

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 13, 2019

AGENCY: MAP
FH #: 7911002H

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 March 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)

Debra Ferguson, Centers for Healthy Living, Fair Hearing Representative

ISSUE

Was the February 14, 2019 determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Personal Care Services from 84 hours per week (12 hours per day, 7 days per week) to live-in per diem, personal assistance (24 hours, 7 days per week) correct?

FACT FINDINGS

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

1. The Appellant, age ninety-four, resides alone, and is in receipt of authorization for Medical Assistance and is enrolled in a managed long term care plan operated by Centers Plan for Healthy Living.

2. The Appellant has been in receipt of an authorization for personal care services for 84 hours per week (12 hours per day, 7 days per week).

3. The Appellant has the following diagnoses: Anxiety, Coronary Heart Disease, depression, vascular dementia, gastritis, constipation, A fib, impaired balance, Parkinson Disease, Ischemic attack, hearing and vision loss. He also suffers from acute grief because of his son's recent death.

4. The Appellant is frequently incontinent of bladder and occasionally incontinent of bowel.

5. The Appellant requested an increase in his personal care service authorization from 84 hours per week (12 hours per day, 7 days per week) to live-in per diem, personal assistance (24 hours, 7 days per week).

6. On November 29, 2018, a registered nurse preformed a community assessment of the Appellant's needs and issued a Uniform Assessment System [UAS] – New York Assessment Report.

7. On February 7, 2019, a registered nurse preformed a community assessment of the Appellant's needs and issued a Uniform Assessment System [UAS] – New York Assessment Report.

8. The February 7, 2019 UAS notes that the Appellant requires **total dependence** for meal preparation, ordinary housework, shopping, transportation and managing medications; managing finances; **maximal assistance** for personal hygiene stairs, bathing, and dressing upper body and dressing lower body, walking, locomotion, and transfer toilet, toilet use.

9. The February 7, 2019 UAS notes, with respect to continence, as follows:

Bladder continence:	Frequently incontinent – Daily, but some control present
Bowel continence:	Occasionally incontinent – less than daily

10. The February 7, 2019 also notes a decline in ADL status and deterioration in overall self-sufficiency since the prior November 29, 2019 UAS report and states "supervision required at all times."

11. The Appellant requested live-in per diem, personal assistance (24 hours, 7 days per week).

12. On February 8, 2019, Centers Plan for Healthy Living issued to the Appellant a written Initial Adverse Determination which advises the Appellant of Centers Plan for Healthy Living's determination to deny the request for live-in per diem, personal assistance (24 hours, 7 days per week) and to continue to provide 84 hours per week (12 hours per day, 7 days per week).

13. The February 8, 2019 Initial Adverse Determination states the grounds for the denial as follows:

You are able to walk with the assistance of a rollator both when indoors and when in outdoors.

You can transfer on and of (sic) of the toilet and take care of your toileting needs with some assistance.

You need some help with bathing and dressing.

No unscheduled daytime or nighttime needs have been identified.

You require safety monitoring and supervision as a standalone task.

You are able to move from a lying position and turn side to side while in bed with some assistance.

You are able to feed yourself once your meals are prepared by your Personal Care Aide.

14. On February 14, 2019, Centers Plan for Healthy Living issued to the Appellant a written Final Adverse Determination which advised the Appellant of Centers Plan for Healthy Living's determination to deny the request for live-in per diem, personal assistance (24 hours, 7 days per week).

15. The February 14, 2019 Final Adverse Determination states "we are not changing our decision to deny the request for an increase in Personal Care Aide services (PCA)." Such determination further stated the "request for an increase in PCA services was denied because you "do not meet the criteria." This decision was based, in part, on the grounds as follows:

You live alone in a one-bedroom apartment on the 14th floor of a building with elevator access.

You recently underwent a follow-up face to face assessment on February 7, 2019 utilizing the New York state Department of Health's Uniform Assessment Tool that showed most of your abilities to perform physical functioning stayed the same since your prior assessment that was completed by Centers Plan for Healthy Living on November 29, 2018.

Your abilities to perform physical functioning stayed the same for dressing lower body, bathing, transfer toilet (getting on and off toilet), toilet use, eating, meal preparation, medication management and ordinary housework.

In summary, most of your abilities to perform physical functioning stayed the same; therefore, your hours stay the same at 12 hours per day, 7 days a week for a total of 84 hours per week.

This decision is based on the NYS Department of Health Uniform Assessment (UAS-NY) and the plan's client tasking tool."

16. On February 13, 2019, the Appellant requested this fair hearing.

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).

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

- (a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:
 - (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
 - (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.
 - (3) Provide that the MCO, PIHP, or PAHP--
 - (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

- (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;
 - (iii) May place appropriate limits on a service
 - (A) On the basis of criteria applied under the State plan, such as medical necessity; or
 - (B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and
- (4) Specify what constitutes “medically necessary services” in a manner that:
 - (i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
 - (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:
 - (A) The prevention, diagnosis, and treatment of health impairments.
 - (B) The ability to achieve age-appropriate growth and development.
 - (C) The ability to attain, maintain, or regain functional capacity.
- (b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:
 - (1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.
 - (2) That the MCO, PIHP, or PAHP:
 - (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
 - (ii) Consult with the requesting provider when appropriate.

- (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

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

- (a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.
- (b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:
 - (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
 - (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.
 - (3) Are adopted in consultation with contracting health care professionals.
 - (4) Are reviewed and updated periodically as appropriate.
- (c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
- (d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

- (a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.
 - (1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
 - (2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
 - (3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees,

or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

- (b) Definitions. As used in this subpart, the following terms have the indicated meanings:

In the case of an MCO or PIHP-“Action” means--

- (1) The denial or limited authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension, or termination of a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 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.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides:

- (2) Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

- (1) making and changing beds;
- (2) dusting and vacuuming the rooms which the patient uses;
- (3) light cleaning of the kitchen, bedroom and bathroom;
- (4) dishwashing;
- (5) listing needed supplies;
- (6) shopping for the patient if no other arrangements are possible;
- (7) patient's laundering, including necessary ironing and mending;
- (8) payment of bills and other essential errands; and
- (9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.

(a) Personal care functions include assistance with the following:

- (1) bathing of the patient in the bed, the tub or in the shower;

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- (2) dressing;
- (3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
- (4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;
- (5) walking, beyond that provided by durable medical equipment, within the home and outside the home;
- (6) transferring from bed to chair or wheelchair;
- (7) turning and positioning;
- (8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
- (9) feeding;
- (10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;
- (11) providing routine skin care;
- (12) using medical supplies and equipment such as walkers and wheelchairs; and
- (13) changing of simple dressings.

(b) Before continuous personal care services or live-in 24-hour personal care services may be authorized, additional requirements for the authorization of such services, as specified in clause (b)(4)(i)(c) of this section, must be met.

(b)(4) The initial authorization process shall include additional requirements for authorization of services in certain case situations:

(i) An independent medical review of the case shall be completed by the local professional director, a physician designated by the local professional director or a physician under contract with the local social services department to review personal care services cases when:

(a) there is disagreement between the physician's order and the social, nursing and other required assessments; or

(b) there is question about the level and amount of services to be provided; or

(c) the case involves the provision of continuous personal care services or live-in 24-hour personal care services as defined in paragraphs (a)(2) and (a)(4), respectively, of this section. Documentation for such cases is subject to the following requirements:

(1) The social assessment shall demonstrate that all alternative arrangements for meeting the patient's medical needs have been explored and are infeasible including, but not limited to, the provision of personal care services in combination with other formal services or in combination with voluntary contributions of informal caregivers. In cases involving live-in 24-hour personal care services, the social assessment shall also evaluate whether the patient's home has sleeping accommodations for a personal care aide. When the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must be authorized for the patient; however, should the patient's circumstances change and sleeping accommodations for a personal care aide become available in the patient's home, the district must promptly review the case. If a reduction of the patient's continuous personal care services to live-in 24-hour personal care services is appropriate, the district must send the patient a timely and adequate notice of the proposed reduction.

(2) The nursing assessment shall document the following:

(i) whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;

(ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day;

(iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day;

(iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and

(v) whether, were live-in 24-hour personal care services to be authorized, the personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(ii) The local professional director, or designee, must review the physician's order and the social and nursing assessments in accordance with the standards for services set forth

in subdivision (a) of this section, and is responsible for the final determination of the amount and duration of services to be authorized.

(iii) When determining whether continuous personal care services or live-in 24-hour personal care services should be authorized, the local professional director, or designee, must consider the information in the social and nursing assessments.

(iv) The local professional director or designee may consult with the patient's treating physician and may conduct an additional assessment of the patient in the home. The final determination must be made with reasonable promptness, generally not to exceed seven business days after receipt of the physician's order and the completed social and nursing assessments, except in unusual circumstances including, but not limited to, the need to resolve any outstanding questions regarding the amount or duration of services to be authorized.

MLTC Policy 15.09: Changes to the Regulations for Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA), effective December 23, 2015, provides:

The purpose of this policy directive is to inform Managed Long Term Care Plans (MLTCPs) of revisions to the Personal Care Services (PCS) and Consumer Directed Personal Assistance (CDPA) regulations at 18 NYCRR § 505.14 and 18 NYCRR § 505.28, respectively. These revised regulations are effective on December 23, 2015.

These changes to the PCS and CDPA regulations include, among other provisions, changes to the definitions and eligibility requirements for continuous ("split-shift") PCS and CDPA as well as live-in 24-hour PCS and CDPA. Consequently, MLTCPs must be aware of, and apply, effective immediately, the revised definitions and eligibility requirements when conducting PCA and CDPA assessments and reassessments. In addition, the revised regulations set forth revised criteria for notices that deny, reduce or discontinue these services. See the attached detailed summary of these changes and the Notice of Adoption, as published in the New York State Register on December 23, 2015.

Regulatory changes for PCS and CDPA applicable to MLTCP's include:

1. The definitions of "some assistance" and "total assistance" are repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.
2. "Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.
3. The definitions and eligibility requirements for "continuous personal care services," "live-in 24-hour personal care services," "continuous consumer directed personal assistance" and "live-in 24-hour consumer directed personal assistance" are revised as follows:

a. *Continuous personal care services* means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

b. *Live-in 24-hour personal care services* means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

c. *Continuous consumer directed personal assistance* means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours in a calendar day for a consumer who, because of the consumer's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks, and needs assistance with such frequency that a live-in 24-hour consumer directed personal assistant would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

d. *Live-in 24-hour consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides, in part, the intent of 18 NYCRR 505.14 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.

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.

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.

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.

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.

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.

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

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

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

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

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and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

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

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

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

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

Important Additional Information on TBA Plans:

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

1. A district cannot use a TBA plan unless the TBA plan was already in use on March 14, 1996, or the district had the Department's approval as of that date to implement a TBA plan. This complies with the temporary restraining order in *Dowd v. Bane*, which the Department notified districts of in a previous GIS message, 96 MA/013, issued April 4, 1996.
2. Districts are not required to include safety monitoring as an independent task on their 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).]

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 in this matter establishes that the Appellant, age ninety-four, resides alone, and is in receipt of authorization for Medical Assistance and is enrolled in a managed long-term care plan operated by Centers Plan for Healthy Living. The Appellant has been in receipt of an authorization for personal care services for 84 hours per week (12 hours per day, 7 days per week). The record also establishes that the Appellant has the following diagnoses: Anxiety, Coronary Heart Disease, depression, vascular dementia, gastritis, constipation, A fib, impaired balance, Parkinson Disease, Ischemic attack, hearing and vision loss. He also suffers from acute grief because of son's recent death.

The record further establishes that the Appellant requested an increase in her authorization for Personal Care Services from 84 hours per week (12 hours per day, 7 days per week) to live-in per diem, personal assistance (24 hours, 7 days per week).

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Bladder continence:	Frequently incontinent – Daily, but some control present
Bowel continence:	Occasionally incontinent – less than daily

The February 8, 2019 UAS also notes “supervision required at all times.”

On February 8, 2019, Centers Plan for Healthy Living issued to the Appellant a written Initial Adverse Determination which advises the Appellant of Centers Plan for Healthy Living's determination to deny the request for live-in per diem, personal assistance (24 hours, 7 days per week). The February 8, 2019 Initial Adverse Determination states, in part, the grounds for the denial as follows:

You are able to walk with the assistance of a rollator both when indoors and when in outdoors.

You can transfer on and of (sic) of the toilet and take care of your toileting needs with some assistance.

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You need some help with bathing and dressing.

No unscheduled daytime or nighttime needs have been identified.

You require safety monitoring and supervision as a standalone task.

You are able to move from a lying position and turn side to side while in bed with some assistance.

You are able to feed yourself once your meals are prepared by your Personal Care Aide.

As Centers Plan for Healthy Living found that the Appellant did not require turning and positioning, it did not recognize the need for 24 hours care, by either 24 hours per day, 7 days per week (live-in) or 24 hours a day (split-shift), or the issue as to whether or not a 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep was not addressed by Centers Plan for Healthy Living in the February 8, 2019 Initial Adverse Determination or the subsequent February 14, 2019 Final Adverse Determination.

The standards for live-in 24-hour personal care services are as follows:

Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, **needs assistance** during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance **is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.**

The definitions of "some assistance" and "total assistance" have been repealed in their entirety. This means, in part, that a "total assistance" need with certain activities of daily living is no longer an eligibility requirement for continuous personal care services or continuous consumer directed personal assistance.

Centers Plan for Healthy Living denied the Appellant's request to increase her Personal Care Assistance services to live-in per diem, personal assistance (24 hours, 7 days per week) as not "meet(ing) the criteria." Centers Plan for Healthy Living stated that "Your abilities to perform physical functioning stayed the same for dressing lower body, bathing, transfer toilet (getting on and off toilet), toilet use, eating, meal preparation, medication management and ordinary housework." However, it is noted that the February 7, 2019 indicates a '**decline**' in ADL status and deterioration in overall self-sufficiency since the prior November 29, 2019 UAS report and states "supervision required at all times." The Agency also recognizes that the Appellant is in need of supervision, in regard to decision making, and states that "Decisions consistently poor or

unsafe; cues/**supervision required at all times.**” Additionally, while the prior November 29, 2018 UAS noted, in reference to reported mood, that the Appellant had a positive attitude, the February 7, 2019, UAS noted that the member has feelings of “depression due to health condition and visits psychiatrist every 2 weeks.”

The Appellant’s representative testified at the hearing that, while the Appellant needs assistance with toileting, he believed that a personal care aide is likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide’s eight-hour period of sleep because the Appellant sleeps from 10:00 PM to 4:00 AM. He also testified that while the Appellant sleeps during the night he consistently requires extensive assistance in transferring in and out of bed and walking and would need assistance upon waking at 4:00 AM. (It is noted that the February 7, 2019 UAS indicates Maximal Assistance is needed in toilet transfer and use). Under the timing of these incidents, it is noted that a live-in would probably have 5 hours of uninterrupted sleep during an 8-hour sleep period.

The Appellant’s representative also introduced a letter from the Appellant’s physician, dated March 7, 2019, indicating the numerous health conditions from which the Appellant suffers and stating that to “insure a safe environment for this patient, I strongly recommend him to have assistance 24 hours 7 days a week.”

Additionally, it is noted that the Appellant is occasionally incontinent of bowel and frequently incontinent of bladder. Such incontinence of bowel may render management of incontinence needs with diapers unsanitary and likely to lead to skin-breakdown and other issues if Appellant is required to wait a substantial number of hours for an attendant to arrive upon waking.

Moreover, as noted above, the February 7, 2019 UAS reports a decline in ADL status and deterioration in overall self-sufficiency. This also supports the Appellant’s representative’s contention that the Appellant, at 94 years old, requires more care.

Centers Plan for Healthy Living did not offer any additional evidence to refute the Appellant’s representative’s testimony, which establishes that a personal care aide is likely to obtain, on a regular basis; five hours daily of uninterrupted sleep during the aide’s eight-hour period of sleep. Accordingly, the Appellant has established that Centers Plan for Healthy Living’s February 14, 2019 determination to deny the Appellant’s request for an increase in Personal Care Services from 84 hours per week (12 hours per day, 7 days per week) to live-in per diem, personal assistance (24 hours, 7 days per week) was not correct.

DECISION AND ORDER

The determination of the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living’s to deny the Appellant’s request for an increase in Personal Care Services from 84 hours per week (12 hours per day, 7 days per week) to live-in per diem, personal assistance (24 hours, 7 days per week), is not correct and is reversed.

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1. Centers Plan for Healthy Living is directed to authorize the Appellant for Live-in 24-hour personal care services (24 hours, 7 days per week).
2. Centers Plan for Healthy Living is directed to notify Appellant in writing upon compliance with this fair hearing decision.

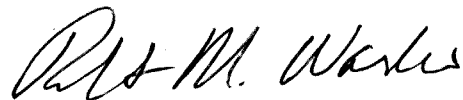
Should Centers Plan for Healthy Living's need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant and the Appellant's Representative promptly in writing as to what documentation is needed. If such information is required, the Appellant or the Appellant's representative must provide it to Centers Plan for Healthy Living promptly to facilitate such compliance.

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

DATED: Albany, New York
04/18/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee