STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 3, 2018
[redacted]
AGENCY: MAP
FH #: 7802537N

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 January 2, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

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

On papers only - Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination by the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to authorize the Appellant for Personal Care Services of 63 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 81, has been enrolled in a Managed Long-Term Care Program through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

2. The Appellant had been authorized for 63 weekly hours of personal care services, under a task-based plan of care.

3. On March 29, 2018, a fair hearing (FH#[redacted]) was requested to review a 2016 determination to reduce the Appellant's personal care services from 77 hours per week to 63 hours per week; the resulting hearing scheduled on April 27, 2018 was defaulted by the Appellant.

4. On April 18, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs. Based on the April 18, 2018 report, Centers Plan for Healthy Living determined that the Appellant needs 63 hours of Personal Care Services weekly.

5. In May 2018, the Office of Administrative Hearings sent a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the April 27, 2018 hearing.

6. On August 3, 2018, the Office of Administrative Hearings received a request from the Appellant's representative to re-open the defaulted hearing, alleging that 63 hours of Personal Care Services weekly is insufficient to meet the Appellant's personal care needs. The Appellant's representative alleged that the Appellant needs 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide.

7. The request to reopen the previous hearing was denied due to lack of good cause for failure to appear at the April 27, 2018 hearing, and the present fair hearing was scheduled.

8. On September 19, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs. Based on the September 19, 2018 report, Centers Plan for Healthy Living determined that the Appellant needs 63 hours of Personal Care Services weekly.

9. The Appellant has been in receipt of 24 hour Continuous Care personal care services, pursuant to a Varshavsky "Aid-to-Continue" directive.

APPLICABLE LAW

Section 358-3.1 of the Regulations provide in part:

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).

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.

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. (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. (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...

42 CFR 438.402 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:

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(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;
(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.

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.

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

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.
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> 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.

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

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 hearing record establishes that the Appellant, age 81, has been enrolled in a Managed Long-Term Care Program through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living.

The hearing record also establishes that on March 29, 2018, a fair hearing (FH# [redacted]) was requested to review a 2016 determination to reduce the Appellant's personal care services from 77 hours per week to 63 hours per week, and the resulting hearing scheduled on April 27, 2018 was defaulted by the Appellant. In May 2018, the Office of Administrative Hearings sent a letter to the Appellant's address of record asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the April 27, 2018 hearing. On August 3, 2018, the Office of Administrative Hearings received a request from the Appellant's representative to re-open the defaulted hearing, alleging that 63 hours of Personal Care Services weekly was insufficient to meet the Appellant's personal care needs. The Appellant's representative alleged that the Appellant needs 24 hours daily, 7 days weekly, continuous service, provided by more than one Personal Care Services aide. However, the request to reopen the previous hearing was denied due to lack of good cause for failure to appear at the April 27, 2018 hearing, and the present fair hearing was scheduled.

The Appellant has been in receipt of 24 hour Continuous Care personal care services, pursuant to a Varshavsky "Aid-to-Continue" directive.

On April 18, 2018, a nursing assessor completed a Uniform Assessment System New York (UANSY) Assessment (Comprehensive) Report of the Appellant's personal care needs. Based on this report, Centers Plan for Healthy Living determined that the Appellant needed 63 hours of Personal Care Services weekly. On September 19, 2018, a nursing assessor completed a Uniform Assessment System New York (UASNY) Assessment (Comprehensive) Report of the Appellant's personal care needs. Based on this report, Centers Plan for Healthy Living determined that the Appellant needed 63 hours of Personal Care Services weekly. There is no

evidence in the record that Centers Plan for Healthy Living ever issued written notice to the Appellant of either of these authorizations, along with information describing the process for appealing these authorizations. Therefore, the Appellant is deemed to have exhausted the appeals process pursuant to applicable federal regulations.

At the time this hearing was requested, only the April 18, 2018 UASNY had been conducted. Review of this assessment put the Plan on notice of the 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 April 18, 2018 UASNY, the Appellant required "Maximal" assistance with performance of all listed ADLs, including walking, locomotion, "transfer toilet", and toilet use. The assessment indicated "Diagnosis present, monitored but no active treatment" with regard to "Full incontinence of feces", "Unspecified urinary incontinence", and "Unspecified abnormalities of gait and mobility". The nurse assessor indicated, "Member requires assistance with ADLs and IADLs due to alzheimer's [*sic*] dementia and osteoporosis. Member ambulates with a one-person assist".

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. The record has been carefully considered and does not support the Plan's determination to authorize Appellant for 63 weekly hours of personal care services. The credible evidence in the record reflects that the Appellant is in need of both daytime and nighttime ambulating and toileting assistance, and therefore in need of 24 hour care as a "Mayer III" patient. While it cannot be determined from this record whether or not a "Live-in" personal care assistant would be able to obtain five hours of interrupted sleep at night, it also cannot be determined from this record whether there would be suitable sleeping accommodation for such an assistant, as the record indicates Appellant lives in a studio apartment and also indicates Appellant lives in a one bedroom apartment. The record does not reflect adequate assessment of Appellant's social circumstances pursuant to Department policy. Pursuant to Section 505.14 of the regulations, when the patient's home has no sleeping accommodations for a personal care aide, continuous personal care services must then be authorized for the patient.

The Plan 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 by the Appellant's Managed Long-Term Care Plan, Centers Plan for Healthy Living, to authorize the Appellant for Personal Care Services of 63 hours per week was not correct and is reversed. Centers Plan for Healthy Living is directed to:

1. Authorize the Appellant for 24-hour personal care services, subject to immediate verification of suitable accommodation for a live-in aide, i. e., Live-in 24-hour personal care services are to be provided if suitable accommodation is found; if not, Continuous personal care services ("split shift") is to be provided to the Appellant.

2. Update its records to indicate that the Appellant is a "Mayer III" client, entitled to 24 hour personal care services.

3. Notify Appellant in writing upon compliance with this fair hearing Decision.

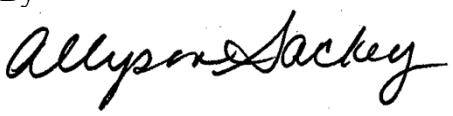
Should Centers Plan for Healthy Living need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to Centers 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
03/04/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee