STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: January 7, 2020
[redacted]
AGENCY: Suffolk
FH #: 8089444H

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 30, 2020, in Suffolk County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Office of Health Insurance Programs (Agency)

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the Agency's determination to authorize Personal Care Services (PCS) Assistance for the Appellant for 9 hours per day, 7 days a week, in lieu of the requested 24-hour, 2/12-hour split shift Continuous Care Services, 7 days a 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 [redacted], is currently in receipt of a Personal Care Services Authorization through Centers Plan For Healthy Living, a Managed Long Term Care Program (MLTC) in the community (Agency or Plan) in the amount of 9 hours per day, 7 days a week.

2. The Appellant resides in her part of a house, wherein her son, her daughter-in-law and their family also reside.

3. The Appellant suffers from Alzheimer's Dementia, Anxiety, Osteoporosis, Adnexal Masses, Incidental Lung node, Dyslipidemia, Vitamin D Deficiency, Recurring Shingles, Hypothyroidism, Unstable Gait and High Fall Risk. The Appellant is mostly wheelchair bound.

4. On July 31, 2019, the Agency obtained a nursing assessment, utilizing the UAS-NY, which recommends that the Appellant continue to receive Personal Care Services (PCS) and the Plan authorized PCS in the amount of 9 hours a day, seven days a week.

5. The Appellant's daughter, and two daughters-in-law provide all the paid functional assistance for the Appellant's needs during the week and the weekend, and her son provides unpaid assistance during nighttime hours. The family believed that they were all apparently providing unpaid round the clock care and are no longer able to keep doing so, as such; on August 27, 2019, they requested an increase in Personal Care Services Authorization in the amount of 24-hour, 2/12-hour split shift Continuous Care Services, 7 days a week for the Appellant.

6. The Appellant's family requested the increased authorization for PCS in the amount of 24 hours per day, 7 days per week (2/12-hour split shift continuous twenty-four-hour care by more than one personal care aide) from the Agency because at that time, the Appellant was still in receipt of PCS authorization for 9 hours per day, 7 days a week; the Agency did not schedule another assessment pursuant to the subject request.

7. By Initial Adverse Determination, dated, September 6, 2019, the Plan denied the services requested on the Appellant's behalf, for 24-hour, continuous ("split-shift") (168 hours per week) and advised the Appellant of its determination to continue to authorize Personal Care Services (PCS) Assistance for the Appellant in the amount of 9 hours per day, 7 days a week, in lieu of the requested 24 hours per day, 7 days per week, continuous ("split-shift") (168 hours per week) on the grounds that it was "not medically necessary".

8. The Appellant's representatives appealed the Initial Adverse Determination. The Plan relied on the referenced assessment it conducted to base its decision. No new assessment was conducted at the time of the subject request as the assessment was current. There was a January 24, 2019, assessment prior to the July 31, 2019, assessment. Apparently, on October 28, 2019, the Plan conducted another assessment but maintained its position on the current authorized PCS hours for this hearing. It was uncontroverted that the Appellant's cognition progressively declines.

9. By Final Adverse Determination notice dated, September 9, 2019, the Plan advised the Appellant of its determination to uphold its September 6, 2019, Initial Adverse Determination.

10. Uniform Assessment System (UAS) Report dated, July 31, 2019, and the subject dispute notice indicated, in relevant part: Meal Preparation: Total dependence, Ordinary Housework: Total dependence, Managing Medications: Total dependence, Managing Finances: Total dependence, Phone Use: Maximal Assistance, Shopping: Total dependence (depend completely upon someone else to complete all parts of this task. You do not participate in this task at all.) Transportation: Total dependence, Bathing: Maximal Assistance by 2+ helpers, Personal Hygiene: Extensive Assistance by 1 helper, Dressing Upper Body: Extensive Assistance by 1 helper, Dressing lower body: Maximal Assistance by 2+ helpers, Walking Extensive Assistance by 1 helper, Locomotion: Total dependence, Toilet Use: Extensive Assistance, Transfer Toilet: Extensive Assistance, (need physical help to complete some parts of this task, like someone to lean on or help you lift a body part and frequently incontinent of bladder and bowel.) Bed Mobility: Extensive Assistance (need physical help to complete most parts of this task, like someone lift from bed…) Eating: Limited Assistance (Guided maneuvering of limbs…). All relevant tasks were rated either total dependence, maximal or assistance.

11. Both parties agree that the Appellant has a degenerative disease, Advanced Alzheimer's Dementia, which causes steady decline in modified cognition and Activities of Daily Living (ADL) functions, with every assessment warranting an agreement for increase in care. The Appellant is also wheelchair bound. The Plan explained that PCS is not for companionship or safety supervision and the Appellant does not meet the criteria for the request made on her behalf.

12. Both parties agree that the Appellant suffers from impaired cognition and mobility resulting in an inability to perform functional tasks and acknowledge the steady cognitive decline. She has Incontinence of Bladder and Bowel if left alone and requires assistance with all ADLs and IADLs. She is either chair, bed or wheelchair bound but her diagnoses render her unable to navigate the wheelchair for any functional activities. Due to the degenerative nature of her diagnoses, the Appellant is unable to sustain functional communication with familiar and unfamiliar listeners and is unable to communicate for safety and social purposes. The Appellant is currently cognitively unable to roll on a bed on her own.

13. On January 7, 2020, the Appellant requested this fair hearing.

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...

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.

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.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home...".

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

(2) Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

After the new/receiving plan conducts an assessment, if the receiving plan determines to terminate, suspend, or reduce the number of personal care hours or services the member was previously receiving, the MLTCP must send the enrollee an Initial Adverse Determination (IAD) termination, suspension, reduction notice with language regarding how to request aid to continue (42 CFR §§ 438.404, 438.420; 18 NYCRR § 358-2.5); an MLTCP should not be sending an IAD Denial notice without language regarding aid to continue. Even though the new/receiving MLTCP did not originally determine the medical necessity of the current PCA hours and only authorized the service due to continuity of care, this should not be treated as a new service request.

NYS DEPARTMENT OF HEATLH
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…

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. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139…

c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period the MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.

d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN and the personal care services worker to develop the plan of care based on the MCO's authorization.

III. Authorization and Notice Requirements for Personal Care Services

e. Standards for review. Requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

f. Timing of authorization review.
    i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
    ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

g. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).

h. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):
    i. that were previously authorized, if any;
    ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
    iii. that are authorized for the new authorization period; and
    iv. the original authorization period and the new authorization period, as applicable.

i. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or

Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

i. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).

ii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.

iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
2. a mistake occurred in the previous personal care services authorization;
3. the member refused to cooperate with the required assessment of services;
4. a technological development renders certain services unnecessary or less time consuming;
5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
7. the member's medical condition is not stable;
8. the member is not self-directing and has no one to assume those responsibilities;
9. the services the member needs exceed the personal care aide's scope of practice.

Section 505.14(a)(3)(iii) of the regulations provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services as defined in paragraphs (2) and (4), respectively, of this subdivision, shall not be authorized to the extent that the patient's need for assistance can be met by 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

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.

Reauthorization for personal care services requires similar assessments as for the initial authorization; however, a nursing assessment is not required for Level I services if the physician's order indicates that the patient's medical condition is unchanged. Reauthorization of Level II services must include an evaluation of the services provided during the previous authorization period and must include a review of the nursing supervisory reports to assure that the patient's needs have been adequately met during the initial authorization period.

When there is a change in the patient's services needs which results solely from a change in his/her social circumstances, including, but not limited to, loss or withdrawal of support provided by informal caregivers, the social services department must review the social assessment, document the patient's social circumstances and make changes in the authorization as indicated. A new physician's order and nursing assessment is not required.

When there is a change in the patient's services needs which results from a change in his/her mental status including, but not limited to, loss of his/her ability to make judgments, the social services department must review the social assessment, document the changes in the patient's mental status and take appropriate action as indicated.

When there is a change in the patient's services needs which results from a change in his/her medical condition, the social services department must obtain a new physician's order and a new nursing assessment and shall complete a new social assessment. If the patient's medical condition continues to require the provision of personal care services, and the nursing assessment cannot be obtained within five working days of the request from the local social services department, the local department may make changes in the authorization in accordance with the procedures specified in 18 NYCRR 505.14(b)(5)(iv).

DISCUSSION

At the hearing, it was established that the Appellant's diagnoses were not in dispute. The Appellant's representatives explained that the Appellant currently resides alone. Her cognitive impairment and physical conditions require that she depends on someone else to complete all her activities of daily living.

The Appellant's family/representatives stated that the Appellant resided with her son and daughter-in-law. They further explained that the Appellant's Personal Care Aides are three family members, her daughter and her two daughters-in-law, who are all employed elsewhere as well. The Appellant's daughter provides aid from about 8:00AM to about 2:00PM. The daughter-in-law, residing with the Appellant, then provides aid from about 2:00PM until the next day because they live together, and paid or not, they would not ignore the Appellant or her needs for all the extra hours just because those hours were unpaid. They stated that the Appellant's son, who resided with her but was not one of her paid aides, took care of her at night nonetheless. They further stated that the Appellant's other daughter-in-law took care of her round the clock on weekends to give the rest of the family providing weekday care some respite from her care.

They indicated that going through the timeline specified, it is clear that from 6:00PM, during bedtime, until the next day at 9:00 AM, the Appellant would have been alone if not for the fact that they are her family, living with her and providing her care too, so they essentially provide round the clock care without getting paid, but they could no longer sustain that. The Appellant is mostly wheelchair-bound and cannot get in and out of bed without help. The family would need to pay someone else out of pocket to provide informal help with her activities of daily living at night but could not afford that. The Appellant's son transfers her to and from her bed, as needed, during the night.

The Appellant's family explained that because everyone caring for the Appellant have other employment, they are all exhausted and sleep-deprived and it is affecting their own wellbeing as well as the Appellant's. The argument is that the current authorized Personal Care Services level means that the Appellant could not get off her bed or wheelchair, depending on where she is left, to use the bathroom or have supper. If she is left on the wheelchair, she would not be able to get to bed to sleep or eat either and vice versa. She would have to sit on the wheelchair and stay in her soiled diaper, without food, without going to bed and without any hygiene functions from 6:00PM until about 9:00AM the next morning, or alternatively, just lie in bed for the same period with the same inabilities. The fact that the Appellant is spared all that is because the family would not allow it by providing task-based care for her outside the paid

hours. The Appellant is unable to simply reposition herself on the bed and improvement was no longer indicated or expected due to advanced age and health degeneration. The Appellant's representatives submitted supporting medical letter from the Appellant's physician to buttress the argument that the Agency's determination in this case was not appropriate or safe for this Appellant. They further referenced several supporting information in the Plan's own evidentiary packet.

The Appellant's family contended that the Plan's actions were not supported by the Appellant's real situation. They stated that the Plan's UAS-NY did not accurately reflect the Appellant's functional needs. They stated that the Appellant's impairments and physical conditions require that she depends on someone else to complete most, if not all, activities of daily living (ADL). They however, indicated that they worried about her being alone a lot and about her safety at night since she might wander down the stairs and had been hurt doing that. Notably, part of the Plan's argument was that PCS was not for safety or companionship. Task-based assessment tool may be suitable for use for enrollees who are not eligible for 24-hour services but could be inappropriate for enrollees who are eligible for 24-hour care.

The representatives pointed out reasonably that by the Agency's own assessment and notice, the Appellant has declined to severely impaired and the assessment stated that she requires either complete physical help or maximum supervision at all times for all functions and activities. They also pointed out that, realistically, due to her cognitive and physical impairment and decline, the Appellant had total dependence for the functions the Agency had labeled maximal. They indicated that despite her sometimes-bright but misleading disposition, the Appellant's capacity is nonexistent as to what she can physically do on her own hence their request for Personal Care Aide Level 2, 24-hour continuous split-shift per diem.

The Appellant's representatives also explained that the Appellant had shingles. Due to that significant illness and courses of treatment, the Appellant suffered a steep decline in every aspect of her life and health and that in turn severely affected the wellbeing of her care givers, adding more load and stress to her care regimen. The family argued that the provision of continuous twenty-four-hour Personal Care Services was the only reasonable choice under the circumstances. They reiterated that the information in the UAS, even with its arguable downplaying of the Appellant's level of dependence, still supports that 9 hours per day is not adequate in this case.

To buttress their contentions, the family submitted letters from the Appellant's primary care physician and her neurologist, who mentioned the Appellant's task-based needs and safety, surveillance and wandering. The family also submitted a detailed hourly log of the Appellant's care for a one-month period into the record of this hearing. The family expressed that they would consider an aide(s) that is not a family member to complete all the Appellant's task-based needs, if necessary.

It is noted that PCS is not for safety, surveillance and wandering. However, the hours required for the Appellant's task-based needs were reviewed based on the evidence proffered on her behalf.

Part of the Plan's contention was that the request was understood as “safety monitoring or supervision” and since request for that as independent or “standalone” task is not a covered task, the Plan indicated that it is not required to provide PCS for such. The determination was ostensibly based in part on the information available to the Agency at the time on the nature of the assistance required by the Appellant. However, irrespective of the language utilized by the Appellant's lay care givers and the physicians for the request in this case, the substantive issue must be decided on its merit. The Appellant's representatives were advised that since assessments for the level of need for services are ongoing, they could procure and submit additional documentation about all the specific overnight needs of the Appellant to the Agency, if necessary.

The log of the Appellant's task-based needs established that the Appellant requires more than her current 9 hours per day PCS. However, it also established that the Appellant averages about 5 hours of sleep per day and does not require up to 24 hours of continuous task-based care each day.

Per applicable Regulations, **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. Whereas, “**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.”

The facts of this case fit the foregoing **Live-in 24-hour personal care services** criteria because it was established that the Appellant's needs and dependence were such that an aide could obtain “five hours daily of uninterrupted sleep during the aide's eight-hour period of sleep”. The crux of the issue would be the nighttime needs of the Appellant and if it is possible for an aide to get at least five hours of sleep while providing care, and that issue was properly developed by the evidence proffered. It was clear that the facts of this case fit the foregoing criteria although the Appellant's family did not come to the hearing prepared to argue such criteria.

Be that as it may, the salient legal point in this case is that the weight of the medical and factual evidence educed at this hearing tilted in favor of the argument that the needs of this Appellant cannot be adequately and safely met by 9 hours per day, 7 days a week personal care aide services, which if followed strictly means that an aide(s) could only care for the Appellant until 6:00PM during the day but could not be available to the Appellant at all for the rest of the night until midmorning. The Agency made a determination based on the information available

but must also assess the ADLs and IADLs needs of the Appellant during nighttime hours. Moreover, the determination in this case is incongruous with the information contained in the UAS and the Appellant's diagnoses and age. The record of this hearing supports a finding that this Appellant would require the provision of **Live-in 24-hour personal care services** to adequately and safely meet and manage her care.

A denial of much-needed assistance could place the Appellant's well-being at risk, and it is possible the request at issue is Medically Necessary. The finding in this decision was based on the weight of the evidence proffered by both parties. The Appellant is entitled to a Safe Care Plan and her circumstances and medical issues are clearly degenerative, as such, nothing in this decision precludes the Appellant and her daughters from submitting new requests to the Plan with medical documentation reflecting the quantifiable task-based needs of the Appellant for more assistance with her ADLs and IADLs or her eligibility for the 24-hour continuous care they had requested.

Consequently, in accordance with regulatory requirements and the circumstances of this case, the Agency's determination of the Appellant's medical need for Personal Care Services in this instance was correct when made but can no longer be implemented.

DECISION AND ORDER

The Agency's determination to authorize Personal Care Services (PCS) Assistance for the Appellant for 9 hours per day, 7 days a week, in lieu of the requested 24-hour, 2/12-hour split shift Continuous Care Services, 7 days a week, was correct when made.

1. The Agency is directed to authorize Personal Care Services to the Appellant for Live-in 24-hour personal care services.

2. The Agency is directed, when conducting its upcoming evaluations of the Appellant's medical need for Personal Care Services, to take into account the Appellant's needs through the night relating to her incontinence and her inability to get into bed from her wheelchair and get out of her bed into her wheelchair.

3. The Agency is directed to inform the Appellant, in writing, of its determination.

Should the Agency 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 must provide it to the Agency promptly to facilitate such compliance.

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

FH# 8089444H

DATED: Albany, New York
02/05/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee