STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 1, 2018
[redacted]
AGENCY: MAP
FH #: 7854417R

In the Matter of the Appeal of [redacted]	:	**DECISION AFTER FAIR HEARING**
from a determination by the New York City Department of Social Services	:	

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on November 27, 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

Julia Rolffot, Manager of Appeals, Fair Hearing Representative

ISSUE

Was the determination by the Managed Long-Term Care plan, Centers Plan for Healthy Living, to authorize a reduction of the Appellant's Personal Care Services from forty-eight (48) hours per week (8 hours per day x 6 days) to forty (40) hours per week (8 hours per day x 5 days) correct?

Was the determination by Centers Plan for Healthy Living to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours from forty (40) hours per week (8 hours per day x 5 days) and/or from forty-eight (48) hours per week (8 hours per day x 6 days) correct with regard to the adequacy of services?

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 ninety (90), has been in receipt of a Medical Assistance authorization, Medicaid benefits, and has been enrolled in a Medicaid Managed Long Term Care plan with Centers Plan for Healthy Living.

2. The Appellant resides with her daughter, age sixty-one (61).

3. The Appellant has been in receipt of a Personal Care Services authorization in the amount of forty (40) hours per week (8 hours per day x 5 days).

4. The Appellant's daughter has been providing informal care services to the Appellant on weekends.

5. The Appellant requested an authorization to increase her Personal Care Services to sixty (60) hours per week (10 hours per day x 6 days).

6. On August 31, 2018, a registered nurse assessor completed a Uniform Assessment System (UAS) evaluation of the Appellant's personal care needs based upon an in-person visit with the Appellant on said date.

7. On August 31, 2018, the Plan completed a Client Task Sheet: PCW/PCA level II evaluation report, which report estimates that the Appellant's personal care needs may be accomplished by providing to the Appellant forty-nine (49) hours of weekly task based services based upon seven (7) hours of services per day each day of the week.

8. The Appellant has a medical diagnosis which includes the following: age related cognitive decline; age related osteoporosis, dizziness and giddiness, fracture of right femur, history of falling, iron deficiency anemia, generalized muscle weakness, constipation, fatigue, generalized pain, artificial right hip joint, abnormalities of gait and mobility, osteoarthritis, urinary incontinence and vitamin B12 deficiency anemia.

9. The nurse assessor reported that the Appellant requires the following degree of assistance with the following activities of daily living: total assistance with meal preparation, ordinary housework, managing finances, shopping and locomotion; maximal assistance with managing medications, phone use, bathing, dressing lower body, walking, toilet transfer and bed mobility; extensive assistance with stairs, transportation, personal hygiene, dressing upper body and toilet use.

10. The nurse assessor also reported that the Appellant's "ADL status" had declined as compared to 90 days ago or from the last assessment.

11. On a date which was not identified at the hearing, the Plan denied the Appellants' request for an authorization to increase Personal Care Services.

12. The Appellant requested an internal appeal.

13. On October 1, 2018, the Plan issued to the Appellant a written Final Adverse Determination Denial notice which advises the Appellant that the Plan was denying the request for an authorization to increase Personal Care Services to sixty (60) hours per week (10 hours per day x 6 days), but that the Plan would authorize a "partial increase" of Personal Care Services to forty-eight (48) hours per week (8 hours per day x 6 days).

14. The Appellant appealed, internally, said determination by the Plan.

15. By written notice of Initial Adverse Determination which is dated October 3, 2018, the Plan advised the Appellant of the Plan's determination to authorize a reduction of the Appellant's Personal Care Services from forty-eight (48) hours per week (8 hours per day x 6 days) to forty (40) hours per week (8 hours per day x 5 days) on the grounds that the Appellant requested a decrease in Personal Care Services.

16. On November 1, 2018, the Appellant requested a fair hearing in this matter.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, 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.

The Department's Managed Care Personal Care Services (PCS) Guidelines dated May 2013 advise that requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with Public Health Law (PHL) Article 49, 18 NYCRR 505.14 (a), the Medicaid Managed Care (MMC) Model Contract and these guidelines. As such, denial or reduction in services must clearly set forth 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.

The NYS Department of Health, Office of Health Insurance Programs, Guidelines for the Provision of Personal Care Services in Medicaid Managed Care (published May 31, 2013), Section III (Authorization and Notice Requirements for Personal Care Services) subsection d (Level and Hours of Service), requires that 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.

By Dear Health Plan Administrator letter dated March 2, 2015, the Department advised of the implementation of model notices as of May 15, 2015, for use by Managed Long Term Care (MLTC) Partial Cap and Medicaid Advantage Plus (MAP) plans, as follows:

Model MLTC Initial Adverse Determination Notice

This model notice was developed for all administrative and medical necessity Actions, except for Actions based on a restriction to benefits. The model contains gray placeholder fields for both static (unchanging) plan-specific information, such as the time allowed to file an appeal, and dynamic fields that change with each Action notice. It is important that plans create mechanisms to ensure the various dynamic placeholders are utilized correctly to match the Action being taken. The model only addresses content requirements, all other notice procedures and requirements such as determination timeframes, provider notice, translations, special needs formats, clinical peer/health professional review, etc., remain the same.

As a reminder, the clinical rationale MUST:

- State the enrollee and the nature of his/her medical condition;
- State the medical service, treatment or procedure in question;
- State the basis or bases on which the plan/utilization review agent determined that the service, treatment or procedure is or was not medically necessary, experimental/investigational, or not materially different from an alternate in-network service, which demonstrates that the plan/agent considered enrollee-specific clinical information in its determination.
- Be sufficiently specific to enable the enrollee and the enrollee's health care provider to make an informed judgment regarding 1) whether or not to appeal the adverse determination, and 2) the grounds for such an appeal; and
- Be written in easily understood language.

Managed Long Term Care Action Taken – Denial, Reduction or Termination of Benefits (211) (LDSS-4687 02/15)

This model notice is designed to ensure enrollees are made aware of their due process rights and must be included with the Model MLTC Initial Adverse Determination Notice and all other Action notices, including those for restrictions to benefits. Considerable input from the advocate community was solicited to help clarify the language, *e.g.* regarding aid continuing rights for

services that are stopped, reduced, or restricted. Plans must develop mechanisms to ensure the form is appropriately completed for the Action being taken.

Below is a list of certain new and noteworthy aspects of this model notice:

The "MLTC reference number" may be any number the plan utilizes to track actions, authorizations, or notices.

"will not be increased" checkbox is to be utilized when an enrollee asks for more of a service during an authorization period, but the increase is denied. This is particularly relevant for enrollees in receipt of CBLTCS or who are homebound.

"detailed explanation of change in medical condition or social circumstances." This information MUST be included in the reason for denial if the Action determines to reduce or stop CBLTCS the enrollee has been receiving.

"ADD SPECIFIC BENEFIT CITATION AS APPLICABLE; for common actions and their corresponding citations, see the citation reference table" The regulatory citations have been updated and cover most medically necessary decisions. However, where there are specific regulations or statutes that govern the Medicaid managed care benefit, the plan must complete this section with additional appropriate citations. The Department will be providing a reference table of common citations that apply to MLTC, such as 18 NYCRR 505.14(a) for personal care services. However, it is the duty of each plan to research and include appropriate citations for every form it sends. Deadline "Date+60" This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.

- Deadline "Date+60" This date must be calculated from the date of the notice, informing the enrollee of the last date by which they must request a fair hearing.

- Essential action information is repeated in the box on the Fair Hearing Request Form sheet. This sheet is separate to allow the enrollee to request a fair hearing by mail and still retain their original notice. The information is repeated to facilitate OTDA processing of the fair hearing request.

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)(5) provides that:

Personal care services include, but are not necessarily limited to, the following:

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

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.

The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the patient's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc.

Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. 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.

Completing accurate and comprehensive assessments is essential to safe and adequate care plan development and appropriate service authorization. Adhering to Department assessments requirements will help assure patient quality of care and district compliance with the administration of the Personal Care Services Program.

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

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

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

This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split-shift or live-in services.

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

Remember that the contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split-shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

In addition to clarifying requirements for client notices under Mayer, the Department's regulations also reflect a Court ruling in Mayer regarding the use of task based assessments [18 NYCRR 505.14(b)(5)(v)(d)]. Specifically, social services districts are prohibited from using task-based assessments when authorizing or reauthorizing personal care services for any recipient whom the district has determined needs 24-hour care, including continuous 24-hour services (split-shift), 24-hour live-in services or the equivalent provided by a combination of formal and informal supports or caregivers. In addition, the district's determination whether the recipient needs such 24-hour personal care must be made without regard to the availability of formal or informal supports or caregivers to assist in the provision of such care. GIS 01 MA/044, issued on December 24, 2001.

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing

and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

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

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

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

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

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

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

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

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

Important Additional Information on TBA Plans:

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

1. A district cannot use a TBA plan unless the TBA plan was already in use on March 14, 1996, or the district had the Department's approval as of that date to implement a TBA plan.

This complies with the temporary restraining order in Dowd v. Bane, which the Department notified districts of in a previous GIS message, 96 MA/013, issued April 4, 1996.

2. Districts are not required to include safety monitoring as an independent task on their task-based assessment (TBA) forms. The Department recently obtained a stay of the August 21, 1997, federal court order that had required safety monitoring to be included as an independent TBA task. [See GIS 97 MA/26, issued November 6, 1997, informing districts of the stay of the order in Rodriguez v. DeBuono (SDNY, 1997).]

Pursuant to GIS 03 MA/003, issued on January 24, 2003, task-based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated 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.

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.

The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

In accordance with GIS 12 MA/026, published October 3, 2012, pursuant to the directives of the U.S. District Court for the Southern District of New York, in connection with the case of Strouchler v. Shah, the GIS directs that, 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.

18 NYCRR 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.

18 NYCRR 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.

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.

"Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.

The definitions and eligibility requirements for "continuous personal care services," "live-in 24-hour personal care services," "continuous consumer directed personal assistance" and "live-in 24-hour consumer directed personal assistance" are revised as follows:

a. 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.

b. 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 Services shall not be authorized to the extent that the individual's need for assistance can be met by voluntary assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of "some assistance" and "total assistance" are repealed.

The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

The social assessment in live-in 24-hour PCS and CDPA cases must evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

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.

DISCUSSION

The record in this matter establishes that the Appellant is ninety (90) years of age and that she has age related debility. It is undisputed between the parties that the Appellant has been hospitalized twice in the last seven (7) months due to falls and that she broke her hip due to a fall in August, 2018, after which she received the most recent hospitalization and rehabilitative

services. The record also establishes that the Appellant wears "pull-up" diapers and that she has a history of urinary incontinence. The record further establishes that the Appellant cannot walk or toilet unassisted and that she has need of assistance throughout her waking hours.

At the hearing the Appellant's daughter, with whom she resides, testified that she, the daughter, usually checks on the Appellant around 5:00 am each morning. No current need for assistance overnight was established at the hearing and the Appellant's daughter acknowledged that no request has been made of the Plan for authorization of twenty-four (24) hour daily care with regard to Personal Care Services.

Review of the Plan's October 1, 2018, Final Adverse determination to deny a request for authorization of Personal Care Services to sixty (60) hours per week (10 hours per day x 6 days) was denied because the Plan had determined that the Appellant "showed that most of your abilities to perform physical functioning stayed the same and some decline[d], therefore your hours were increased to 8 hours per day, 6 days a week for a total of 48 hours per week." It is noted that the Plan's notice does not explain why the Appellant does not need assistance on the 7th day of each week. Review of the Plan's October 3rd Initial Adverse Determination shows that the Plan advised that authorization of the Appellant's Personal Care Services would revert back to forty (40) hours per week (8 hours per day x 5 days) because the Appellant requested said reduction in hours. At the hearing the Appellant's daughter credibly testified that they complained to the Plan when the Plan denied the requested increase to ten (10) hours a day for a minimum six days per week. It appears that said complaint was considered a rejection of the authorization of forty-eight (48) hours per week. It is also noted that the reversion to forty (40) hours was made via deduction of one day of services. The Appellant's daughter contends that six days of services was requested, rather than seven (7), because they were led to believe that the Appellant would not be provided with seven (7) days of services per week. The Appellant's daughter plausibly and persuasively testified that the Appellant requires daily assistance with her activities of daily living such that the Appellant's daughter is required to fill in and provide, as an informal care giver, such services to the Appellant.

The Appellant's daughter is not bound, under law or otherwise, to provide the Appellant with informal care services. The record in this matter fails to establish that the Appellant only requires assistance with her activities of daily living six days per week. Review of the Plan's most recent task sheet shows that the Appellant was assessed to require assistance seven days per week and that the nurse determined that the Appellant's needs for assistance could be managed with seven (7) hours per day. However, based upon the most recent nurse assessment, the record shows that the Appellant requires assistance throughout her waking hours with transfers from seated to standing, with locomotion and walking, and with toilet transfers and toilet use. The Plan's determinations to wit: (1) denial of an authorization of ten (10) hours per day and (2) authorization to reduce Personal Care from six (6) days per week to five (5) days per week cannot, therefore, be sustained.

DECISION AND ORDER

The determination by Centers Plan for Healthy Living to authorize a reduction of the Appellant's Personal Care Services from forty-eight (48) hours per week (8 hours per day x 6 days) to forty (40) hours per week (8 hours per day x 5 days) is not correct and is reversed.

Centers Plan for Healthy Living is directed to:

1. Take no further action upon the Plan's determination to authorize a reduction of the Appellant's Personal Care Services to forty (40) hours per week (8 hours per day x 5 days).

The determination by Centers Plan for Healthy Living to deny the Appellant's request for an authorization to increase the amount Personal Care Services hours from forty (40) hours per week (8 hours per day x 5 days) and/or from forty-eight (48) hours per week (8 hours per day x 6 days) is not correct and is reversed.

Centers Plan for Healthy Living is directed to:

1. Immediately provide to the Appellant an authorization of Personal Care Services in the amount of seventy (70) hours per week (10 hours per day x 7 days).

2. Continue the Appellant's Personal Care Services in the amount of seventy (70) hours per week (10 hours per day x 7 days) unchanged.

Should Centers Plan for Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant 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 Managed Long Term Care plan promptly to facilitate such compliance.

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

FH# 7854417R

DATED: Albany, New York
12/05/2018

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee