STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 17, 2018
[redacted]
AGENCY: MAP
FH #: 7879518Q

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 February 5, 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)

Debra Ferguson, Fair Hearing Representative

ISSUE

Was the September 26, 2018 Initial Adverse Determination of the Centers Plan for Healthy Living Managed Care Plan, to deny Appellant's request for an increase in personal care service hours from seventy hours (70) weekly (10 hours per day x 7 days per week) to an increase to eighty-four hours (84) weekly (12 hours per day x 7 days per week) correct?

Was the October 5, 2018 Final Adverse Determination of the Centers Plan for Healthy Living Managed Care Plan, to deny appellant's request for an increase in personal care service hours from seventy hours (70) weekly (10 hours per day x 7 days per week) to an increase to eighty-four hours (84) weekly (12 hours per day x 7 days 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 84 and disabled, has been in receipt of a Medical Assistance authorization of Medicaid benefits and is enrolled in a Managed Care Plan with Centers Plan for Healthy Living.

2. The Appellant is currently authorized to receive seventy (70) hours weekly (10 hours per day x 7 days per week) of personal care services.

3. The Appellant receives personal care services through Centers Plan for Healthy Living Managed Care Program Consumer Directed Personal Assistance Services (CDPAP).

4. The Appellant has a diagnosis of [redacted].

5. The Appellant requested on September 13, 2018 an increase in the personal care hours, claiming a need for an increase to eighty-four (84) hours per week (12 hours per day x 7 days per week) weekly of personal care assistance. At the time of the Appellant's request the Appellant had been receiving seventy (70) hours weekly (10 hours per day x 7 days per week) of personal care services.

6. On February 26, 2018, the plan completed a Uniform Assessment System New York Assessment (Comprehensive) Report which is based upon a visit to and interview the Appellant by a registered Nurse Assessor on February 26, 2018.

7. By Notice of Initial Adverse Determination, dated September 26, 2018, the plan advised the appellant that the request for an increase in personal care hours to eighty-four (84) hours weekly (12 hours per day x 7 days per week) was denied because the health care service is not medically necessary.

8. By Notice of Final Adverse Determination, dated October 5, 2018 the plan advised the Appellant that the request for an increase in personal care hours to eighty-four (84) hours weekly (12 hours per day x 7 days per week) determined that the denial for an increase in

CDPAP services at 12 hours per day, 7 days a week for a total of 84 hours per week is upheld (continues to be denied) because the service is not medically necessary.

9. On December 17, 2018, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 358-5.9 of the Regulations provides that, at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance or Services, the Appellant must establish that the Agency's denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits.

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 438.404(b) of 42 CFR Subpart F provides in part:

(b) Content of notice. The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take;

(2) The reasons for the action...

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home."

Section 505.14(a) of the Regulations provides in part that:

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

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

Note: Effective April 1, 2011 Social Services Law §365-a(2)(e)(iv), which is reflected in this regulation, was amended to provide that personal care services pursuant to this paragraph shall not exceed eight hours weekly for individuals whose needs are limited to nutritional and environmental support functions.

(ii) Level II shall include the performance of nutritional and environmental support functions and personal care functions.

(a) Personal care functions shall include some or total assistance with the following:

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

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) preparing meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(8) feeding;

(9) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(10) providing routine skin care;

(11) using medical supplies and equipment such as walkers and wheelchairs; and

(12) changing of simple dressings.

Pursuant to the New York State Department of Health Guidelines for Consumer Directed Personal Assistance Services, published June 30, 2013, the scope of services regarding Consumer Directed Personal Assistance Services includes the following:

a. Purpose: Consumer Directed Personal Assistance Services is intended to permit chronically ill or physically disabled individuals receiving home care services greater flexibility and freedom of choice in obtaining such services.

b. An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative. Personal care services, home health aide services, and skilled nursing tasks shall have the same meaning as 18 NYCRR § 505.28 (b)(9), (7), & (11) respectively.

c. The terms consumer directed personal assistant and designated representative shall have the same meaning as 18 NYCRR § 505.28(b)(3) & (5).

e. Level of Service:

i. The assessment for home-based services identifies the tasks necessary to keep the enrollee safely in the home. The plan of care is developed by the enrollee with the assistance of the MCO, provider and any individuals the enrollee chooses to include.
ii. The plan of care is developed in conjunction with the enrollee based on the assessment and considers the number of hours authorized to accomplish the tasks. These tasks may include level 1 and level 2 PCS, home health aide services and/or skilled nursing tasks.
iii. The MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e).
iv. CDPAS services are managed by the enrollee in accordance with the enrollee's plan of care. The authorization should provide the number of hours authorized however, it is the enrollee who decides how those hours are arranged over the week. The MCO does maintain the right to determine whether the number of hours is appropriate to the plan of care. The FI is not responsible for assuring that the member is managing the plan of care.

18 NYCRR 505.28(b)(3) provides that "a consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer". However, a consumer directed personal assistant may include "any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary."

When the change in service needs results from a change in the consumer's medical condition, "including the consumer's loss of the ability to instruct, supervise or direct the consumer directed personal assistant", the district must obtain a new physician's order and nursing assessment. 18 NYCRR 505.28(f)(2)(ii).

Pursuant to GIS 03 MA/003, task based assessments must be developed which meet the scheduled and unscheduled day and nighttime needs of recipients of personal care services. This GIS was promulgated 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. The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night.

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.

DISCUSSION

The record in this matter establishes that the Appellant's Managed Care Consumer Directed Personal Assistance Services Plan, (CDPAP), Centers Plan for Healthy Living, had authorized Personal Care Services in the amount of seventy (70) hours weekly (10 hours per day x 7 days per week). The record also establishes that the Appellant requested on September 13, 2018, an increase of Personal Care Service hours from seventy (70) hours weekly (10 hours per day x 7 days per week) to an increase to eighty -four (84) hours per week (12 hours per day x 7 days per week) of CDPAP Personal Care Service hours. By Initial Adverse Determination dated September 26, 2018, the Managed Care Plan determined to deny the Appellant's request for an increase from seventy (70) hours weekly (10 hours per day x 7 days per week) to an increase to eight-four (84) hours (12 hours per day x 7 days) per week of personal care services. By Final Adverse Determination dated October 5, 2018, the Managed Care Plan determined to uphold its denial of the appellant's request for an increase and continued approval of seventy (70) hours per week (10 hours per day x 7 days) weekly of CDPAP, personal care services. The Appellant requested this fair hearing.

At the hearing the Managed Care Consumer Directed Personal Assistance Services (CDPAP) Plan, Centers Plan for Healthy Living submitted the Initial Adverse Determination Notice dated September 26, *2018*, marked as *MLTC Exhibit 1*; Final Adverse Determination Notice dated October 5, 2018 marked as *MLTC Exhibit 2;* Tasking Tool dated August 2, 2018 marked as *MLTC Exhibit 3,* Uniform Assessment System-New York Comprehensive Community Assessment Report marked as *MLTC Exhibit 4,* Tasking Tool dated February 26, 2018 marked as *MLTC Exhibit 5*, Uniform Assessment System-New York Comprehensive Community Assessment Report marked as *MLTC Exhibit 6*, Comments dated August 3, 2018 marked as *MLTC Exhibit 7*, Comparison Report dated August 3, 2018 marked as *MLTC Exhibit 8*, and Service Plan marked as *MLTC Exhibit 9*.

Centers Plan for Healthy Living initial adverse notice dated September 26, 2018 states in pertinent part:

"Why did we decide to deny the request?

On 09/24/2018, Centers Plan for Healthy Living decided to deny this service because the health care service is not medically necessary.

Your grandson requested an increase in your Consumer Directed Personal Assistant Program (CDPAP) services because he wants someone to supervise you in the evening hours and wants someone to assist you with completing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). A Registered Nurse from Centers Plan for Healthy Living visited you in your home on 8/3/2018 and completed a face-to-face assessment,

using the New York State Uniform Assessment System (UAS-NY). This assessment has identified your current health status, personal care skills and general care needs.

Based on this assessment, it was identified that:

You are able to walk with assistance of a walker (seated rolling).

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

You are able to take care of your toileting needs with some assistance.

You are able to bathe yourself with some assistance.

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

You require safety monitoring and supervision as a standalone task.

Your requested increase in CDPAP services along with your recent UAS-NY assessment were thoroughly reviewed by Centers Plan for Healthy Living. Based on clinical documentation presented, your current CDPAP services of ten (10) hours per day, seven (7) days per week (totaling seventy (70) hours per week) are appropriately and safely meeting your personal care needs. Therefore, your Consumer Directed Personal Assistant Program (CDPAP) services will remain the same.

Centers Plan for Healthy Living will continue to assess your health care needs. If you have any questions regarding your care, your Care Management team is available to assist at 1-855-270-1600 (toll free), 7 days a week, 8 AM-8PM.

See MLTC Exhibit 1, Centers Plan for Healthy Living Initial Adverse Determination dated September 26, 2018.

Centers Plan for Healthy Living Final Adverse Determination Notice dated October 5, 2018 states in pertinent part:

"Why am I getting this notice?

You are getting this notice because on October 3, 2018 at 1:50 a.m., you or your asked for a Plan Appeal about our decision to deny an increase in Personal Care Aide services.

On October 4, 2018, the Medical Director on the behalf of Centers Plan for Healthy Living decided we are not changing our decision to deny your request for an increase in Personal Care Aide services.

From September 1, 2018 to February 28, 2019, the plan approved: 10 hours – 7 day(s) per week – 70 hours per week.

On September 13, 2018 you or your provider requested approval for :12 hours – 7 day(s) per week – 84 hours per week.

On September 24, 2018 the plan approved: 10 hours – 7 day(s) per week – 708 hours per week.

On October 4, 2018, the plan approval stays at: 10 hours – 7 day(s) per week – 70 hours per week from September 27, 2018 to February 28, 2019.

Why did we decide to deny the request?

The Medical Director on behalf of Centers Plan for Healthy Living decided to deny this service because the service is not medically necessary.

The denial for an increase in CDPAP services at 12 hours per day, 7 days a week for a total of 84 hours per week is upheld (continues to be denied).

Your hours stay the same at 10 hours per day, 7 days a week for a total of 70 hours per week.

The member lives with her son in a two bedroom on the fifth floor of an apartment building that is elevator accessible.

You recently underwent a follow-up face-to-face clinical assessment on 8/3/18 utilizing the New York State Department of Health's Uniform Assessment System Tool) showed that most of your abilities to perform physical functioning stayed the same or improved compared to a prior assessment that was complete by Centers Plan for Healthy Living on 2/26/18.

Your ability to perform physical functioning stayed the same for meal preparation, medication management, and ordinary housework.

Your ability improved to perform dressing upper and lower body personal hygiene (cleaning yourself), bathing, transfer toilet (getting on and off the toilet) and toilet use.

In summary, you showed that most of your abilities to perform physical functioning stayed the same or improved; therefore, your hours stayed the same at 10 hours per day, 7 days a week for a total of 70 hours per week.

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

See *MLTC Plan Exhibit 2,* Final Adverse Determination Notice dated October 5, 2018.

A review of the MLTC Plan's Uniform Assessment System – New York Comprehensive Community Assessment Report (UAS) dated February 26, 2018 indicates that the Appellant requires assistance:

Total Dependence:
Meal preparation
Ordinary housework
Managing finances
Shopping
Bathing
Personal hygiene
Dressing upper body
Dressing lower body
Toilet use

Maximal Assistance:
Managing medications
Phone use
Stairs
Transportation
Walking
Locomotion
Transfer toilet
Eating

Bladder: Frequently incontinent – daily, but some control present
Bowel: Frequently incontinent – daily, but some control present
Member uses pull ups. Member's son and PCW were educated on the prevention of skin breakdown and verbalized understanding.

See *MLTC Exhibit 6,* UAS dated February 26, 2018

A review of the MLTC Plan's Uniform Assessment System – New York Comprehensive Community Assessment Report (UAS) dated August 3, 2018 indicates that the Appellant requires assistance:

Total Dependence:
Meal preparation
Ordinary housework
Managing finances
Shopping

Maximal Assistance:
Managing Medications
Phone use
Stairs
Transportation
Bathing
Dressing Lower Body

Extensive Assistance:
Personal hygiene
Dressing upper body
Walking
Locomotion
Transfer toilet

Limited Assistance:
Toilet use
Bed mobility

See MLTC Exhibit 4, UAS dated August 3, 2018

A review of *MLTC Plan Exhibit 5,* Client Tasking Sheet dated February 26, 2018, indicates that the Appellant requires 70 hours per week (10 hours per day x 7 days per week) of personal care services.

A review of *MLTC Plan Exhibit 3*, Client Task Sheet dated August 3, 2018, indicates that the Appellant requires 42 hours per week (6 hours per day x 7 days per week) of personal care services.

Centers Plan for Healthy Living's main contentions at the fair hearing were that there was no change in Appellant's medical condition from the UAS assessment dated August 3, 2018 from that of her 90 days prior to that assessment of February 26, 2018; that no medical documentation was submitted by the Appellant to justify an increase; that safety monitoring as a stand-alone purpose to supervise the Appellant is not covered and that the Appellant's medical conditions improved resulting in the Appellant requiring less assistance and therefore the Appellant's request to increase Personal Care Services is not medically necessary.

The Appellant's Representative (I.e., the Appellant's son) contended that Center's Plan for Healthy Living's documentation has inaccuracies and inconsistencies and accordingly, his mother medically requires the requested increase in Personal Care Services.

The Appellant's Representative/son, contended that the Appellant requires an increase in Personal Care Services on the grounds that the services are medically necessary and are not stand- alone safety supervision for companionship purposes. The Appellant's Representative's main contention was that the increase of hours is for safety supervision linked to daily living

tasks such as bathing, personal hygiene, toileting, escort, eating and dressing. He further testified that the Appellant cannot be left alone, because she is severely mentally impaired as indicated in the MLTC Exhibit 6 UAS dated February 26, 2018. The Appellant's Representative testified that the Appellant is 84 years old, and has the medical diagnoses of: [redacted].

In support of Appellant's claim, the Appellant submitted a medical document from the Appellant's Doctor dated May 15, 2018 which stated:

"To Whom It May Concern:
Has a Medical History of: [redacted] – eg. Fire, need close observation all the time. Is a patient of the [redacted] Hospital Geriatric Clinic and has been receiving treatment for the above mentioned medical conditions. She was last seen in the clinic on 4/13/18. For more information contact the Medical Records Department. [redacted] Attending Physician."

See *Appellant Exhibit A* dated May 15, 2018.

In addition, the Appellant's Representative submitted a physician's order for personal care/consumer directed personal assistance services dated February 1, 2019, which stated:

"Pt. is stable with vision impaired both eyes dependent on ADL's and IADLs and with advance dementia need full care… Patient is with advance dementia dependent for ADL's and IADL's fall precaution and safety."

See *Appellant Exhibit B* dated February 1, 2019 Physician's order for personal care/consumer directed personal assistance services.

The Appellant's son testified that the Appellant requires medication management at nighttime, that she cannot manage her medication alone at nighttime, and that the personal care services attendant leaves in the afternoon leaving the Appellant all alone for the evening and night. The Appellant's son stated that the Managed Long-Term Care Plan's notices are incorrect stating that he resides with the Appellant and that the Appellant actually resides alone. Moreover, the Appellant testified that the UAS's confirm that the Appellant is incontinent of bowel and bladder and has advanced dementia. The Appellant's Representative testified that the Appellant has night time unscheduled needs regarding toilet use. He stated that in the evening,

the Appellant "runs around the home, throws her pampers off, plays in the bathroom with the pampers and throws the pampers on the walls.

The evidence from both sides has been carefully reviewed (documents as well as the credible testimony) and the MLTC Centers Plan for Healthy Living's Initial Adverse Determination dated September 26, 2018 to deny the Appellant's request for an increase of personal care services (CDPAP) from seventy (70) hours weekly (10 hours per day x 7 days per week) to an increase to eighty-four (84) hours per week (12 hours per day x 7 days per week) of personal care services (CDPAP) was correct when made, however, in light of the new evidence presented by the Appellant at the fair hearing, the MLTC Centers Plan for Healthy Living's determination cannot be sustained.

The MLTC Centers Plan for Healthy Living's Final Adverse Determination dated October 5, 2018 to deny the Appellant's request for an increase of personal care services (CDPAP) from seventy (70) hours weekly (10 hours per day x 7 days per week) to an increase to eight-four (84) hours per week (12 hours per day x 7 days per week) of personal care services (CDPAP) was correct when made, however, in light of the new evidence presented by the Appellant at the fair hearing, the MLTC Centers Plan for Healthy Living's determination cannot be sustained.

DECISION AND ORDER

The September 26, 2018, Initial Adverse Determination of the Managed Care Consumer Directed Personal Assistance Services CDPAP, Centers Plan for Healthy Living, to deny appellant's request for an increase in personal care hours from seventy (70) hours weekly (10 hours per day x 7 days per week) to and increase to eighty-four (84) hours weekly (12 hours per day x 7 days per week) was correct when made, however, The Managed Care Plan Centers Plan for Healthy Living Consumer Directed Personal Services (CDPAP), is directed to:

1. immediately provide the appellant with an authorization of Personal Care Services in the amount of eighty-four (84) hours (12 hours per day x 7 days) weekly.

2. notify the Appellant in writing of the plan's authorization increasing Personal Care Services to eighty-four (84) hours weekly (12 hours per day x 7 days per week) in compliance with this decision.

The October 5, 2018 Final Adverse Determination of the Managed Care Consumer Directed Personal Assistance Services (CDPAP) Centers Plan for Healthy Living to deny appellant's request for an increase in personal care hours from seventy (70) hours weekly (10 hours per day x 7 days per week) to an increase to eight-four (84) hours weekly (12 hours per day x 7 days per week) to an increase to eight-four (84) hours weekly (12 hours per day x 7 days per week) was correct when made, however, The Managed Care Plan Centers Plan for Healthy Living Consumer Directed Personal Services (CDPAP), is directed to:

1. immediately provide the appellant with an authorization of Personal Care Services in the amount of eighty-four (84) hours (12 hours per day x 7 days) weekly.

2. notify the Appellant in writing of the plan's authorization increasing Personal Care Services to eighty-four (84) hours weekly (12 hours per day x 7 days per week) in compliance with this decision.

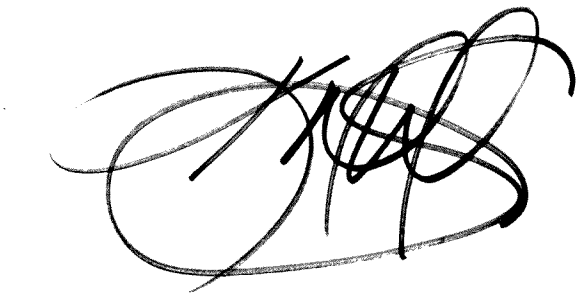
Should the Managed Care Centers Plan for Healthy Living Consumer Directed Personal Assistance Services (CDPAP), need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Managed Care Plan promptly to facilitate such compliance.

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

DATED: Albany, New York
02/13/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee