STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 20, 2018
[redacted]
AGENCY: MAP
FH #: 7724090H

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on May 10, 2018, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

No appearance by Agency

ISSUE

Was the determination of the Managed Long-Term Care Plan dated March 7, 2018 to deny the Appellant's request for an increase in Personal Care Services from 9.5 hours per day for 6 days per week and 9 hours per day for 1 day per week, for a total of 66 hours per week, to 12 hours per day for 7 days per week, for a total of 84 hours per week, correct?

FINDINGS OF FACT

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

1. The Appellant, [redacted], resides with her husband, [redacted]. The Appellant has been in receipt of a Medical Assistance authorization and is enrolled as a participant in the Centers Plan for Healthy Living Managed Long-Term Care Plan (hereinafter referred to as "the Plan"). The Appellant has been in in receipt of a Personal Care Services authorization (hereinafter

referred to as "PCS") in the amount of 9.5 hours per day for 6 days per week and 9 hours per day for 1 day per week, for a total of 66 hours per week,

2. The Appellant filed an application with the Plan to increase her authorization for PCS services to 12 hours per day for 7 days per week, for a total of 84 hours per week.

3. By means of an Initial Adverse Determination dated March 7, 2018, the Plan notified the Appellant of the Plan's determination to deny the Appellant's request for personal care service hours in the amount of 12 hours per day for 7 days per week.

4 On March 20, 2018, this hearing was requested.

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 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.
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> (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.

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a

health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the program.

GIS 11 MA/009 provides that effective August 1, 2014, personal care services for non-dual eligible individuals are the responsibility of Managed Care Organizations and are now part of the Medicaid Managed Care Benefits Package under the Medicaid Managed Care Contract.

Pursuant to Social Services Law §365-a(2)(e) Medicaid provides personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Social Services Law §365-a(2)(e)(iv) provides 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.

NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

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

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i. Personal care services include some or total assistance with:
    1. Level I functions as follows:
        a. Making and changing beds;
        b. Dusting and vacuuming the rooms which the member uses;
        c. Light cleaning of the kitchen, bedroom and bathroom;
        d. Dishwashing;
        e. Listing needed supplies;

f. Shopping for the member if no other arrangements are possible;
g. Member's laundering, including necessary ironing and mending;
h. Payment of bills and other essential errands; and
i. Preparing meals, including simple modified diets.

2. Level II personal care services include Level I functions listed above and the following personal care functions:
   a. Bathing of the member in the bed, the tub or the shower;
   b. Dressing;
   c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
   d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
   e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
   f. Transferring from bed to chair or wheelchair;
   g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
   h. Feeding
   i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
   j. Providing routine skin care;
   k. Using medical supplies and equipment such as walkers and wheelchairs; and
   l. Changing of simple dressings.

MLTC Policy 16.07, issued on November 17, 2016, provides as follows:

"This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the

performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.
If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring, supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates.

NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of

particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night (emphasis in original). A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night**.** All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link: **http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf**

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight-hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at **mltcworkgroup@health.ny.gov**."

In Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y. 1996), Plaintiffs challenged New York City's efforts to reduce their personal care services. The Court found that prior to issuing any reduction notice, the Agency must first identify some development that justifies altering a

recipient's level of services. Specifically, the Agency was enjoined from reducing recipient's home care services unless the Agency's notice states that a reduction is justified because of a series of reasons as listed immediately above.

GIS 96/MA 019 states, in part,

> "In general, Mayer et al. v. Wing, (S.D.N.Y.) holds that a social services district must have a legitimate reason to reduce or discontinue a recipient's personal care services. Before reducing or discontinuing personal care services, the district must individually assess the recipient to determine whether the reduction or discontinuance is justified by State law or Department regulation. A social services district cannot reduce or discontinue a recipient's personal care services arbitrarily, capriciously or as part of a blanket, across-the-board reduction or discontinuance of services that does not consider each individual recipient's particular circumstances. This general principle is entirely consistent with the Department's policy.
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> The Mayer court, however, illustrated this general principle by setting forth six specific circumstances in which social services districts may reduce or discontinue recipients' personal care services. Effective immediately, a social services district may reduce or discontinue a recipient's personal care services only when the district has first identified that the proposed reduction or discontinuance is justified by one or more of the following reasons:
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> (1) the recipient's medical, mental, economic or social circumstances have changed;
> (2) a mistake occurred in the previous authorization of services;
> (3) the recipient refused to comply with the required reassessment of services;
> (4) a technological development renders certain services unnecessary or less time consuming;
> (5) the recipient can be more appropriately and cost-effectively served through other MA programs or services, such as assisted living programs, personal emergency response services, shared aide or other programs or services set forth in State statute or Department regulations. (This circumstance would permit districts to discontinue services based upon the results of the fiscal assessment); or,
> (6) based upon a task-based assessment that the district conducted of the recipient, the district believes that the personal care services provided under the last authorization or reauthorization can be provided in fewer hours than they were previously.
>
> When a social services district has determined to reduce or discontinue a recipient's personal care services because one or more of these circumstances exist, the district must include the specific reason for the reduction or discontinuance in the timely and adequate notice that the district sends to the recipient. This is consistent with long-standing Department policy and regulations."

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.
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> 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.
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> 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.)
>
> 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 is 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 is 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 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 (S.D.N.Y., 1997).]"

DISCUSSION

Evidence presented at the hearing on May 10, 2018 establishes that the Appellant has been in receipt of PCS services in the amount of 9.5 hours per day for 6 days per week and 9 hours per day for 1 day per week, for a total of 66 hours per week. The Appellant filed an application with the Plan to increase her authorization for PCS services to 12 hours per day for 7 days per week.

At the hearing the Appellant's attorney submitted an Initial Adverse Determination dated March 7, 2018, in response to the Appellant's request for PCS consisting of 12 hours per day for 7 days per week. The notice stated that the Appellant has been receiving PCS of 9.5 hours per day for 6 days per week and 9.0 hours for one day per week. The March 7, 2018 notice further stated that in response to the Appellant's request for an increase in PCS to 12 hours per day 7 days per week, the Plan had denied the Appellant's request for the increase and the determined that the Appellant PCS would remain the same PCS of 9.5 hours per day for 6 days per week and 9.0 hours for one day per week.

At the hearing the Appellant's attorney submitted Uniform Assessment System (UAS) Comprehensive Community Assessment Report dated February 26, 2018. The UAS report shows that the Appellant requires maximal assistance with walking, toilet use, and bed mobility. The report notes a decline in ADL (Activities of Daily Living) since a prior UAS on November 27, 2017, and also a deterioration in overall self-sufficiency as compared to the prior UAS. In regard to bladder continence, the Appellant is described as frequently incontinent. The Appellant is described as bowel continent, with complete control. The report describes the Appellant as diagnosed with conditions including osteoporosis, repeated falls, rheumatoid arthritis, unspecified dementia, and unspecified urinary incontinence. The report also describes that Appellant's daughter [redacted] as very supportive and involved in all aspects of the Appellant's care. The report states that Appellant is totally dependent for meal preparation, locomotion, and maximal assistance for toilet use and eating

As noted, the Appellant has been receiving PCS of 9.5 hours per day for 6 days per week and 9.0 hours for one day per week. The current hours run from 9:300 AM to 6:30 PM for 6 days per week, and 9:00 AM to 6:00 PM for one day per week. In regard to specific unmet needs, the Appellant's daughter stated that the Appellant's aide puts the Appellant in bed at 6:30 PM, which is not the time the Appellant wishes to go to sleep. The aide has to put the Appellant

in bed. The Appellant is urinary incontinent, cannot use the commode by herself, and needs to eat something, take her medicine, and have her diaper changed before she gets into bed.

The Appellant's daughter stated that she cannot continue to provide care for the Appellant after the aide leaves at 6:30 PM.

All the evidence has been considered. The evidence shows that the Appellant suffers from falls, is urinary incontinent, needs to have her diaper changed before she goes to sleep, and needs assistance with getting into bed. The Plan's assessment fails to address the Appellant's apparent needs for assistance between the hours of 6:30 PM and 9:00 PM. The evidence presented at the hearings indicates that the Appellant needs at least 12 hours a day of Personal Care Services for 7 days a week. The Plan's determination to deny the Appellant's request for an increase to 12 hours a day is therefore incorrect.

DECISION AND ORDER

The Plan's determination to deny the Appellant's request for an increase in the weekly number of hours of Personal Care Services from 66 hours to 84 hours was not correct and is reversed.

1. The Plan is directed to authorize increased Personal Care Services to the Appellant in the amount of 12 hours a day, 7 days weekly.

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

DATED: Albany, New York
05/15/2018

NEW YORK STATE
DEPARTMENT OF HEALTH
By

C. C. Oluoch

Commissioner's Designee