

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 12, 2018

AGENCY: MAP

FH #: 7842128P

In the Matter of the Appeal of	:
	: 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 December 5, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



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

D. Feurgeson, Centers Plan for Healthy Living, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to authorize the Appellant for personal care services of 84 hours per week 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 89, has been enrolled in and has received care and services, including Personal Care Services, through a Managed Long-Term Care Plan operated by Centers Plan for Healthy Living.

2. The Appellant was in receipt of Personal Care Services in the amount of 56 hours

weekly (8 hours daily, 7 days a week).

3. The Appellant requested an increase in Personal Care Services hours from 56 hours weekly (8 hours daily, 7 days a week) to 7 days weekly, continuous service provided by more than one Personal Care Services aide.

4. By "Initial Adverse Determination" notice dated August 30, 2018, Centers Plan for Healthy Living determined to deny Appellant's request for an increase of Personal Care Services from 56 hours weekly (8 hours daily, 7 days a week) to 7 days weekly, continuous service provided by more than one Personal Care Services aide, because the "the health care service is not medically necessary."

5. The Appellant appealed the August 30, 2018 determination.

6. On September 6, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs.

7. By "Final Adverse Determination" notice dated September 17, 2018, Centers Plan for Healthy Living determined to partially approve the Appellant's request, and granted the Appellant an increase of Personal Care Services to 84 hours weekly (12 hours per day, 7 days a week).

8. On October 12, 2018, the Appellant requested this fair hearing to contest the Managed Long-Term Care Plan's determination.

9. On October 25, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b).

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to

prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

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

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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...

42 CFR 438.402 provides, in part:

(a)The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F.

(b)Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c)Filing requirements -

(1)Authority to file.

(i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

(A)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

42 CFR 438.408 provides, in part:

(f)Requirements for State fair hearings -

(1)Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides:

(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.

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(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;

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- (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.

Office of Health Insurance Programs Division of Long Term Care
MLTC Policy 14.08: Paying for Live-In 24 Hour Care for Personal Care Services and Consumer Directed Personal Assistance Services

Date of Issuance: November 24, 2014

This purpose of this policy is to clarify the Guidelines for the Provision of Personal Care Services (PCS) in Medicaid Managed Care Section I (a)(x) and Guidelines for Consumer Directed Personal Assistance Service (CDPAS). This policy provides guidance on live-in 24 hour Personal Care Services and live-in 24 hour Consumer Directed Personal Assistance. This clarification is being provided in accordance with guidance issued from the US Department of

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Labor (29 CFR 785.22) and the NYS Department of Labor (Counsel Opinion Letter, N.Y. Dept. of Labor, RO-09-00169 “Live-In Companions”).

Previous guidance on how to pay individuals working on live-in cases indicated that the rate of payment was based on 12 hours of care. Effective immediately, MLTCPs and their network providers are required to provide a rate of payment that is based on at least 13 hours of care. The payment of live-in cases under this policy will be retroactive to April 1, 2014.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services Date of Issuance: November 17, 2016

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or “as needed” basis, such as might occur when an enrollee’s medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

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. 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 services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.

**NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS**

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

II. Accessing the benefit

- a. Request for Service: A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request.
Note: When a request for PCS is made, the MCO must provide the member with information about the Consumer Directed Personal Assistance Program ("CDPAP") using the brochure provided by SDOH. There is a further discussion about CDPAP below.
- b. Nursing and Social Assessment:
 - i. Initial assessment
Once the request is received the MCO is responsible for arranging an assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.
 - ii. Social Assessment
In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated, whether the member's home has adequate sleeping accommodations for a personal care aide.

This nursing assessment and the social assessment can be completed at the same time.

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.

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.

General Information System message GIS 97 MA 033 notified local districts as follows:

The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.

Districts were first advised of the Mayer case in May 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24 hour care, including continuous 24 hour services ("split-shift"), 24 hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.

This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and

support the determination that the recipient is, or is not, medically eligible for split shift or live-in services.

When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.

Remember that the contribution of family members or friends 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.)

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

1. Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24 hour split shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24 hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24 hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The district should authorize services in an amount that is less than 24 hour live-in services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of live-in services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

Important Additional Information on TBA Plans:

Until notified otherwise by the Department, the following also apply to the use of TBA plans:

1. A district cannot use a TBA plan unless the TBA plan was already in use on March 14, 1996, or the district had the Department's approval as of that date to implement a TBA plan. This complies with the temporary restraining order in Dowd v. Bane, which the Department notified districts of in a previous GIS message, 96 MA/013, issued April 4, 1996.
2. Districts are not required to include safety monitoring as an independent task on their TBA forms. The Department recently obtained a stay of the August 21, 1997 federal court order that had required safety monitoring to be included as an independent TBA task. [See GIS 97 MA/26, issued November 6, 1997, informing districts of the stay of the order in Rodriguez v. DeBuono (S.D.N.Y., 1997).]

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

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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.

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.

18 NYCRR 358-5.9(a) provides:

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 the Appellant, age 89, has been enrolled in and has received care and services, including Personal Care Services, through a Managed Long-Term Care Plan operated by Centers Plan for Healthy Living. The Appellant was in receipt of Personal Care Services in the amount of 56 hours weekly (8 hours daily, 7 days a week). The Appellant requested an increase in Personal Care Services hours from 56 hours weekly (8 hours daily, 7 days a week) to 7 days weekly, continuous service provided by more than one Personal Care Services aide. By “Initial Adverse Determination” notice dated August 30, 2018, Centers Plan for Healthy Living determined to deny Appellant’s request for an increase of Personal Care Services from 56 hours weekly (8 hours daily, 7 days a week) to 7 days weekly, continuous service provided by more than one Personal Care Services aide, because the “the health care service is not medically necessary.” The Appellant appealed the August 30, 2018 determination. On September 6, 2018, a nursing assessor completed a Uniform Assessment System New York (UASNY) Assessment (Comprehensive) Report of the Appellant’s personal care needs. By “Final Adverse Determination” notice dated September 17, 2018, Centers Plan for Healthy Living determined to partially approve the Appellant’s request, and granted the Appellant an increase of Personal Care Services to 84 hours weekly (12 hours per day, 7 days a week).

Federal regulations require that the State's contracts with managed long term plans must provide, among other things, that the services the managed long term care plan offer 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 and that the managed long care plan may place appropriate limits on services on the basis of medical necessity, but the criteria for determining medical necessity may be no more restrictive than that applicable to fee-for-service recipients.

According to the September 6, 2018 UASNY, the Appellant required “Maximal” assistance with performance of all listed ADLs, including walking, locomotion, “transfer toilet”, toilet use, and bed mobility. The assessment indicated the Appellant was incontinent and “wears

pull-ups”. According to the record, the Appellant has a history of stroke, and the assessment indicated Appellant has cognitive impairment and “...has limited use of left upper and lower extremity. He requires weight bearing assistance during ambulation with rolling walker and drags his left foot during ambulation. Member is unable to go from sitting to standing without assistance of one person...”. Thus, review of the Plan’s own evidence puts it on notice of Appellant’s status as a “[REDACTED]” patient, such that evaluation of the Appellant’s personal care services needs under a task based plan of care was prohibited. Pursuant to General Information System message GIS 97 MA 033, the Appellant should be provided with a personal care services authorization in an amount which, “when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours.” Authorizing Appellant for 12 hours per day, 7 days a week suggests recognition of Appellant’s need for 24 hour care, pursuant to MLTC Policy 14.08, which recognized that individuals working on 24 hour “live-in” cases had been paid at a rate based of 12 hours of care. In addition, the record reflects inadequate evaluation of the informal support available to the Appellant, suggesting Appellant is not receiving care, either formal or informal, for the other 12 hours of the day.

Regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. The record has been carefully considered and does not support the Plan’s determination. The record reflects Appellant is in need of 24 hour care as a “[REDACTED]” patient. While it cannot be determined from this record whether or not a “Live-in” personal care assistant would be able to obtain five hours of interrupted sleep at night, it also cannot be determined from this record whether there would be suitable sleeping accommodation for such an assistant. The record does not reflect adequate assessment of Appellant’s social circumstances pursuant to Department policy, and the September 6, 2018 UASNY indicates that Appellant resides in a one-bedroom apartment. Pursuant to Section 505.14 of the regulations, when the patient’s home has no sleeping accommodations for a personal care aide, continuous personal care services must then be authorized for the patient.

According to the Appellant’s Representative, on October 3, 2018, the Appellant suffered from a stroke causing him to lose significant strength and making it difficult for him to conduct all individual daily living activities. The Plan conducted a Uniform Assessment System New York Assessment (Comprehensive) Report of the Appellant’s personal care needs on October 25, 2018, and there is no evidence in the record that the Plan issued a new authorization for services pursuant to that assessment. However, as discussed above, Appellant had already established eligibility for 24 hour care prior to this incident, based on the record through the date of the issued Final Adverse Determination.

The Plan is reminded that GIS 97 MA 033 advises that the contribution of family members to the care of a personal care services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever.

DECISION AND ORDER

The determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to authorize the Appellant for personal care services of 84 hours per week was not correct and is reversed. Centers Plan for Healthy Living is directed to:

1. Authorize the Appellant for 24-hour personal care services, subject to immediate verification of suitable accommodation for a live-in aide, i. e., Live-in 24-hour personal care services are to be provided if suitable accommodation is found; if not, Continuous personal care services ("split shift") is to be provided to the Appellant.
2. Update its records to indicate that the Appellant is a "[REDACTED]" client, entitled to 24 hour personal care services.
3. Notify Appellant in writing upon compliance with this fair hearing Decision.

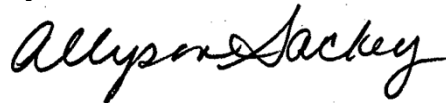
Should Centers Plan for Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to Centers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

As required by Section 358-6.4 of the Regulations, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
02/05/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee