denied the request for increase from 49 to 70 hours. The determination stated in detail that,

"You requested an increase in your Personal Care Aide Services because (sic) generally weaker and need more assistance with daily activities and to prevent falls. A Registered Nurse from Centers Plan for Healthy Living (CPHL) visited you in your home on 7/19/2019 and completed a face-to-face assessment using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills, and general care needs.

Based on this assessment, it was identified that:

- You utilizes (sic) manual wheelchair for indoor and outdoor activities with assistance.
- You can transfer on and off the toilet and take care of your toileting needs with assistance.
- You are able to move from lying position and turn side to side when in bed.
- You are able to use urinal without any assistance.
- You are able to feed yourself once your meals are prepared by your Personal Care Aide.
- You are able to direct your own care.
- You can activate a Personal Emergency Response if necessary.
- You require safety monitoring and supervision as a standalone task

Your requested increase in Personal Care Aide Services, along with your recent UAS-NY assessment and notes from your PCP, Dr. Yan-Jin Yang, Neurologist, Dr. Manning and New York-Presbyterian Brooklyn Methodist Hospital ER discharge summary from 7/8/2019 were thoroughly reviewed by Centers Plan for Healthy Living. Based on clinical documentation presented, your current Personal Care Aide Services of (7) hours per day, seven (7) days per week (totaling forty-nine (49) hours per week) are appropriately and safely meeting your personal care needs. Therefore, your Personal Care Aide Services will remain the same."

At the hearing, Centers Plan also submitted into evidence the August 12, 2019 Final Adverse determination that upheld the denial of the request for an increase of Personal Care Services Authorization from 49 hours per week to 70 hours weekly on the grounds of "not medically necessary."

At the hearing, the Appellant's representatives testified that Appellant, who is homebound and suffering from debilitating and ongoing medical conditions, had deteriorated physically and mentally, and was now totally dependent on others for assistance with all his activities of daily living. To corroborate their testimony of Appellant's medical history, Appellant's representatives submitted into evidence, as Appellant's Exhibit #4, a medical letter of necessity

dated November 8, 2019 that stated –

"This letter is being written on behalf of (Appellant) to advocate for an increase in home heath (sic) hours. He has been followed at the Hospital for Special Surgery since 2014. He is a 76-year-old gentleman with an extensive medical history that includes inclusion body myositis. This condition results in progressive upper and lower extremity weakness, both proximally (muscles close to the spine such as hips/thighs) and distally (muscles further from the spine including wrist/fingers). Over the last year or so, there has been significant decrease in his strength with weakness now in all four extremities. In addition to the above mentioned, he is status post cervical and lumbar decompressions for spinal stenosis, status post right hip replacement, and with history of CVA. His medical history includes coronary artery disease with history of cardiac stents. All these factors into his loss of mobility and inability to complete activities of daily living.

Previously he was able to ambulate with walker. Over the last year, he has lost the ability to do so. He is now dependent in terms of mobility including walking and transfers. He lives alone and has a home health aide 7 hour out to (sic) the day. Once the aide leaves, he is confined to his bed until the next day. He now uses a urinal to urinate. For bowel movements, he does his best to wait for the aide to return the next day, and if unable to hold that long, is forced to defecate in his pants as he is not able to get up. He is no longer independent with dressing or bathing. Due to loss of fine motor skills, he can no longer open pill bottles, doors, or use key independently. He needs built up hand grips for feeding and writing. We are currently maximizing his function with adaptive equipment such as splinting, built up hand grips. However even with these devices, he is quite limited.

Unfortunately, (Appellant) has also developed some early dysphagia and has a pending speech evaluation. He currently requires thickeners to assure he can swallow properly. This along (sic) takes dexterity to open and add the thickener. Not to mention he is unable to pour juice/water from a container, or open a package to eat something.

He has had several falls in his home due to inability to stand and walk independently. And once down, he does not have the strength to get up and will be down until is home health aides. Given his extensive spine surgeries, osteoporosis, right hip replacement, a fall could be disastrous in terms of potential injury..."

During the hearing, Appellant's representative testified further that Centers Plan, in denying the request to increase the Appellant's personal care authorization from 49 hours weekly to 70 hours weekly, failed to consider an allotment of time for Appellant's unscheduled needs, pursuant to MLTC Policy 16.07, GIS 03 MA/033 and Department of Health guidance. Appellant's representative submitted into evidence as Appellant's Exhibit #1, the January 22, 2019 "Dear Health Plan Administrator" letter issued by the New York Department of Health that advised-

"This communication is intended to highlight and reinforce Managed Long Term Care Plans' ("MLTCPs" or "Plans") adherence to their obligations relating to enrollee assessments,

informal supports, and the development of the Person-Centered Service Plan ("PCSP" or "plan of care") and when the PSCP must be provided to the enrollee.

PCSPs should be based on the initial assessment and reassessments of the enrollee. The Plan must address all the enrollees assessed scheduled and unscheduled needs and/or personal goals…The Plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour service. If the enrollee has any unscheduled needs which will not be met by PCS or CDPAS, the Plan must identify how such needs will be met by documenting specialized equipment or supplies. Ultimately, the schedule of home care aide hours and the mix of other services and supplies documented in the PCSP must adequately meet the enrollee's scheduled and unscheduled needs."

The hearing record has been reviewed. At a hearing concerning the adequacy of Medical Assistance coverage or services, the Appellant or his representative must establish that the Appellant's medical conditions necessitate frequent assistance with personal care services that must be met with an increase in hours. Documentation and testimony must establish that the Appellant is entirely dependent on caregivers for completion of her activities of daily living (ADLs). In addition, at the hearing the Appellant must establish he is eligible for a greater amount of assistance or benefits. In this present hearing, the Appellant's representatives' testimony of Appellant's medical history and deteriorating health were found to be credible and supported by corroborating medical documentation. Centers Plan denial of the request for an increase of Personal Care Services Authorization from 49 hours per week to 70 hours weekly was on the basis of the health care service not being medically necessary. Appellant's representatives successfully rebutted the denial on the basis of not medically necessary, by providing compelling and persuasive testimony and documentation of Appellant's complex and ongoing medical history that necessitate an increase in his personal care services hours from 49 hours weekly to 70 hours weekly.

The hearing record also established that Centers Plan's evidence packet also included an updated NYS assessment dated July 22, 2019 documented that

" Member is diagnosed with Muscle weakness (generalized), Spinal stenosis, cervical region and OA; his health conditions cause stiffness and debility. Member was observed unable to walk and stand up, only can support himself with PCA maximal assistance…."

Furthermore, it is noted that the credible evidence submitted by Appellant's representatives at the hearing reflects the Appellant has frequent and unscheduled, such that the Appellant is in need of personal care hours of 10 hours, 7 days a week for a total of 70 hours a week. Regulations permit the allocation of hours for unscheduled needs. The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care provides, in part, that the –

"assessment process should evaluate and document when and to what degree the member 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. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs."

It is noted that ambulating, transferring, transitioning and toileting, even if not required every hour, are generally considered unscheduled needs, also known as "span of time" consideration. Pursuant to General Information Systems Message GIS 03 MA/03, " Social service 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 patient's appropriateness for services and the amount, frequency and duration of a service authorization…The assessment 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.

GIS 03 MA/03 instructs that the assessment process should also evaluate the availability of informal supports who may be willing to and available to provide assistance with needed tasks…" In that regard, the Appellant who lives alone and is homebound, does not appear to have available informal support willing or able to provide personal care assistance to the Appellant after his aide leaves for the day.

Furthermore, pursuant to MLTC Policy 16.07, Guidance on Task-based Assessment Tools, for Personal Care Services and Consumer Directed Personal Assistance Services, "All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent, the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day and night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance." Thus, span of time analysis is not only permissible, but mandatory.

Lastly, it is noted that because of Appellant's medical history and deteriorating health conditions, the Appellant has need for supervision. Regulations provided that safety supervision hours can accompany authorized tasks. GIS 03 MA/03, which was released to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello, elaborated on this. In relevant portion, this GIS Message states, in part, that "

> 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."

The credible evidence establishes that the Appellant has a need for assistance with ambulation, toileting and transferring that is unscheduled and unpredictable. In addition, because of his medical history Appellant is at a risk for falls. As the Appellant is therefore eligible for a "span of time" Personal Care Services authorization for such unscheduled and unpredictable, Centers Plan's determination to deny Appellant's request for increase in Personal Care Services authorization from 7 hours a day, 7 days per week to 10 hours, 7 days per week cannot be sustained.

DECISION AND ORDER

Centers Plan's determination to deny Appellant's request for an increase in Personal Care from 49 hours weekly to 70 hours weekly is not correct and is reversed.

1. Centers Plan is directed to increase Appellant's Personal Care Services to the amount of 70 hours a week.

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

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

DATED: Albany, New York
02/11/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee