STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 30, 2018
[redacted]
AGENCY: MAP
FH #: 7816962R

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 December 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 (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 partially approve the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from 10 hours per day, 5 days per week, and 8.5 hours per day, 2 days per week (67 hours weekly) to 24 hours per day, 7 days per week, provided on a live-in basis, 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 91, 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 10 hours per day, 5 days per week, and 8.5 hours per day, 2 days per week (67 hours weekly).

3. At some point, unidentified in the record, the Appellant's Representative requested an increase in the Appellant's PCS provided to the Appellant from 10 hours per day, 5 days per week, and 8.5 hours per day, 2 days per week (67 hours weekly) to 24 hours per day, 7 days per week, provided on a live-in basis.

4. On March 8, 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 March 8, 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, toileting and bed mobility; incontinence; dizziness and an unsteady gait; fatigue; moderate, intermittent pain; with deteriorated functionality.

5. The March 8, 2018 "assessment" of the Appellant generated a Task-Based Assessment Tool ("TBA") scoring the Appellant at 70 hours weekly.

6. The March 8, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 38.

7. On August 15, 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 August 15, 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, toileting and bed mobility; incontinence; dizziness and an unsteady gait; fatigue; moderate, intermittent pain; with unchanged functionality.

8. The August 15, 2018 "assessment" of the Appellant generated a Task-Based Assessment Tool ("TBA") scoring the Appellant at 70 hours weekly.

9. The August 15, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 38.

10. The Appellant moved from a 2-bedroom apartment to a studio apartment in August 2018.

11. By Initial Notice of Adverse Determination dated August 24, 2018, the Plan informed the Appellant of its determination to approve the Appellant for 10 hours per day, 7 days per week (70 hours weekly), but to otherwise deny the Appellant's request.

12. By Final Notice of Adverse Determination dated August 30, 2018, the Plan upheld its Initial Determination because of unchanged functionality.

13. On August 30, 2018, the Appellant 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.

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.

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.

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 (S.D.N.Y., 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.

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.

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 505.14(b)(3)(1)(a), provides, in pertinent part, as follows:

(3) Such medical professional must not recommend the number of hours of personal care services that the patient should be authorized to receive.

DISCUSSION

At the hearing, the Plan presented the following documents and information in support of its determinations. The Appellant has been in receipt of PCS in the amount of 10 hours per day, 5 days per week, and 8.5 hours per day, 2 days per week (67 hours weekly). At some point, unidentified in the record, the Appellant's Representative requested an increase in the Appellant's PCS provided to the Appellant from 10 hours per day, 5 days per week, and 8.5 hours per day, 2 days per week (67 hours weekly) to 24 hours per day, 7 days per week, provided on a live-in basis.

On March 8, 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 March 8, 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, toileting and bed mobility; incontinence; dizziness and an unsteady gait; fatigue; moderate, intermittent pain; with deteriorated functionality. The March 8, 2018 "assessment" of the Appellant generated a Task-Based Assessment Tool ("TBA") scoring the Appellant at 70 hours weekly. The March 8, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 38.

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hours weekly. The August 15, 2018 "assessment" of the Appellant generated a Nursing Facility Level of Care ("NFLOC") scoring the Appellant at 38.

The Appellant moved from a 2-bedroom apartment to a studio apartment in August 2018. By Initial Notice of Adverse Determination dated August 24, 2018, the Plan informed the Appellant of its determination to approve the Appellant for 10 hours per day, 7 days per week (70 hours weekly), but to otherwise deny the Appellant's request. By Final Notice of Adverse Determination dated August 30, 2018, the Plan upheld its Initial Determination because of unchanged functionality.

Still at the hearing, the Appellant's Representative presented the following relevant testimony and information in support of the Appellant's contentions. The Appellant's Representative explained that the Appellant suffered 'bruising' on the Appellant's arms and legs from struggling to turn and position in bed. It is noted, as the Plan correctly pointed out, that there was no open wound noted for the Appellant in its UAS reports. The Appellant's Representative further explained that the Appellant awoke to require hydration and medication. It is further noted that the Plan provided the Appellant with durable medical equipment ("DME") in the form of a bedside table in order to meet these needs. The Appellant's Representative also explained that the Appellant awakens from a need to toilet, requiring assistance to utilize the commode, and that this takes several attempts before the Appellant actually has to 'go'. The Plan's provision of DME in the form of a commode as well as the Appellant's functional need for transferring assistance is corroborated by the Plan's own UAS report. The Appellant's Representative additionally explained that the Appellant feels insecure without the presence of another upon awakening. It is noted that, pursuant to GIS 03 MA/03, safety monitoring is not a required standalone task. The Appellant's contentions confuse emotional desire for companionship with clinically documented medical need. It is medical need that justifies PCS services, not the personal preferences. The record is missing any significant evidence to establish a connection between any substantial change in the Appellant's medical conditions and functionality that could serve to justify an increase in PCS.

At the adjourned hearing, the parties provided 'duty sheets' and 'visit records', many starting at 20:00 on a 24-hour clock and evincing a plethora of IADL and ADL tasks. However, neither is clearly facially demonstrative of compliance with the Hearing Officer's directive with respect to their conduct of an Over Night Sleep Study ("ONSS"). These documents are therefore equivocal as to the issue of nightly needs and their frequency.

Accordingly, the Plan's determination cannot be sustained because the Appellant has daily and nightly functional deficits and consequent unpredictable needs. However, the mere fact that the Appellant resides in a studio does not, in itself, negate the ability to provide for a live-in aide and said aide's ability to obtain 5 hours of uninterrupted sleep, pursuant to GIS 12 MA/026.

DECISION AND ORDER

The the determination by the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to partially approve the Appellant's request for an increase in the amount of Personal Care Services provided to the Appellant from 10 hours per day, 5 days per week, and 8.5 hours per day, 2 days per week (67 hours weekly) to 24 hours per day, 7 days per week, provided on a live-in basis, is not correct.

1. The Plan is directed to authorize Personal Care Services for the Appellant in the amount of 24 hours per day, 7 days per week, provided on a live-in basis.

2. The Plan is directed to notify Appellant in writing upon compliance with this decision.

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

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

DATED: Albany, New York
01/02/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee