

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 19, 2019

AGENCY: MAP
FH #: 7997808M

In the Matter of the Appeal of	:
	: 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 August 13, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant



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


D. Ferguson, Plan Representative

ISSUE

Was the April 4, 2019 determination by the managed care plan to continue to provide the Appellant with personal care services in the amount of 12 hours a day by 7 days a week (84 hours weekly) correct?

FINDINGS OF FACT

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

1. The Appellant , has been in receipt of a Personal Care Services Authorization in the amount of 12 hours per day, 7 days a week (84 hours weekly) provided through Centers Plan For Healthy Living ("the Plan").

2. On March 22, 2019, the Plan received a medical request for Personal Care Services for Appellant which was completed by the Appellant's physician/nurse practitioner on March 20, 2019 and which recommends Personal Care Services in the amount of 24 hours per day, 7 days per week, continuous care ('split-shift').

3. On April 2, 2019, the Plan issued an Initial Adverse Determination wherein it notified the Appellant that it was continuing to provide 12 hours a day by 7 days a week (84 hours weekly) and denied the request to increase the amount of personal care services because "the service is not medically necessary".

4. An internal plan appeal of the April 2, 2019 determination was requested.

5. By a Final Adverse Determination Notice dated April 4, 2019, the Plan advised Appellant of its determination continuing to provide 12 hours a day by 7 days a week (84 hours weekly) and denying the request to increase the amount of personal care services because "the service is not medically necessary". The notice further stated, "You recently underwent a follow-up face-to-face clinical assessment on March 20, 2019 utilizing the New York State Department of Health's Uniform Assessment System Tool that showed many of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on January 29, 2019. Your abilities to perform physical functioning stayed the same; therefore, your hours stay the same at 12 hours per day, 7 days per week for a total of 84 hours.

6. On July 19, 2019, the Appellant requested this fair hearing to contest the Managed Long-Term Care Plan's determination.

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--

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(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.

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(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

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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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.
2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.
3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.
4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:
B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.

Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

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:

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(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;

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- (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.

Administrative Directive 12 OMM/ ADM-1 advised in relevant part that new language has been incorporated defining continuous personal care services and continuous consumer directed personal assistance as constituting uninterrupted care provided by more than one person to a consumer who requires total assistance with toileting and/or walking and/or transferring and/or feeding and which involves more than 16 hours of care per day during times that cannot be predicted or scheduled. The amended regulations also provide definitions of live-in 24 hour personal care services and live-in 24 hour consumer directed personal assistance, where no such definitions previously existed in regulation.

Specifically, the new definitions of continuous personal care services or continuous consumer directed personal assistance mean the provision of uninterrupted care, by more than one person, for more than 16 hours per day, for a consumer who, because of his or her medical condition and disabilities, requires total assistance with toileting, transferring, walking or feeding at times that cannot be predicted or scheduled. As in the past, the consumer's need for assistance is not capable of being scheduled; that is, it occurs at times that cannot be predicted, which is the language used in the amended regulations.

“Total assistance” remains defined in the regulations as meaning that a specific function or task (for continuous care, the tasks of toileting, walking, transferring or feeding) is performed and completed for the patient.

In instances when continuous personal care services or continuous consumer directed personal assistance is being considered, the nursing assessment must determine and document that the consumer requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted or scheduled [§505.14 (b)(4)(i)(c)(2) and §505.28 (d)(3)(ii)(g)].

Definitions of live-in 24-hour personal care services and live-in 24 hour consumer directed personal assistance have been added to the regulations [§505.14 (a)(5) and §505.28 (b)(8)]. This level of service has existed but is now defined in the Department's regulations. Potentially eligible individuals must have a medical condition and disabilities (functional deficits) requiring

some or total assistance with one or more personal care or CDPAP functions during the day and night and have a need for such assistance during the night that is infrequent or that can be predicted or scheduled. “Some assistance” remains defined in the regulations as meaning that a specific function or task is performed and completed by the patient with help from another individual.

The regulations require that, for recipients who may be eligible for live-in 24 hour services, the social assessment must include an evaluation whether the recipient’s home has adequate sleeping accommodations for a live-in aide [§505.14 (b)(3)(ii)(c) and §505.28 (d)(2)(v)]. Examples of adequate accommodations include an available spare bedroom, room partition or a fold-out sofa. Availability of sleep-in space for the aide shall be determined on a case by case basis by the local district, taking into account the consumer’s living situation. In determining the appropriateness of live-in 24 hour services, the local district should also assess whether the client can be safely left alone without care for a period of one or more hours per day.

The regulations promote the efficient use of resources designed to enhance the independence of individuals in support of their desire to remain in the community. To that end, the regulations require that personal care services and consumer directed personal assistance shall not be authorized if the patient’s need for assistance can be met by:

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, by promoting the consumer’s independence in the home or other location, services provided would also be cost-effective; or

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. [§§ 505.14(a)(4)(iii) and 505.28(e)(1)]

With regard to adaptive or specialized equipment (the “efficiencies”), the nursing assessment shall include a professional evaluation whether such adaptive or specialized equipment or supplies can meet the recipient’s need for assistance and whether such equipment or supplies can be provided safely and cost-effectively when compared to the provision of aide services. Such adaptive or specialized equipment or supplies include, but are not limited to, bedside commodes, adult diapers, urinals, walkers and wheelchairs

[§§ 505.14(b)(3)(iii)(b)(5) and (b)(3)(iv)(a)(7) and §505.28(d)(3)(ii)(f)].

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

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 message GIS 12 MA/ 026 advises that 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

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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.

Administrative Directive 92 ADM-49 clarifies State policy with regard to the requirement that an applicant for/ recipient of Personal Care Services have a stable health condition, and be able to self-direct, and be able to direct a Personal Care Services worker. The ADM reiterates that responsibility for making certain choices can be delegated to a self-directive individual, or to an organization.

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 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record at the hearing established that the Appellant [REDACTED], has been in receipt of a Personal Care Services Authorization in the amount of 12 hours per day, 7 days a week for a total of 84 hours weekly. On March 22, 2019, the Plan received a medical request for Personal Care Services for Appellant which was completed by the Appellant's physician/nurse practitioner on March 20, 2019 and which recommends Personal Care Services in the amount of 24 hours per day, 7 days per week, continuous care ('split-shift'). On April 2, 2019, the Plan issued an Initial Adverse Determination wherein it notified the Appellant that it was continuing to provide 12 hours a day by 7 days a week (84 hours weekly) and denied the request to increase the amount of personal care services because "the service is not medically necessary". An internal plan appeal of the April 2, 2019 determination was requested, and by a Final Adverse Determination Notice dated April 4, 2019, the Plan advised Appellant of its determination continuing to provide 12 hours a day by 7 days a week (84 hours weekly) and denying the request to increase the amount of personal care services because "the service is not medically necessary". The notice further stated, "You recently underwent a follow-up face-to-face clinical assessment on March 20, 2019 utilizing the New York State Department of Health's Uniform Assessment System Tool that showed many of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on January 29, 2019. Your abilities to perform physical functioning stayed the same; therefore, your hours stay the same at 12 hours per day. 7 days per week for a total of 84 hours.

At the hearing, the Plan submitted the Uniform Assessment System-New York Comprehensive Community Assessment Reports (UAS) dated January 29, 2019 and March 20, 2019. Attached to each report was a Level II Client Task Sheet. The Plan's reason for denying the Appellant's request stated, "many of your abilities to perform physical functioning stayed the same since your prior assessment". However, a review of the two UAS reports shows several changes. Walking, Locomotion, and toilet transfer all went from "Limited Assistance" to "Extensive Assistance", Bed Mobility went from "Supervision – Oversight & cueing" to Limited Assistance", and "Overall Self-Sufficiency in the March 20, 2019 UAS shows the Appellant's status as "Deteriorated." Additionally, the Appellant's Cognitive Skills had gone from "Minimally impaired" to "Moderately impaired", and on both reports the Appellant's decision-making skills continued to decline. As to falls, while the January UAS listed no falls, the March UAS listed "One fall in last 30 days".

The Appellant's attorney submitted letters from the Appellant physician [REDACTED], MD dated March 8, 2019 and June 28, 2019. Both letters stated the Appellant suffers from "multiple medical problems including Abnormalities of Gait and Mobility, Repeated Falls, Alzheimer's Disease, Urine Incontinence, Incontinence of Feces, Hypertension, Atherosclerotic Heart Disease, Aphasia following Cerebral Infarction, Insomnia." The March 8, 2019 letter also states that the Appellant "has a very unsteady gait and a history of multiple falls". The June 28, 2019 letter added "He was evaluated by the ER, 2 weeks ago after he fell at night".

The Appellant's niece testified that the Appellant cannot walk alone and cannot get out of the chair without assistance or risk falling. The Appellant had fallen a number of times at night

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after the homecare attendant had already left, and most recently had broken a coffee table glass causing bleeding. She also spoke about her uncle's bladder and bowel incontinence, saying he will be unaware when he is having a bowel movement and sometimes just have the movement on the floor.

The testimony and documents establish that 24-hour care is required, however, there was insufficient proof to show that the level of care necessitated continuous care. Therefore 24-hour 'live-in' would be the correct level of care.

DECISION AND ORDER

The April 4, 2019 determination by the managed care plan to continue to provide personal care services in the amount of 12 hours a day by 7 days a week (84 hours weekly) was not correct and is reversed.

1. The Plan is directed to authorize Personal Care Services to the Appellant in the amount of 24 hour 'live-in' care.

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
01/24/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "T. A. Selekmun", followed by a period.

Commissioner's Designee