STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 29, 2019
[redacted]
AGENCY: MAP
FH #: 7935693Y

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 June 11, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

Debora Ferguson, Fair Hearing Representative

ISSUE

Was the determination by the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's Representative's request for an increase in Personal Care Services provided to the Appellant from 5.5 hours per day, 7 days per week, (38.5 hours weekly), to 12 hours per day, 7 days per week (84 hours weekly), correct?

FINDINGS OF FACT

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

1. The Appellant, age 85, has been in receipt of Medical Assistance benefits, including Personal Care Services ("PCS") through a Managed Long-Term Care ("MLTC") Health Care Plan ("the Plan") operated by Centers Plan for Healthy Living.

2. The Appellant has been in receipt of PCS in the amount of from 5.5 hours per day, 7 days per week, (38.5 hours weekly).

3. The Appellant's Representative requested an increase in PCS provided to the Appellant from 5.5 hours per day, 7 days per week, (38.5 hours weekly), to 12 hours per day, 7 days per week (84 hours weekly).

4. On December 19, 2018, the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on December 19, 2018, wherein the following was noted regarding the Appellant: dependence in Independent Activities of Daily Living ("IADLs"), such as errands and chores; dependence in Activities of Daily Living ("ADLs"), such as bathing, dressing, grooming, ambulating, transferring and toileting, including eating and bed mobility; bladder incontinence; dizziness; an unsteady gait; shortness of breath, fatigue, and moderate, intermittent pain; with unchanged cognition and functionality.

5. The December 19, 2018 "assessment" of the Appellant generated a Task-Based Assessment ("TBA") tasking the Appellant at 38.5 hours weekly.

6. The December 19, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 23.

7. On February 13, 2019, the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on February 13, 2019, wherein the following was noted regarding the Appellant: dependence in Independent Activities of Daily Living ("IADLs"), such as errands and chores; dependence in Activities of Daily Living ("ADLs"), such as bathing, dressing, grooming, ambulating, transferring and toileting, including bed mobility; bladder incontinence; dizziness; an unsteady gait; shortness of breath, fatigue, and moderate, intermittent pain; with unchanged cognition, but functionality.

8. The December 19, 2018 "assessment" of the Appellant generated a Task-Based Assessment ("TBA") tasking the Appellant at 35 hours weekly.

9. The December 19, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 19.

10. By Initial Notice of Adverse Determination dated March 25, 2019, the Plan informed the Appellant of its determination deny the Appellant's request for an increase in PCS provided to the Appellant because of unchanged functionality.

11. By Final Notice of Adverse Determination dated April 11, 2019, the Plan upheld its Initial Determination.

12. On March 29, 2019, the Appellant's Representative requested this fair hearing to contest the Plan's determination.

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). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a). Section 358-5.9 of the Regulations provides in part: (a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

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:

The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

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

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

(2) Some or total assistance shall be defined as follows:

(i) Some assistance shall mean that a specific function or task is performed and completed by the patient with help from another individual.

(ii) Total assistance shall mean that a specific function or task is performed and completed for the patient.

(3) Continuous personal care services means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient’s medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

(5) Live-in 24-hour personal care services means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.
(6) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

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

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

(a) Personal care functions shall include some or total assistance with the following:
(1) bathing of the patient in the bed, the tub or in the shower;
(2) dressing;
(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;
(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;
(6) transferring from bed to chair or wheelchair;
(7) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
(8) feeding;
(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;
(10) providing routine skin care;
(11) using medical supplies and equipment such as walkers and wheelchairs; and
(12) changing of simple dressings.

GIS 15 MA/24, published on December 31, 2015, advises of the revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR section 505.14 and 18 NYCRR section 505.28, and notes the following changes: The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

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

12 OHIP/ADM-1 states, in part:

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

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.

Section 505.14(a)(4) provides a new definition of "Live-in 24-Hour Personal Care Services" as follows: 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.

Section 505.14(a)(2) provides a new definition of "Continuous Personal Care Services" ("Split-Shift Care") as follows: 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.

The United States Court of Appeals for the Second Circuit has reversed the lower court decision in Rodriguez et al v. DeBuono and Wing (S.D.N.Y.) that safety monitoring should be an included task in task based assessments. This means that agencies that use task based assessment plans in their Personal Care Services Programs are NOT required to include safety monitoring as a separate task on their TBA forms, assess the need for safety monitoring as a separate task or calculate any minutes allotted for safety monitoring as part of the total personal care services hours authorized for Personal Care Services applicants and recipients.

The federal Center for Medicare and Medicaid Services State Medicaid Manual states, in part, at section 4480 regarding Personal Care Services (speaking of activities of daily living, or "ADL's"):

> 1. Cognitive Impairments. --An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

General Information Service Message GIS 03 MA/003, released on January 24, 2003 by the New York State Department of Health, reads as follows:

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are NOT required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between safety monitoring as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

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

When the district, in accordance with 505.14(a)(4), determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs. In determining the appropriate amount of hours to authorize, the district must review the physician's order and the nursing and social assessments to assure that the authorization and scheduling of hours in

combination with any informal support contributions, efficiencies and specialized medical equipment, is sufficient to meet the patient's personal care needs.

DISCUSSION

The record establishes the following relevant facts. The Appellant, age 85, has been in receipt of Medical Assistance benefits, including Personal Care Services ("PCS") through a Managed Long-Term Care ("MLTC") Health Care Plan ("the Plan") operated by Centers Plan for Healthy Living. The Appellant has been in receipt of PCS in the amount of from 5.5 hours per day, 7 days per week, (38.5 hours weekly). The Appellant's Representative requested an increase in PCS provided to the Appellant from 5.5 hours per day, 7 days per week, (38.5 hours weekly), to 12 hours per day, 7 days per week (84 hours weekly).

On December 19, 2018, the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on December 19, 2018, wherein the following was noted regarding the Appellant: dependence in Independent Activities of Daily Living ("IADLs"), such as errands and chores; dependence in Activities of Daily Living ("ADLs"), such as bathing, dressing, grooming, ambulating, transferring and toileting, including eating and bed mobility; bladder incontinence; dizziness; an unsteady gait; shortness of breath, fatigue, and moderate, intermittent pain; with unchanged cognition and functionality. The December 19, 2018 "assessment" of the Appellant generated a Task-Based Assessment ("TBA") tasking the Appellant at 38.5 hours weekly. The December 19, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 23.

On February 13, 2019, the Plan conducted an "assessment" of the Appellant for the generation of a Uniform Assessment System ("UAS") report regarding the Appellant that was "finalized" on February 13, 2019, wherein the following was noted regarding the Appellant: dependence in Independent Activities of Daily Living ("IADLs"), such as errands and chores; dependence in Activities of Daily Living ("ADLs"), such as bathing, dressing, grooming, ambulating, transferring and toileting, including bed mobility; bladder incontinence; dizziness; an unsteady gait; shortness of breath, fatigue, and moderate, intermittent pain; with unchanged cognition, but functionality. The December 19, 2018 "assessment" of the Appellant generated a Task-Based Assessment ("TBA") tasking the Appellant at 35 hours weekly. The December 19, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 19.

By Initial Notice of Adverse Determination dated March 25, 2019, the Plan informed the Appellant of its determination deny the Appellant's request for an increase in PCS provided to the Appellant because of unchanged functionality. By Final Notice of Adverse Determination dated April 11, 2019, the Plan upheld its Initial Determination.

The Appellant's Representative attested to the Appellant's frequent toileting and incontinence needs because of, among other things, the Appellant's cardiac medication. The Appellant's Representative further attested to the Appellant's otherwise predominantly sedentary existence with a schedule from 11am to 9pm. The Appellant's Representative's testimony is credited because of its plausibility and corroboration, including corroboration by the Plan's own evidence.

GIS 03 MA/003 states “a care plan must be developed that meets the patient’s scheduled and unscheduled day and nighttime personal care needs.”

Accordingly, the Plan’s determination cannot be sustained because the Appellant has functional deficits and consequent unpredictable needs.

However, the record reveals that the Appellant’s Representative’s contentions confuse emotional desire with medical need. It is medical need for assistance with the completion of tasks that justifies the services requested, not personal preferences or companionship. Safety monitoring and cognitive prompting as standalone functions are not cognizable pursuant to GIS 03/MA/03.

The Appellant’s predominantly sedentary existence reveals that 10 hours daily would suffice to meet the Appellant’s needs.

DECISION AND ORDER

The determination by the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant’s Representative’s request for an increase in Personal Care Services provided to the Appellant from 5.5 hours per day, 7 days per week, (38.5 hours weekly), to 12 hours per day, 7 days per week (84 hours weekly) is not correct.

1. The Plan is directed to authorize the Appellant for Personal Care Services in the amount of 10 hours per day, 7 days per week (70 hours weekly).

2. The Plan is directed to notify the Appellant in writing, when it has complied with the aforementioned directives.

Should the Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's Representative 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
06/14/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee