STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 4, 2018
[redacted]
AGENCY: MAP
FH #: 7753833R

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 4, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Manage Long Term Care Plan

Appearance waived

ISSUE

Was the Managed Long-Term Care Plan's determination of April 10, 2018 to authorize the Appellant to receive Personal Care Services in the amount of 56 hours per week (8 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 94, who is residing by herself, has been in receipt of Medicaid and has been enrolled in a partially capitated Managed Long Term Care Plan operated by the Centers Plan for Healthy Living (hereinafter referred to as "MLTC Plan" or "Centers Plan") and had been in receipt of an authorization for personal care services in the amount of 52.5 hours per week authorized over 7 days per week 7.5 hours per day.

2. The Appellant's representative requested an increase in the Appellant's personal care services authorization from 52.5 hours per week to 80 hours per week, authorized over 12 hours per day 6 days a week and 8 hours per day 1 day per week.

3. On March 28, 2018, the MLTC Plan conducted an assessment of the Appellant's personal care needs, wherein the reviewing nurse determined that there has been a decline in the Appellant's ADL status (ability to perform activities of daily living) and deterioration in Appellant's overall self-sufficiency since her previous assessment; and computed that the Appellant's PCS needs totaled 56 hours per week.

4. By Initial Adverse Determination dated April 10, 2018, the Center Plan advised the Appellant that her request for an increase in the Personal Care Services authorization from 52.5 hours per week to 80 hours per week is denied and that Appellant's PCS authorization will be partially increased to 8 hours per day 7 days a week for a total of 56 hours per week which is adequate to meet Appellant's needs.

5. On May 4, 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.
> >
> > (3) Provide that the MCO, PIHP, or PAHP--
> >
> > > (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services"' in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be

made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--

(i) The enrollee and his or her representative;

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

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

The Medicaid Advantage and Advantage Plus Model Contract provides, in part:

10.1 Contractor Responsibilities

The Contractor agrees to provide the Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package, as described in Appendix K-1 of this Agreement, to Enrollees of the Contractor’s Medicaid Advantage Plus Product subject to any exclusions or limitations imposed by Federal or State law during the period of this Agreement. Such services and supplies shall be provided in compliance with the requirements of the Contractor’s Medicare Advantage Coordinated Care Plan contract with CMS, the State Medicaid Plan established pursuant to § 363-a of the State Social Services Law, and all other applicable federal and state statutes, regulations and policies.

21.2

d) The Contractor's Medicaid Advantage Plus Product network must contain all of the provider types necessary to furnish the Medicaid Services identified in Appendix K-2.

14.2 Filing and Modification of Medicaid Advantage Plus Action Appeals and/or Grievance Procedures

a) The Contractor's Action and Grievance System Procedures governing services determined by the Contractor to be a Medicaid only benefit and services determined by the Contractor to be a benefit under both Medicare and Medicaid shall be approved by the SDOH and kept on file with the Contractor and SDOH.

b) The Contractor shall not modify its Action and Grievance System Procedures without the prior written approval of SDOH.

14.3 Medicaid Advantage Plus Action and Grievance System Additional Provisions

a) The Contractor must have in place effective mechanisms to ensure consistent application of review criteria for Service Authorization Determinations and consult with the requesting provider when appropriate.

b) If the Contractor subcontracts for Service Authorization Determinations and utilization review, the Contractor must ensure that its subcontractors have in place and follow written policies and procedures for delegated activities regarding processing requests for initial and continuing authorization of services consistent with Article 49 of the PHL, 10 NYCRR Part 98, 42 CFR Part 438, Appendix F of this Agreement, and the Contractor's policies and procedures.

c) The Contractor must ensure that compensation to individuals or entities that perform Service Authorization and utilization management activities is not structured to include incentives that would result in the denial, limiting, or discontinuance of Medically Necessary services to Enrollees.

d) The Contractor or its subcontractors may not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, Enrollee's condition, or cost of services. The Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity or utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

e) The Contractor shall ensure that its Medicaid Advantage Plus Grievance System includes methods for prompt internal adjudication of Enrollee Complaints, Complaint Appeals and Action Appeals and provides for the maintenance of a written record of all Complaints, Complaint Appeals and Action Appeals received and reviewed and their disposition, as specified in Appendix F of this Agreement.

f) The Contractor shall ensure that persons with authority to require corrective action participate in the Medicaid Advantage Plus Grievance System.

g) The Contractor's Grievance System Procedures for services determined by the Contractor to be a Medicaid only benefit and services determined by the Contractor to be a benefit under both Medicare and Medicaid shall be described in the Contractor's Medicaid Advantage Plus member handbook and shall be made available to all Medicaid Advantage Plus Enrollees.

h) When the Contractor makes a final adverse determination about an Action it has taken, the Contractor will advise Enrollees of their right to a fair hearing as appropriate and comply with the procedures established by SDOH for the Contractor to participate in the fair hearing process, as set forth in Section 24 of this Agreement. Such procedures shall include the provision of a Medicaid notice in accordance with 42 CFR 438.210 and 438.404.

i) When the Contractor makes a final adverse determination about an Action it has taken, the Contractor will also advise Enrollees of their right to an External Appeal, related to services determined by the Contractor to be a Medicaid only benefit or services determined by the Contractor to be a benefit under both Medicare and Medicaid, in accordance with Section 25 of this Agreement.

MLTC policy memo 13.09(a) reminds Plans of MLTC Policy 13.09: *Transition of Semi-Annual Assessment of Members to the Uniform Assessment System for New York* which indicates that effective October 1, 2013, the Uniform Assessment System for New York (UAS-NY) will replace the Semi-Annual Assessment of Members (SAAM).

As per the statewide implementation plan, Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013;** the SAAM assessment must **not** be used for these new enrollees. Additionally, the UAS-NY must be used for *all* reassessments beginning **October 1, 2013**.

All SAAM assessments conducted from June 16, 2013 through September 30, 2013 must be submitted to the Department of Health by October 31, 2013 via the regular SAAM submission process.

MLTC policy memo 13.09(b) advises in part:

1. Is it permissible for an MLTC Plan to have the nurse complete the 22 items to calculate the Nursing Facility Level of Care in order to determine if the individual meets the initial eligibility for one of the MLTC products? If the individual scores below a 5, the individual would not be assessed using the full UAS-NY Community Assessment.

No. All MLTC Plans (Partial Capitation, PACE and MAP) are required to conduct the full UAS-NY Community Assessment. The purpose of this tool, in use across all long term care programs and provider types, is to obtain consistent information related to Medicaid recipient care needs. The Department of Health will use this information to effectively inform future community based long term care policy for its entire population. Additionally, this assessment will be used by MLTC Plans to demonstrate reasons for denial of enrollment at Fair Hearings and as such will need to present a clear and consistent representation of the Medicaid recipient's total health care needs to justify their action.

It is important to note that the Nursing Facility Level of Care is not a determining factor for all Partial Capitation MLTC eligibility. Please refer to the MLTC contract for the full eligibility criteria.

Section 505.14(a)(1) of the Regulations, as amended effective December 23, 2015, 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.

(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;

(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.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

arranging for the delivery of personal care services according to subdivision (c) of this section….
monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

NYS DEPARTMENT OF HEATLH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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I. 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.

II. Authorization and Notice Requirements for Personal Care Services

a. 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.

b. 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).

c. 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).

d. 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.

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;

- Visual function;

- Communication;

- Activities of daily living functional potential;

- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);

- Urinary incontinence and indwelling catheter;

- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);

- Activities;

- Falls;

- Nutritional status;

- Feeding tubes;

- Dehydration/fluid maintenance;

- Dental Care;

- Pressure ulcers;

- Psychotropic drug use; and

- Physical restraints.

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4480. PERSONAL CARE SERVICES

C. Scope of Services – Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

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.

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

GIS 03 MA/03 was released to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. In relevant portion, this GIS Message states:

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

18 NYCRR Section 360-10.8 provides, in part, that, at a fair hearing concerning any type of Managed Care issue, the Plan must prepare evidence to justify its challenged determinations. The same Regulation provides that the Plan may present the evidence at the hearing or submit written evidence. If the Plan will not be making a personal appearance at the fair hearing, the written material must be submitted at least three business days prior to the scheduled hearing: to the office of administrative hearings (OAH); and to the enrollee or enrollee's representative, unless the material was previously provided to the enrollee or the enrollee's authorized representative in accordance with paragraph (3) of this subdivision. If the hearing is scheduled fewer than three business days after the request, the Plan must deliver the evidence to the hearing site no later than one business day prior to the hearing; otherwise it must appear in person. If the Plan has reversed its initial determination and provided the service to the enrollee, the Plan may request a waiver of personal appearance and submit papers explaining that it has withdrawn the initial determination and is providing the services or treatment. Only the enrollee or the enrollee's authorized representative may withdraw his or her request for a fair hearing.

Section 358-5.9 of the Regulations provide 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.

DISCUSSION

The record establishes that the Appellant, age 94, who is residing by herself, suffers from numerous chronic medical conditions, including coronary heart disease, actinic keratosis,

blindness (left eye), constipation, dizziness and giddiness, essential (primary) hypertension, hyperlipidemia, insomnia, localized edema, muscle weakness, shortness of breath, unspecified abnormalities of gait and mobility, asthma, glaucoma, atherosclerosis, osteoarthritis, polymyalgia, urinary incontinence. Evidence regarding these diagnoses was obtained from the MLTC Plan's evidence packet, and the medical documentation submitted by the Appellant.

The record also establishes that the Appellant, has been in receipt of Medicaid and has been enrolled in a partially capitated Managed Long Term Care Plan operated by the Centers Plan for Healthy Living (hereinafter referred to as "MLTC Plan" or "Centers Plan"); and that the Appellant had been in receipt of an authorization for personal care services in the amount of 52.5 hours per week authorized over 7 days per week, 7.5 hours per day.

The record further establishes that the Appellant's representative requested an increase in the Appellant's personal care services authorization from 52.5 hours per week to 80 hours per week, authorized over 12 hours per day 6 days per week and 8 hours per day, 1 day per week; and that by Notice dated April 10, 2018, the Centers Plan advised the Appellant that her request for an increase in the Personal Care Services authorization from 52.5 hours per week to 80 hours per week is denied and that Appellant's PCS authorization will be partially increased to 8 hours per day 7 days per week for a total of 56 hours per week which is adequate to meet Appellant's needs.

The Appellant's representative/grandson testified during the hearing that the Appellant presently receiving personal care services from 8am to 4pm. The Appellant's representatives alleged during the hearing that Appellant requires additional 4 hours of personal care services from 4pm to 8pm to assist the Appellant with mobility and transfer, toilet use and toilet transfer (including diaper change), dinner preparation and service and medications. The Appellants' representative testified that the Appellant's mobility functions are impaired and deteriorated significantly since last assessment of November 2017; and that the Appellant had 3 falls since the previous assessment with the latest fall on April 14, 2018. The Appellant's representative further testified that the use of the walker is no longer feasible and that the Appellant is completely wheelchair bound due to swelling of her legs as a result of a heart conditions. The Appellant's representative also testified that the Appellant is not able to wheel herself due to weakness and lack of strength. The Appellant's representative further testified that the Appellant needs assistance with getting ready for bed and actually positioning Appellant in bed, which requires physical lifting of her legs because the Appellant cannot raise her legs on her own. The Appellant's representative further testified that, unless family pays out of pocket for aide services or friends stop by to assist the Appellant with dinner and getting ready for bed, the Appellant is left in bed at 4pm when home attendant leaves until next morning at 8am. In support of his testimony, the Appellant's representative provided a letter from the Appellant's treating physician dated April 23, 2018 stating that the Appellant needs "total assistance with ADLs and personal hygiene. [Appellant] needs help with transfer from a bed to a wheelchair, from bed to commode, dressing/undressing, feeding, bathing, personal hygiene as well as all ADLs."

The Appellant's home aide testified during the hearing that the Appellant requires total assistance with toilet use including change of pullup/diapers and that she is no longer able to use

commode and that the aide usually changes Appellant's diapers 6 to 7 times and sometimes up to 10 times during her 8-hour shift and that Appellant often needs to be cleaned up due to frequent accidents. The Appellant's aide further testified that the Appellant needs reminders to take her medication and that aide needs to hold the glass of water for the Appellant because she cannot raise her hands due to arthritis and muscle weakness.

At the hearing, in support of its determination, the MLTC Plan presented Appellant's Uniform Assessment System Assessment Report ("UAS Report") dated March 28, 2018, wherein the reviewing nurse determined that there has been a decline in the Appellant's ADL status (ability to perform activities of daily living) and deterioration in overall self-sufficiency since her previous assessment. The reviewing nurse further determined that the Appellant is "totally dependent – full performance by others during all episodes" for bathing, personal hygiene, dressing upper and lower body, toilet use, meal preparation, ordinary household and shopping; and required "maximal assistance – weight bearing support (including lifting limbs) by 2+ helpers – or – weight bearing support for more than 50% of subtasks" with walking, locomotion, transfer toilet, bed mobility, eating and stairs; and required "extensive assistance – weight bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks" with managing medication and phone use. The reviewing nurse further commented that Appellant "had several recent falls which impaired member's functionality and ability to perform ADL's…requires total assistance with upper and lower body mechanics as she cannot raise arms above shoulder level and cannot bend down on her own…requires assistance I/ADLs due to SOB (shortness of breath), legal blindness and l/e edema which limits walking. PCA providers medication setup help and reminders..." According to the medication list the Appellant was prescribed 13 different mediation with at least one to be taking every 6 hours. The reviewing Summary of Hours prepared based on March 28, 2018 assessment indicated that the MLTC Plan computed that the Appellant's PCS needs totaled and computed that the Appellant's PCS needs totaled 56 hours per week.

In adherence with MLTC policy guidelines MLTC Plans are required to provide, at minimum, benefits in an amount that is equal to that which would be provided under Medicaid fee-for-service. Additionally, the record, specifically the MLTC Plan's own evaluation as well as the testimony of Appellant's representative and home attendant, reflects that Appellant has unscheduled needs which should be factored into the time allotment. Regulations allow discretion for unscheduled needs to be provided for. (See, e.g., GIS 03 MA/003.) For the Appellant, 1225 minutes a week for unscheduled needs has been found to be reasonable here.

Since it has been established that the Appellant requires total assistance with many activities of daily living, and requires additional time for performance of such activities, even with the assistance of her aide, the Appellant requires, at minimum, the following time per week for her Personal Care Services needs:

TASK	MINUTES/DAY	MINUTES PER WEEK
Bathing	20.00	140.00
Dressing	15.00	105.00

Grooming	15.00	105.00
Routine Skin Care	10.00	70.00
Shampooing		30.00
Indoor Mobility	20.00	140.00
Toileting		
Toilet	60.00	420.00
Change Diaper	60.00	420.00
Transferring		
(@ 15 minutes/event)	75.00	525.00
Outdoor Mobility		120.00
Prepare for bed	30.00	210.00
Medications		
(@ 5 minutes/event)	20.00	140.00
Meal Preparation	60.00	420.00
Feeding		
Help with eating		
(@ 15 minutes/event)	45.00	315.00
Chore Service		420.00
Other:		
Unscheduled Needs Appellant requires additional time with tasks due to dizziness and giddiness limited use of upper extremities, abnormal gait, and constant risk of falling)	175.00	1225.00
TOTAL		4805.00

divided/60=80 hours weekly (rounded downwards)

The 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. After review of the hearing record, it is hereby held that the Appellant's representative has established the medical necessity for 80 hours per week of Personal Care Services, to be provided 7 days weekly. As such, the Managed Long-Term Care Plan's determination of April 10, 2018 to authorize the Appellant to receive Personal Care Services in the amount of 56 hours per week (8 hours per day, 7 days per week) cannot be sustained.

DECISION AND ORDER

The Managed Long-Term Care Plan's determination of April 10, 2018 to authorize the Appellant to receive Personal Care Services in the amount of 56 hours per week (8 hours per day, 7 days per week) is not correct and is reversed.

1. The MLTC Plan is directed to increase Appellant's Personal Care Services authorization to the amount of 80 hours per week, authorized over 7 days weekly.

2. The MLTC Plan is directed to advise Appellant upon the MLTC Plan complying with this fair hearing decision.

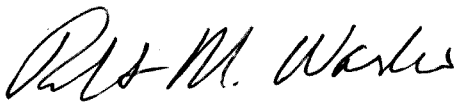
Should the MLTC Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the MLTC Plan promptly to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

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

DATED: Albany, New York
08/20/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee