

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

REQUEST: December 18, 2018

AGENCY: MAP  
FH #: 7880385Y

---

In the Matter of the Appeal of	:
	: <b>DECISION</b>
	<b>AFTER</b>
	: <b>FAIR</b>
	<b>HEARING</b>
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 February 21, 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)

Deborah Ferguson, Fair Hearing Representative

**ISSUE**

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the request, on the Appellant's behalf, for an increase in personal care services hours to 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, age 88, is in receipt of authorization for Medical Assistance and is enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living.
2. On or about June 18, 2018, a request was made on the Appellant's behalf for an

FH# 7880385Y

increase in personal care services from 9 hours per day, 7 days per week, to 12 hours per day, 7 days per week.

3. On June 29, 2018, Centers Plan for Healthy Living completed a Uniform Assessment System Report of the Appellant.

4. On June 29, 2018, Centers Plan for Healthy Living completed a Client Task Sheet for the Appellant which determined he required 63.00 weekly hours of personal care services.

5. By notice dated July 12, 2018, Centers Plan for Healthy Living denied the request for an increase in the Appellant's personal care services to 12 hours per day, 7 days per week.

6. Appellant's representative appealed the July 12, 2018 determination.

7. By Final Adverse Determination dated September 10, 2018, Centers Plan for Healthy Living upheld its initial determination.

8. On December 14, 2018, Centers Plan for Healthy Living completed a Uniform Assessment System Report of the Appellant.

9. On December 14, 2018, Centers Plan for Healthy Living completed Client Task Sheet for the Appellant which determined he required 66.5 weekly hours of personal care services.

10. This fair hearing was requested on December 18, 2018.

### **APPLICABLE LAW**

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.

FH# 7880385Y

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 provides, in part:

- (a) The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F.

(b)Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c)Filing requirements -

(1) Authority to file.

(i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

(A)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

42 CFR 438.408 provides, in part:

(f) Requirements for State fair hearings -

(1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

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;

FH# 7880385Y

- (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.

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 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).]

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

FH# 7880385Y

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 establishes that the Appellant, age 88, lives alone and has diagnoses which include schizophrenia, dementia, and diabetes, along with glaucoma and low vision in both eyes, hearing loss, generalized muscle weakness, gait abnormalities, osteoarthritis in his back and knees, and unspecified tremors. The record also establishes that the Appellant is in receipt of Medical Assistance, enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living (“the Plan”), and has been in receipt of personal care services in the amount of 63 hours per week, under a task based plan of care. This hearing was requested to review the Plan’s denial of the request to provide the Appellant with an increase to 84 weekly hours of personal care services.

The September 10, 2018 Final Adverse Determination upheld the Plan’s initial determination on the basis that in the June 29, 2018 assessment, Appellant had demonstrated no changes with most of his physical functioning since his prior assessment completed on January 17, 2018. Although duly notified of the time and place of the hearing, the Plan failed to produce the Appellant’s complete case record, including the complete referenced January 17, 2018 assessment. Nonetheless, review of the Plan’s own evidence put it on notice of Appellant’s status as a “Mayer III” patient, such that evaluation of the Appellant’s personal care services needs under a task based plan of care was prohibited. Pursuant to General Information System message GIS 97 MA 033, the Appellant should be provided with a personal care services authorization in an amount which, “when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours.”

According to the June 29, 2018 assessment, the Appellant requires “Maximal” assistance with walking, locomotion, “transfer toilet”, and toilet use, and he is “Frequently” incontinent of bowel and bladder and uses diapers. The nurse assessor’s notes indicate, “Member requires assistance with ADLs and IADLs due to cognitive deficit, generalized weakness, and OA...Member uses walker along with assistance from others to ambulate indoors and outdoors”. The assessment also noted Appellant had a history of falls during the previous three months.

At the hearing, the Appellant’s representative stated that the Appellant’s aide works from

FH# 7880385Y

8:00 a.m. to 5:00 p.m., at which time Appellant is put to bed where he stays until the next morning. He stated the Appellant eats dinner before he goes to bed and generally eats nothing else until the aide comes back the next day. Appellant's representative also stated the Appellant wakes in the middle of the night when his medications wear off, and he tries to get out of bed to go to the bathroom, sometimes falling; he stated the aide has found Appellant on the floor at least twice when coming on duty in the morning.

The regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. In this case, the Appellant's representative has done so. The credible evidence reflects that among things, the Appellant is in need of both daytime and nighttime unscheduled ambulation and toileting assistance, and is therefore in need of 24 hour care as a "Mayer III" patient. As such, pursuant to General Information System message GIS 97 MA 033, the Appellant should be provided with a personal care services authorization in an amount which, "when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours." On this record, the request for services of 12 hours per day suggests informal support is provided to Appellant for the remaining 12 hours per day, such that Appellant would be provided with 24 hour care. In the event of a change in circumstance, Appellant's representative must notify the Plan. Accordingly, the determination not to increase the Appellant's personal care hours is not sustained.

Centers Plan for Healthy Living is reminded that GIS 97 MA 033 advises that the contribution of family members to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever.

### **DECISION AND ORDER**

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the request, on the Appellant's behalf, for an increase in personal care services hours to 84 hours per week, was not correct and is reversed. Centers Plan for Healthy Living is directed to:

1. Authorize personal care services to the Appellant in the amount of 12 hours per day, 7 days per week, for a total of 84 weekly hours.
2. Update its records to indicate that the Appellant is a "Mayer III" client, entitled to 24 hour personal care services in the absence of formal or informal supports.
3. Notify Appellant's representative, in writing, upon compliance with this fair hearing Decision.

Should Centers Plan for Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant's representative

FH# 7880385Y

promptly in writing as to what documentation is needed. If such information is required, the Appellant's representative must provide it to Centers Plan for Healthy Living promptly to facilitate such compliance.

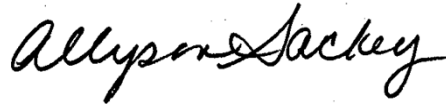
FH# 7880385Y

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  
03/08/2019

NEW YORK STATE  
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, reading "Allyson Sackey". The signature is written in a cursive style with a large, stylized 'A' and 'S'.

Commissioner's Designee