STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: February 13, 2018
[redacted]
AGENCY: MAP
FH #: 7704209Y

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 March 22, 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)
Appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long-Term Care Plan to deny the Appellant's representative's request for an increase to the Appellant's Consumer Directed Personal Assistance Services ("CDPAS") to 84 hours a week (authorized over12 hours daily 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 88, who resides with her son, has been in receipt of Medicaid and is enrolled in a partial capitation Managed Long Term Care Plan ("MLTC Plan") operated by Centers Plan for Healthy Living (hereinafter "Centers Plan" or "MLTC Plan").

2. The Appellant has been in receipt of an authorization for Consumer Directed Personal Assistance Program ("CDPAP") and was receiving Consumer Directed Personal Care Services ("CDPAS") in the amount of 49 hours per week, authorized over 7 hours per day, 7 days per week.

3. The Appellant's representative requested an increase in Appellant's Consumer Directed Personal Care Services to 12 hours daily 7 days weekly.

4. On January 29, 2018, the MLTC Plan re-evaluated the Appellant's Personal care needs wherein the reviewing nurse determined that the Appellant's ADL status had "declined" and that Appellant's overall self-sufficiency had "deteriorated" since the previous assessment on September 18, 2017. The Task Sheet prepared based on the assessment of January 29, 2018 indicated that the MLTC Plan determined that the Appellant's PCS needs ("PCS") totaled 56 hours per week with a recommendation for authorization for 56 hours per week, authorized over 8 hours per day, 7 days per week.

5. On February 7, 2018, the MLTC Plan advised the Appellant that her request for an increase of Consumer Directed Personal Care Services to 12 hours daily, 7 days weekly was denied; however, based on the MLTC Plan's assessment of January 29, 2018 and the client's tasking tool the Appellant's CDPAS authorization would be increased to 56 hours per week, authorized over 8 hours per day, 7 days per week.

7. On February 13, 2018, the Appellant requested this fair hearing.

8. As a result of the matter of Varshavsky v. Perales, this fair hearing was rescheduled to be heard in the Appellant's home on March 22, 2019.

APPLICABLE LAW

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

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

> (a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:
>
> (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
>
> (2) Require that the services identified in paragraph (a)(1) of this section be

furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

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

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

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

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

In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total 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:

(2) Some or total assistance shall be defined as follows:

i) Some assistance shall mean that a specific function or task is performed and completed by the patient with help from another individual.

ii) Total assistance shall mean that a specific function or task is performed and completed for the patient.

(3) Continuous personal care services means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

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(5) Live-in 24-hour personal care services means the provision of care by one person for a patient who, because of the patient's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted.

NYS DEPARTMENT OF HEALTH

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

I. Scope of the Personal Care Benefit

(a) vii. Personal care services includes some or total assistance with:

1. Level I functions as follows:

a. Making and changing beds ;

b. Dusting and vacuuming the rooms which the member uses;

c. Light cleaning of the kitchen, bedroom and bathroom;

d. Dishwashing;

e. Listing needed supplies;

f. Shopping for the member if no other arrangements are possible;

g. Member's laundering, including necessary ironing and mending;

h. Payment of bills and other essential errands; and

i. Preparing meals, including simple modified diets.

2. Level II personal care services include Level I functions listed above and the following personal care functions:

a. Bathing of the member in the bed, the tub or the shower;

b. Dressing;

c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;

e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;

f. Transferring from bed to chair or wheelchair;

g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;

h. Feeding;

i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;

j. Providing routine skin care;

k. Using medical supplies and equipment such as walkers and wheelchairs; and

l. Changing of simple dressings….

III. Authorization and Notice Requirements for Personal Care Services

e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

ii. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).

iii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.

iv. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:

1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

2. a mistake occurred in the previous personal care services authorization;

3. the member refused to cooperate with the required assessment of services;

4. a technological development renders certain services unnecessary or less time consuming;

5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;

6. the member's health and safety cannot be reasonably assured with the provision of personal care services;

7. the member's medical condition is not stable;

8. the member is not self-directing and has no one to assume those responsibilities;

9. the services the member needs exceed the personal care aide's scope of practice.

The CMS State Medicaid Manual provides guidelines as to the services and benefits that must be provided under State Medicaid programs, including managed long-term care. It provides, in relevant part:

A State developed alternate resident assessment instrument must provide frameworks for comprehensive assessment in the following care areas:

- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of daily living functional potential;
- Rehabilitation potential (HCFA's instrument combines the Rehabilitation RAP with the ADLs RAP);
- Urinary incontinence and indwelling catheter;
- Psychosocial well-being (In the HCFA-designated instrument, in addition to a distinct psychosocial well-being protocol, there are three distinct RAPs that bear on psychosocial functioning: "mood", "behavior", and "delirium".);
- Activities;
- Falls;
- Nutritional status;
- Feeding tubes;
- Dehydration/fluid maintenance;
- Dental Care;
- Pressure ulcers;
- Psychotropic drug use; and
- Physical restraints.

Section 365-f of the Social Services Law pertains to the Consumer Directed Personal

Assistance Program ("CDPAP") and provides:

1. Purpose and intent. The consumer directed personal assistance program is intended to permit chronically ill and/or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services. The department shall, upon request of a social services district or group of districts, provide technical assistance and such other assistance as may be necessary to assist such districts in assuring access to the program.

2. Eligibility. All eligible individuals receiving home care shall be provided notice of the availability of the program and shall have the opportunity to apply for participation in the program. On or before October first, nineteen hundred ninety-six each social services district shall file an implementation plan with the commissioner of the department of health. An "eligible individual", for purposes of this section is a person who:

(a) is eligible for long term care and services provided by a certified home health agency, long term home health care program or AIDS home care program authorized pursuant to article thirty-six of the public health law, or is eligible for personal care services provided pursuant to this article;

(b) is eligible for medical assistance;

(c) has been determined by the social services district, pursuant to an assessment of the person's appropriateness for the program, conducted with an appropriate long term home health care program, a certified home health agency, or an AIDS home care program or pursuant to the personal care program, as being in need of home care services or private duty nursing and is able and willing or has a legal guardian able and willing to make informed choices, or has designated a relative or other adult who is able and willing to assist in making informed choices, as to the type and quality of services, including but not limited to such services as nursing care, personal care, transportation and respite services; and

(d) meets such other criteria, as may be established by the commissioner, which are necessary to effectively implement the objectives of this section.

3. Division of responsibilities. Eligible individuals who elect to participate in the program assume the responsibility for services under such program as mutually agreed to by the eligible individual and provider and as documented in the eligible individual's record. Such individuals shall be assisted as appropriate with service coverage, supervision, advocacy and management. Providers shall not be liable for fulfillment of responsibilities agreed to be undertaken by the eligible individual. This subdivision, however, shall not diminish the participating provider's liability for failure to exercise reasonable care in properly carrying out its responsibilities under this program, which shall include monitoring such individual's continuing ability to fulfill those responsibilities documented in his or her records. Failure of the individual to carry out his or her agreed to responsibilities may be considered in

determining such individual's continued appropriateness for the program....

Local Commissioners Memorandum 95 LCM-102 pertains to the Consumer Directed Personal Assistance Program (CDPAP) and, states in part:

> Section 91 of Chapter 81 of the Laws of 1995 added a new Section 367-f to the Social Services Law. This Section states that "...each local district shall ensure access to a consumer directed personal assistance program operated pursuant to section three hundred sixty-five-f of this title is available in the district to allow persons receiving home care pursuant to this title to directly arrange and pay for such care."
>
> The purpose of CDPAP is to allow chronically ill and/or physically disabled individuals receiving home care services under the Medical Assistance program greater flexibility and freedom of choice in obtaining such services while reducing administrative costs....
>
> Eligible individuals who elect to participate in CDPAP assume the responsibility for services under the program as mutually agreed to by the eligible individual and the provider as documented in the individual's record. Such responsibilities may include:
>
> 1. Recruit workers
> 2. Hire workers
> 3. Train workers
> 4. Supervise workers
> 5. Fire workers
> 6. Arrange for back-up coverage when necessary
> 7. Arrange/coordinate provision of other services
> 8. Maintain records for processing of payroll and benefits.

Providers shall not be liable for fulfillment of responsibilities agreed to be undertaken by individuals participating in CDPAP. This does not, however, diminish the provider's liability for failure to exercise reasonable care in properly carrying out its responsibilities under this program. Such responsibilities include monitoring the individual's continuing ability to fulfill those responsibilities documented in his or her record. An individual's failure to carry out the agreed responsibilities may be considered in determining that person's continued appropriateness for the program.

The New York State Department of Health released a statement entitled "Policy for the Transition of Consumer Directed Personal Assistance Services into Managed Care." This announces, in part, the CDPAP is to be covered by Managed Care Plans and MLTC Plans commencing November 1, 2012.

18 NYCRR 505.14(g) provides, in part:

(g) Case management.

(1) All patients receiving personal care services must be provided with case management services according to this subdivision...

(3) Case management includes the following activities...

arranging for the delivery of personal care services according to subdivision (c) of this section….

monitoring personal care services to ensure that such services are provided according to the authorization and that the patient's needs are appropriately met...

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.

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.

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**.**

Section 505.14(a)(4)(iii) of the regulations provides personal care services shall not be authorized if the patient's need for assistance can be met by either or both of the following:

(a) voluntary assistance available from informal caregivers including, but not limited to, the patient's family, friends or other responsible adult; or formal services provided by an entity or agency; or

(b) adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers and wheelchairs, when such equipment or supplies can be provided safely and cost-effectively.

Under Section 505.14(a)(4) of the Regulations, 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 the regulations of the Department of Health.

General Information Service message GIS 15 MA/24 advises social services districts of the revisions to the Personal Care Services (18 NYCRR 505.14) and Consumer Directed Personal Assistance Program (18 NYCRR 505.28) regulations, effective December 23, 2015.

Regulations at 18 NYCRR 505.28 provide, with regard to the Consumer directed personal assistance program.

(a) Purpose. The consumer directed personal assistance program is intended to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.

(b) Definitions. The following definitions apply to this section:

(1) "consumer" means a medical assistance recipient who a social services district has determined eligible to participate in the consumer directed personal assistance program.

(2) "consumer directed personal assistance" means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

(3) "consumer directed personal assistant" means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative. 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.

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

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(9) a "self-directing consumer" means a consumer who is capable of making choices regarding the consumer's activities of daily living and the type, quality and management of his or her consumer directed personal assistance; understands the impact of these choices; and assumes responsibility for the results of these choices.

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(c) Eligibility requirements. To participate in the consumer directed personal assistance program, an individual must meet the following eligibility requirements:

(1) be eligible for medical assistance;

(2) be eligible for long term care and services provided by a certified home health agency, long term home health care program or an AIDS home care program authorized pursuant to Article 36 of the Public Health Law; or for personal care services or private duty nursing services;

(3) have a stable medical condition;

(4) be self-directing or, if non self-directing, have a designated representative;

(5) need assistance with one or more personal care services, home health aide services or skilled nursing tasks;

(6) be willing and able to fulfill the consumer's responsibilities specified in subdivision (g) of this section or have a designated representative who is willing and able to fulfill such responsibilities; and

(7) participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes specified in subdivisions (d) and (f) of this section.

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(**f) Reassessment and reauthorization processes**.

(1) Prior to the end of the authorization period, the social services district must reassess the consumer's continued eligibility for the consumer directed personal assistance program in accordance with the assessment process set forth in subdivision (d) of this section.

(i) The reassessment must evaluate whether the consumer or, if applicable, the consumer's designated representative satisfactorily fulfilled the consumer's responsibilities under the consumer directed personal assistance program. The social services district must consider whether the consumer or, if applicable, the consumer's designated representative has failed to satisfactorily fulfill the consumer's responsibilities when determining whether the consumer should be reauthorized for the consumer directed personal assistance program.

(ii) When the social services district determines, pursuant to the reassessment process, that the consumer is eligible to continue to participate in the consumer directed personal assistance program, the district must reauthorize consumer directed personal assistance in accordance with the authorization process specified in subdivision (e) of this section. When the district determines that the consumer is no longer eligible to continue to participate in the consumer directed personal assistance program, the district must send the consumer, and such consumer's designated representative, if any, a timely and adequate notice under Part 358 of this chapter of the district's intent to discontinue consumer directed personal assistance on forms required by the department.

(2) The social services district must reassess the consumer when an unexpected change in the consumer's social circumstances, mental status or medical condition occurs during the authorization or reauthorization period that would affect the type, amount or frequency of consumer directed personal assistance provided during such period. The district is responsible for making necessary changes in the authorization or reauthorization on a timely basis in accordance with the following procedures:

(i) When the change in the consumer's service needs results solely from an unexpected change in the consumer's social circumstances including, but not limited to, loss or withdrawal of informal supports or a designated representative,

the social services district must review the social assessment, document the consumer's changed social circumstances and make changes in the authorization or reauthorization as needed. A new physician's order and nursing assessment are not required; or

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

(**g**) **Consumer responsibilities**. A consumer or, if applicable, the consumer's designated representative has the following responsibilities under the consumer directed personal assistance program:

(1) managing the plan of care including recruiting and hiring a sufficient number of individuals who meet the definition of consumer directed personal assistant, as set forth in subdivision (b) of this section, to provide authorized services that are included on the consumer's plan of care; training, supervising and scheduling each assistant; terminating the assistant's employment; and assuring that each consumer directed personal assistant competently and safely performs the personal care services, home health aide services and skilled nursing tasks that are included on the consumer's plan of care;

(2) timely notifying the social services district of any changes in the consumer's medical condition or social circumstances including, but not limited to, any hospitalization of the consumer or change in the consumer's address, telephone number or employment.

(3) timely notifying the fiscal intermediary of any changes in the employment status of each consumer directed personal assistant;

(4) attesting to the accuracy of each consumer directed personal assistant's time sheets;

(5) transmitting the consumer directed personal assistant's time sheets to the fiscal intermediary according to its procedures;

(6) timely distributing each consumer directed personal assistant's paycheck**,** if needed;

(7) arranging and scheduling substitute coverage when a consumer directed personal assistant is temporarily unavailable for any reason; and

(8) entering into a department approved memorandum of understanding with the fiscal intermediary and with the social services district that describes the parties' responsibilities under the consumer directed personal assistance program.

(**h**) **Social services district responsibilities**. Social services districts have the following responsibilities with respect to the consumer directed personal assistance program:

(1) annually notifying recipients of personal care services, long term home health care program services, AIDS home care program services or private duty nursing services of the availability of the consumer directed personal assistance program and affording them the opportunity to apply for the program;

(2) complying with the assessment, authorization, reassessment and reauthorization procedures specified in subdivisions (d) through (f) of this section;

(3) receiving and promptly reviewing, the fiscal intermediary's notification to the district pursuant to subparagraph (i)(1)(v) of this section of any circumstances that may affect the consumer's or, if applicable, the consumer's designated representative's ability to fulfill the consumer's responsibilities under the program and making changes in the consumer's authorization or reauthorization as needed;

(4) discontinuing, after timely and adequate notice in accordance with part 358 of this chapter, the consumer's participation in the consumer directed personal assistance program and making referrals to other services that the consumer may require when the district determines that the consumer or, if applicable, the consumer's designated representative is no longer able to fulfill the consumer's responsibilities under the program or no longer desires to continue in the program;

(5) notifying consumers, on forms required by the department, of the district's decision to authorize, reauthorize, increase, reduce, discontinue or deny services under the consumer directed personal assistance program, and of the consumer's right to request a fair hearing pursuant to part 358 of this chapter. The social services district's decision to deny, reduce or discontinue consumer directed personal assistance must be stated in the notice.

(i) Appropriate reasons and notice language to be used when denying consumer directed personal assistance include but are not limited to the following:

(a) the consumer's health and safety cannot be assured with the provision of consumer directed personal assistance. The notice must identify the reason or reasons that the consumer's health and safety cannot be assured with the provision of such assistance;

(b) the consumer's medical condition is not stable. The notice must identify the consumer's medical condition that is not stable;

(c) the consumer is not self-directing and has no designated representative to assume those responsibilities;

(d) the consumer refused to cooperate in the required assessment;

(e) a technological development, which the notice must identify, renders certain services unnecessary or less time-consuming;

(f) the consumer resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed assistance; and

(g) the consumer or, if applicable, the consumer's designated representative is unable or unwilling to fulfill the consumer's responsibilities under the program.

(ii) Appropriate reasons and notice language to be used when reducing or discontinuing consumer directed personal assistance include but are not limited to the following:

(a) the consumer's medical or mental condition or economic or social circumstances have changed and the district determines that the consumer directed personal assistance provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. For proposed discontinuances, this includes but is not limited to cases in which: the consumer's health and safety can no longer be assured with the provision of consumer directed personal assistance; the consumer's medical condition is no longer stable; or the consumer is no longer self-directing and has no designated representative to assume those responsibilities. The notice must identify the specific change in the consumer's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the assistance should be reduced or discontinued as a result of the change;

(b) a mistake occurred in the previous authorization or reauthorization for consumer directed personal assistance. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior assistance is not needed as a result of the mistake;

(c) the consumer refused to cooperate in the required reassessment;

(d) a technological development, which the notice must identify, renders certain assistance unnecessary or less time-consuming;

(e) the consumer resides in a facility or participates in another program or receives other services, which the notice must identify, which are responsible for the provision of needed assistance; and

(f) the consumer or, if applicable, the consumer's designated representative is no longer able or willing to fulfill the consumer's responsibilities under the program or the consumer no longer desires to continue in the program.

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

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

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

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

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

2. "Turning and positioning" is added as a specific Level II personal care function and as a CDPA function.

3. The definitions and eligibility requirements for "continuous personal care services", "live-in 24-hour personal care services," "continuous consumer directed personal assistance" and "live-in 24-hour consumer directed personal assistance" are revised as follows:

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

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

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

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

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits 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.

DISCUSSION

The record establishes that the Appellant, age 88, who is residing alone, suffers from numerous chronic medical conditions, including Alzheimer's, dementia, anxiety disorder, depression, chronic pain syndrome, edema, essential (primary) hypertension, gastro-esophageal reflux disease, insomnia, primary generalized (osteo)arthritis, thyrotoxicosis (unspecified without thyrotoxic crisis or storm), unspecified abnormalities of gait and mobility, urinary incontinence. Evidence regarding these diagnoses was obtained from the MLTC Plan's evidence packet, and the medical documentation submitted by the Appellant.

The record also establishes that the Appellant, has been in receipt of Medicaid and is enrolled in a partially capitated Managed Long Term Care Plan ("MLTC Plan") operated by Centers Plan for Healthy Living (hereinafter "Centers Plan" or "MLTC Plan"); and that the Appellant has been in receipt of an authorization for Consumer Directed Personal Assistance Program ("CDPAP") and was receiving Consumer Directed Personal Care Services ("CDPAS") in the amount of 49 hours per week, authorized over 7 hours per day, 7 days per week.

The record also establishes that the Appellant's representative requested an increase in Appellant's Consumer Directed Personal Care Services to 12 hours daily, 7 days weekly; and that by notice dated February 7, 2018, the MLTC Plan advised the Appellant that her request for increase of Consumer Directed Personal Care Services to 12 hours daily, 7 days weekly was denied. However, based on the MLTC Plan's assessment of January 29, 2018 and the client's tasking tool the Appellant's CDPAS authorization will be increased to 56 hours per week, authorized over 8 hours per day, 7 days per week.

The Appellant's representative, who is Appellant's son, testified that he is the Appellant's aide and that his hours are 9am to 5pm. The Appellant's son testified that when the Appellant is left by herself she can turn on gas or water and that the most important issue is the Appellant's safety. The Appellant's son further testified that the Appellant requires assistance with cooking, cleaning, going outside and constant supervision because Appellant's "head does not work" and it is documented by neurologist. The Appellant's son also testified that during the day he helps Appellant to walk to and from the bathroom and then waits outside the door with the Appellant using the bathroom by herself. The Appellant's representative/son further testified that Appellant was hit by a car in the summer of last year and that recently after assessment (the MLTC Plan's assessment of January 29, 2018) Appellant started to have pain on her side and was prescribed physical therapy twice per week. The Appellant's son further testified that the Appellant did not experience any falls within the last 90 days. The Appellant's son further testified that he lives with the Appellant because he is taking care of her beyond the time that is approved by the MLTC Plan.

At the hearing, the MLTC Plan presented a Physician's Order for Personal Care/Consumer Directed Personal Assistance Services, dated January 15, 2018, from the Appellant's physician. This Order stated that the Appellant's primary diagnosis is Alzheimer's Dimension with Disbalance/central vertigo listed as secondary diagnosis. The Order further stated that Appellant ambulated with a device and further stated that "[Appellant] periodically requires human

assistance…periodically drops cane or walker and wanders w/o realizing of risk of falling." In the Section of the Order regarding prohibited activities and functional limitations, the Appellant's physician stated "fall prevention, distancing from cooking (stove), electrical equipment. Needs supervision for safety, again wandering and falls." The Order further stated that the Appellant needed to follow a low fat and low sodium diet; that the Appellant was prescribed 7 medications with one to be taken 3 times per day; and that she received physical therapy for her knees, gait treatment and balance therapy. In the Contributing Factors Section of the Order, the Appellant's physician stated that "[Appellant] need assistance in the performing tasks of daily living – cooking, dressing, bathing (personal hygiene), shopping, remembering appointments, medications, paying bills. She needs to follow structure and routine. [Appellant] has impaired special orientation and needs human assistance finding her way…becomes irritable/anxious with unfamiliar faces, and periodically displays aggressiveness. [Appellant] will be safe with 24 h care."

At the hearing, MLTC Plan presented the assessment of January 29, 2018, wherein the reviewing nurse determined that the Appellant's ADL status had "declined" and that Appellant's overall self-sufficiency had "deteriorated" since previous the assessment on September 18, 2017. The Task Sheet prepared, based on the assessment of January 29, 2018, indicated that the Appellant's PCS needs ("PCS") totaled 56 hours per week with a recommendation for authorization for 56 hours per week, authorized over 8 hours per day, 7 days per week. The reviewing nurse determined that the Appellant requires "maximal assistance – weight bearing support (including lifting limbs) by 2+ helpers – or – weight bearing support for more than 50% of subtasks with meal bathing, personal hygiene, dressing upper and lower body, walking, locomotion, transfer toilet and toilet use, bed mobility, transportation, managing medication and finances; that the Appellant required "extensive assistance – weight bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks" with eating and phone use; and was "totally dependent" with meal preparation, ordinally housework and shopping. The UAS Report further indicated that the Appellant was prescribed 8 different medication to be taken once daily. The reviewing nurse further commented that "[Appellant] requires assistance with I/ADL's due to cognitive impairment, member's son reports that member requires constant supervision and is unsafe alone…ambulates using cane…son pre pours medication and administers them to member." The UAS Report of January 29, 2018 further indicated that the Appellant was frequently incontinent of bladder (daily but some control present) and continent of bowel (complete control).

The Plan is not required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized, although, the appropriate monitoring of the Appellant 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 is allowed.

Since it has been established that the Appellant requires maximal and extensive assistance with a number of activities of daily living, the Appellant requires, at minimum, the following time per week for her Personal Care Service needs:

TASK	MINUTES/DAY	MINUTES PER WEEK
Bathing	20.00	140.00
Dressing	15.00	105.00
Grooming	15.00	105.00
Routine Skin Care	10.00	70.00
Shampooing		30.00
Indoor Mobility	20.00	140.00
Toileting		
Toilet	60.00	420.00
Transferring		
(@ 15 minutes/event)	60.00	420.00
Outdoor Mobility		120.00
Preparation for bed	30.00	210.00
Medications		
(@ 5 minutes/event)	15.00	105.00
Meal Preparation	60.00	420.00
Help with Eating		
(@ 15 minutes/event)	45.00	315.00
Chore Service	60.00	420.00
TOTAL		3,020.00

divided/60= 50 hours weekly (rounded downwards)

At the March 22, 2019 home hearing, the Appellant's son reiterated that his mother needs the additional care because she might dress, go out the door herself onto the street and wander, getting lost or injured. This contradicted his testimony that he must help his mother walking; and contradicted the Plan reports, which state that the Appellant needed maximal assistance with regular ADLs. The Appellant again presented the January 18, 2018 "Physician Order for Personal Care Services" document, however, the doctor's reasoning is mostly directed towards safety monitoring due to wandering. The majority of the testimony and documentation stressed the Appellant's safety. As noted above, the Plan is not required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized.

Pursuant to the above cited Regulations, at a fair hearing concerning the denial of services, an Appellant must establish that he or she is eligible for a greater amount of such services. The record fails to establish that the MLTC Plan's authorization of 56 hours of CDPAS per week is insufficient to assist the Appellant's with performance of Level II necessary personal services listed above, including monitoring of the Appellant to ensure that necessary tasks are safely completed. It is therefore held that, based on all of the foregoing, the Appellant's representative failed to so establish that the determination of the Appellant's Managed Long-Term Care Plan to deny the Appellant's representative's request for an increase to the Appellant's Consumer Directed Personal Assistance Services ("CDPAS") to 84 hours per week (authorized over12 hours daily, 7 days per week) was not correct.

This Decision After Fair Hearing does not prevent the Appellant from requesting future increases in her Personal Care Services hours by providing the Plan with medical documentation demonstrating alleged changes in the Appellant's current medical conditions.

DECISION

The determination of the Appellant's Managed Long-Term Care Plan to deny the Appellant's representative's request for an increase to the Appellant's Consumer Directed Personal Assistance Services ("CDPAS") to 84 hours per week (authorized over12 hours daily, 7 days per week) is correct.

DATED: Albany, New York
04/03/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee