STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 12, 2018
[redacted]
AGENCY: MAP
FH #: 7702617R

In the Matter of the Appeal of

[redacted]

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

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on March 8, 2018, 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

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the Appellant's Managed Long Term Care Plan's determination not to provide the Appellant with Personal Care Aide service hours in the amount of 84 hours per week (12 hours per day, 7 days 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 85, lives alone, has been in receipt of Medical Assistance benefits, and is enrolled in a partially capitated Managed Long Term Care Plan through Centers Plan For Healthy Living (the Plan).

2. The Appellant had been in receipt of a Personal Care Aide services authorization in the amount of 40 hours per week (6 hours per day, 6 days per week and 4 hours, 1 day per week).

3. The Appellant requested that the Plan increase her Personal Care Aide service hours to 84 hours per week (12 hours per day, 7 days per week).

4. On January 22, 2018, the Plan issued to the Appellant a written Initial Adverse Determination which advises the Appellant of its determination not to increase the number of Personal Care Aide service hours to 84 hours per week, but instead, to approve an increase to 52.5 hours per week (7.5 hours per day, 7 days per week).

5. On February 12, 2018, 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.

18 NYCRR 505.14(a)(3)(iii)(b) provides, in part, that:

The social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers…

18 NYCRR 505.14(a)(2) provides that:

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.

18 NYCRR 505.14(a)(4) provides that:

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 designation, Mayer 3, relates to provisions for those clients who have a medical need for continuous personal care services or live-in 24-hour personal care services and who have social supports who provide some interim personal care during the day and/or night.

A GIS message 97/MA/033 dated November 26, 1997, provides clarifying instructions regarding Mayer v. Wing (S.D.N.Y., 1996). 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.

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 [in the GIS message].

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.

DISCUSSION

The evidence establishes that the Appellant requested that the Plan increase her Personal Care Aide service hours to 84 hours per week (12 hours per day, 7 days per week). On January

22, 2018, the Plan issued to the Appellant a written Initial Adverse Determination which advises the Appellant of its determination not to increase the number of Personal Care Aide service hours to 84 hours per week, but instead, to approve an increase to 52.5 hours per week (7.5 hours per day, 7 days per week).

In support of its determination, the Plan presented a Uniform Assessment System Report (UAS) of the Appellant's personal care needs, conducted on January 5, 2018. The UAS states that the Appellant is totally dependent on others for meal preparation, shopping and housework. She requires maximal assistance with managing medications, stairs, transportation, bathing, walking, locomotion, toilet transfer, toilet use, and bed mobility. The UAS also notes that the Appellant's change in activity of daily living (ADL) status has declined in the last 90 days and overall self-sufficiency has deteriorated. She suffers from heart disease, depression, anxiety, high blood pressure, dementia, and had both hips replaced, according to records submitted by the Plan and the Appellant.

The Plan failed to provide the Tasking Tool at the hearing, although the January 22, 2018 determination states that the decision is based, in part, on the tasking tool.

At the hearing, the Appellant's daughter/representative testified that if her mother's hours are not increased to 12 hours per day, then she will be alone when she wakes up and goes to bed, although she needs both morning and evening care because she needs reminders to take medications and has high blood pressure. Her husband passed away in December 2017 and he had a live-in aide who did many things for both of her parents, including meal preparation, chores and shopping. The Appellant needs assistance with bathing, dressing, walking and going to appointments, according to the representative. According to a letter dated December 28, 2017, from the Appellant's doctor, [redacted], MD, the Appellant would benefit from an increase in service hours to 12 hours per day, 7 days per week. The representative's testimony is found credible because of its detail and because it is corroborated by the case records.

The designation, Mayer 3, relates to provisions for those clients who have a medical need for continuous personal care services or live-in 24-hour personal care services and who have social supports who provide some interim personal care during the day and/or night. At the hearing, the Appellant's representative acknowledged that the Appellant needs both morning and evening care and help when she wakes up and goes to bed.

While housework, shopping, and meal preparation can be scheduled for weekdays, assistance with transportation, bathing, stairs, dressing, medication management, and equipment management would be required over the weekend as well. The Plan is reminded that contribution of family members or friends to the care of an applicant or recipient of care services is voluntary and cannot be coerced or required in any manner whatsoever. The record establishes that the Appellant's condition has worsened, and she requires continuous assistance with numerous tasks beyond the hours authorized by the Plan.

Federal regulations require that the State's contracts with Managed Long Term Care 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 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. In addition, Section 358-5.9 of the Social Services Law provides that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance benefits or services, 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 credible evidence establishes that the Appellant's condition has been worsening and she would be medically eligible for, at minimum, live-in 24-hour personal care services under the Regulations if she had no informal caregiver support because she needs assistance during a calendar day with toileting, walking, bed mobility and transferring. The Appellant's family support may not be coerced into providing informal support, but the family members are voluntarily willing to commit to providing nighttime support, 12 hours per day. Upon this basis, the Appellant's request for a Personal Care Aide service authorization in the amount of 84 hours per week (12 hours per day, 7 days per week) is persuasive. Accordingly, the Plan determination to deny an increase in Personal Care Aide service hours to 84 hours per week (12 hours per day, 7 days per week) cannot be sustained.

For all of the foregoing reasons, the Appellant has established that the Plan's determination not to increase the number of personal service hours was not correct. Accordingly, the Plan's determination to deny an increase in service hours cannot be sustained.

DECISION AND ORDER

The Plan's determination not to provide the Appellant with Personal Care Aide service hours in the amount of 84 hours per week (12 hours per day, 7 days per week) is not correct and is reversed.

1. The Plan is directed to authorize the Appellant for Personal Care Aide service for 84 hours per week (12 hours per day, 7 days per week).

2. Provide the Appellant Personal Care Aide service authorization pursuant to the Appellant's status as a Mayer 3 individual.

3. Continue to provide the Appellant with an authorization of Personal Care Aide service in the amount of 84 hours per week (12 hours per day, 7 days per week) in accordance with the foregoing.

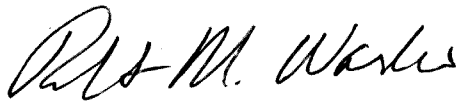
Should the Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate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

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

DATED: Albany, New York
03/22/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's

Designee