**STATE OF NEW YORK**
**DEPARTMENT OF HEALTH**

**REQUEST:** June 19, 2018
[redacted]
**AGENCY:** MAP
**FH #:** 7776770Z

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 October 10, 2018, 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")

Centers Plan for Healthy Living's appearance waived by the Office of Administrative Hearings

## ISSUE

Was the June 15, 2018 determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in Consumer Directed Personal Assistance Services (CDPAS) hours from 56 hours per week (eight hours per day, seven days per week) to 84 hours per week (12 hours per day, seven 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, has been enrolled in a Managed Long Term Care Program and has been receiving care and services, including Consumer Directed Personal Assistance Services (CDPAS), through a Managed Long Term Care Health Plan operated by Centers Plan for

Healthy Living.

2. The Appellant has been in receipt of Consumer Directed Personal Assistance Services (CDPAS) hours in the amount of 56 hours per week (eight hours per day, seven days per week).

3. The Appellant requested that her Consumer Directed Personal Assistance Services (CDPAS) hours be increased from 56 hours per week (eight hours per day, seven days per week) to 84 hours per week (12 hours per day, seven days per week).

4. On March 12, 2018, a nurse from Centers Plan for Healthy Living completed a Uniform Assessment System New York Assessment (Comprehensive) Report (UAS Report) of the Appellant's Consumer Directed Personal Assistance Services' (CDPAS) needs, and recommended that the Appellant receive Consumer Directed Personal Assistance Services (CDPAS) in the amount of 49 hours per week.

5. On March 23, 2018, Centers Plan for Healthy Living issued an "Initial Adverse Determination" notice that stated that the Appellant's request for an increase in Consumer Directed Personal Assistance Services (CDPAS) has been denied.

6. The Appellant appealed the Plan's March 23, 2018 determination.

7. Subsequent to the Appellant's appeal, the Plan increased the Appellant's Consumer Directed Personal Assistance Services (CDPAS) hours to 56 hours per week.

8. On June 15, 2018, Centers Plan for Healthy Living issued a "Final Adverse Determination" notice that stated that the Appellant's request for an increase in Consumer Directed Personal Assistance Services (CDPAS) has been denied because the service is not medically necessary.

9. On June 19, 2018, the Appellant requested the present hearing.

**APPLICABLE LAW**

18 NYCRR § 505.28 concerns the Consumer Directed Personal Assistance Program and states, in part:

(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:

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(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.

(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 some or total 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.

(d) Assessment process. When the social services district receives a request to participate in the consumer directed personal assistance program, the social service district must assess whether the individual is eligible for the program. The assessment process includes a physician's order, a social assessment and a nursing assessment and, when required under paragraph (5) of this subdivision, a referral to the local professional director or designee.

18 NYCRR § 505.14(h) states, in part:

(2) Payment for personal care services shall not be made to a patient's spouse, parent, son, son-in-law, daughter or daughter-in-law, but may be made to another relative if that other relative:

(i) is not residing in the patient's home; or

(ii) is residing in the patient's home because the amount of care required by the patient makes his presence necessary.

**New York State Department of Health**
**Guidelines for Consumer Directed Personal Assistance Servic**es

Overview

The inclusion of Consumer Directed Personal Assistance Services (CDPAS) into the Medicaid Managed Care and Managed Long Term Care (MCO) benefit package occurred on November 1, 2012. This paper provides guidelines for the administration of this benefit.

I. Scope of Services

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).

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II. Authorization and Notice Requirements for CDPAS

a. The MCO determines the need for personal care, home health aide and/or skilled nursing tasks and if the enrollee is eligible for CDPAS. Authorization of CDPAS occurs after the MCO has received the medical request for services; completion of the nursing and social assessments and the plan of care; and the enrollee has signed an acknowledgement about the roles and responsibilities of the enrollee and the MCO.

c. The duration of the authorization must not exceed six (6) months. The duration for the authorization period must be based on the enrollee's needs as reflected in the required assessments. The MCO must consider the enrollee's prognosis, potential for recovery, and the expected duration and availability of any informal supports identified in the plan of care. See 18 NYCRR § 505.28(e)(3) & (4).

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. <u>The FI is not responsible for assuring that the member is managing the plan of care.</u>
v. **NOTE**: As in the personal care services benefit, authorization for housekeeping-only tasks are limited to eight (8) hours per week.

The Model Contract for partially capitated managed long term care plans provides in relevant part that: Person centered service planning and care management entails the establishment and implementation of a written care plan and assisting Enrollees to access services authorized under the care plan. Person centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Enrollee, as well as the Enrollee's functional level and support systems. Care management includes referral to and coordination of other necessary medical, social, educational, financial and other services of the

person centered service plan that support the Enrollee's psychosocial needs irrespective of whether such services are covered by the MLTCP. The Contractor's care management system shall ensure that care provided is adequate to meet the needs of individual Enrollees and is appropriately coordinated, and shall consist of both automated information systems and operational policies and procedures.

General Information System message GIS 02 MA/024, dated September 3, 2002, describes the scope of services under the consumer directed program and advises that the Consumer Directed Personal Assistance Program authorized by Social Services Law section 365-f, enables Medicaid recipients who are eligible for home care services to have greater flexibility and freedom of choice in obtaining needed services. CDPAP participants may hire, train, supervise and discharge their aides and, in particular, may exercise greater control regarding the manner in which their aides complete the various personal care tasks and other services for which the CDPAP participant has agreed to accept responsibility under the program.

Medicaid recipients eligible to participate in the CDPAP may need assistance with personal care services and/or other home care services. The CDPAP aide may perform home health aide and skilled nursing services when a registered professional nurse has determined that the individual who will instruct the CDPAP aide is self-directing and capable of providing such instruction. [Education Law § 6908(1)(a)(iii)]. The scope of services that a CDPAP aide may provide thus includes all services provided by a personal care services aide as well as all services provided by a home health aide, registered nurse, licensed practical nurse, physical therapist, occupational therapist or speech pathologist.

Accordingly, social services districts' CDPAP assessments and authorizations should include the full scope of home care services that the Medicaid recipient may require and for which he or she, or his self-directing representative, agrees to be responsible under the CDPAP program. When issuing an authorization, districts must include not only the personal care or home health aide services tasks with which the recipient needs assistance but also any skilled tasks that the CDPAP aide will provide such as nursing services, physical therapy, occupational therapy or speech pathology services. The social services district should determine the amount of time required to complete a task by evaluating the task to be performed and discussing with the Medicaid recipient, or representative, the steps needed to complete the task. Tasks that are needed, but for which the Medicaid recipient or his or her representative is unwilling or unable to assume responsibility under the CDPAP, may be provided through another source, such as a licensed home care services agency, CHHA, LTHHCP or a private duty nurse. Social services districts' authorizations and reauthorizations of CDPAP services should be based upon their comprehensive nursing and social assessments as well as upon the guidance in this GIS message.

General Information Services Message GIS 04 MA/10 provides in relevant portion:

The purpose of this GIS is to clarify the scope of services that an aide in the Consumer Directed Personal Assistance Program ("CDPAP") may provide, particularly with regard to occupational therapy, physical therapy, and speech therapy services.

The scope of services that a CDPAP aide may provide includes all services provided by a personal care services aide, home health aide, registered nurse, or licensed practical nurse. A CDPAP aide is able to provide nursing services because the Education Law specifically exempts CDPAP aides from having to be licensed under Article 139 of the Education Law, otherwise known as the Nurse Practice Act.

The Education Law provisions governing physical therapists (Article 136), occupational therapists (Article 156) and speech therapists (Article 159) do not exempt CDPAP aides from their licensure requirements. CDPAP aides may not perform skilled services that may be performed only by these professionals or any other health care professional subject to the Education Law's licensure provisions. A CDPAP aide may not evaluate the recipient, plan a therapy program, or provide other skilled therapy services unless the aide is also licensed under the appropriate Education Law provision. Any required skilled therapy services must be provided through another source, such as a licensed home care services agency, CHHA, LTHHCP, or a licensed therapist in private practice. Although a CDPAP aide may not provide skilled therapy services directly, an aide may, under the direction of the consumer, assist with the performance of therapy programs that a licensed therapist has planned for that CDPAP recipient.

An attachment to Local Commissioners Memorandum 06 OMM/LCM-1 contains questions and answers relating to the CDPAP. Question and Answer sequences 1, 4 and 8 are as follows:

**1. Q.** What is the scope of tasks allowed under the CDPAP?

**A.** Under the CDPAP, the personal assistant's scope of tasks includes only those tasks that may be performed by a personal care aide, home health aide, licensed practical nurse or registered professional nurse. See GIS 04 MA/010, issued April 27, 2004.

**4. Q.** May family members be CDPAP providers?

**A.** CDPAP is funded under the Personal Care Services Program (PCSP) benefit in the State's Medicaid Plan. As such, it must operate in accordance with all applicable Federal and State Medicaid statutes and regulations. Personal Care Services regulation 18 NYCRR § 505.14 (h)(2) states that payment for personal care services shall not be made to a consumer's spouse, parent, son, son-in-law, daughter, or daughter-in-law. However, payment may be made to another relative who is not residing in the consumer's home; or, is residing in the consumer's home because the amount of care required by the consumer makes his/her presence necessary.

**8. Q.** Can a CDPAP personal assistant perform medical procedures? Is nurse monitoring/supervision of the personal assistant/consumer required?

**A**. The CDPAP personal assistant may perform any personal care aide, home health aide, or nursing task that the consumer has been assessed as needing and has been prior authorized to receive; provided, however, that the personal assistant has been trained to perform the task and is supervised and directed while performing the task. Nurse supervision/monitoring is not required as the determination that the consumer (or his/her self-directing other) has the ability to direct his or her own care and train his/her assistants in needed tasks is made during the assessment process and before the prior authorization of service. Social Services Law § 365-f requires the vendor

agency (fiscal intermediary) to monitor the consumer's continuing ability to fulfill his/her responsibilities in CDPAP. The LDSS must ask the fiscal intermediary how it will fulfill that responsibility.

An attachment to Local Commissioners Memorandum 06 OMM/LCM-2 contains questions and answers relating to the CDPAP. Question and Answer sequences 1, 5, 7 and 8 are as follows:

**1. Q.** Can a legal guardian or "self-directing other" function as a CDPAP personal assistant?
**A.** No. A consumer's legal guardian or "self-directing other" may not serve as a CDPAP personal assistant.

**5. Q.** What tasks may a CDPAP personal assistant perform and what are the imitations?
**A.** The CDPAP personal assistant's tasks include those which may be provided by a personal care aide, home health aide or a nurse:
♦ Personal care services tasks include the Level I tasks of assistance with certain nutritional and environmental support functions and the additional Level II tasks of assistance with certain personal care functions. See 18 NYCRR 505.14(a)(6) for a comprehensive listing of tasks.
♦ Home health aide tasks include personal care services tasks, as well as, some health related tasks, e.g. preparation of meals for modified or complex modified diets; special skin care; use of medical equipment, supplies and devices; dressing change to stable surface wounds; performance of simple measurements and tests to routinely monitor the medical condition; performance of a maintenance exercise program; and care of an ostomy when the ostomy has reached its normal function.
♦ Nursing tasks including, but not limited to, wound care, taking vital signs, administration of medication (including administration of eye drops and injections), intermittent catheterization and bowel regime.
(Also see response to Q. #7)

**7. Q.** Is safety monitoring available in CDPAP?
**A.** Safety monitoring as a discrete task in and of itself, is not an available CDPAP service. Prior authorization of hours for the sole purpose of safety monitoring is not appropriate. Safety monitoring can and should only be provided in CDPAP as part of the personal assistant's performance of medically necessary tasks authorized or listed on the plan of care.
Social services districts should authorize assistance with recognized, medically necessary tasks. As previously advised, (See GIS 03 MA/003 Rodriguez v. Novello, issued January 24, 2003) social services districts are not required to allot time for safety monitoring as a separate task as part of the total hours authorized.
Districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand alone function while no task is being performed, and the authorization of adequate time to allow for the appropriate monitoring of the consumer while providing assistance with the performance of a task, such as transferring, toileting or walking, to assure the task is safely completed.

**8. Q.** What is the definition of non-self-directing?

**A.** As defined in 92 ADM-49, a non-self directing consumer lacks the capability to make choices about the activities of daily living, **does not** understand the implications of these choices, and **does not** assume responsibility for the results of these choices. A non-self-directing individual may exhibit one or more of the following characteristics:
♦ May be delusional, disoriented at times, have periods of agitation, or demonstrate other behaviors, which are inconsistent and unpredictable;
♦ May have a tendency to wander during the day or night and to endanger his or her physical safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home;
♦ May not understand what to do in an emergency situation or how to summon emergency assistance; or
♦ May not understand the consequences of other harmful behaviors such as, but not limited to, not following medication regimes, refusing to seek assistance in a medical emergency, or leaving gas stoves unattended.
Where there is a disagreement between the physician's order and the social, nursing and other required assessments, or there is a question about the level and amount of services to be provided, or if the case involves the provision of continuous Personal Care Services (i.e., uninterrupted care by more than one person), an independent medical review of the case must be completed by the local professional director, by a physician designated by the local professional director, or by a physician under contract with the Agency to review personal care services cases, who shall make the final determination about the level and amount of care to be provided.

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Regulations at 18 NYCRR § 505.14(a)(5) provides:

(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.

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(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.

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.

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.

Regulations at § 505.14(b)(5) provides in pertinent part that the social services district's determination to deny, reduce, or discontinue personal care services must be stated in the client notice. Appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

(i) the client's health and safety cannot be assured with the provision of personal care services. The notice must identify the reason or reasons that the client's health and safety cannot be assured with the provision of personal care services;

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

(iii)the client is not self-directing and has no one to assume those responsibilities;

(iv)the services the client needs exceed the personal care aide's scope of practice. The notice must identify the service or services that the client needs that exceeds the personal care aide's scope of practice;

(v) the client refused to cooperate in the required assessment;

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

(vii) the client 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 personal care services; and

(viii) the client can be more appropriately and cost-effectively served through other Medicaid programs or services, which the notice must identify.

Appropriate reasons and notice language to be used when reducing or discontinuing personal care services include but are not limited to the following:

(ix)the client's medical or mental condition or economic or social circumstances have changed and the district determines that the personal care services 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 client's health and safety can no longer be assured with the provision of personal care services; the client's medical condition is no longer stable; the client is no longer self-directing and has no one to assume those responsibilities; or the services the client needs exceed the personal care aide's scope of practice. The notice must identify the specific change in the client's medical or mental condition or economic or social circumstances from the last authorization or reauthorization and state why the services should be reduced or discontinued as a result of the change;

(x) a mistake occurred in the previous personal care services authorization or reauthorization. The notice must identify the specific mistake that occurred in the previous authorization or reauthorization and state why the prior services are not needed as a result of the mistake;

(xi)the client refused to cooperate in the required reassessment;

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

(xiii) the client 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 personal care services, and;

(xiv) the client can be more appropriately and cost-effectively served through other Medicaid programs and services, which the notice must identify.

**NYS DEPARTMENT OF HEALTH**
**OFFICE OF HEALTH INSURANCE PROGRAMS**

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

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**a. II. Authorization and Notice Requirements for Personal Care Services**

a. Standards for review. Requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria**;** and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.

b. Timing of authorization review.

i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).

ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review

under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).

c. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).

d. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):

i. that were previously authorized, if any;

ii. that were requested by the Enrollee or his/her designee, if so specified in the request;

iii. that are authorized for the new authorization period, and;

iv. the original authorization period and the new authorization period, as applicable.

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.

i. 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).

ii. 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.

iii. 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.

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR §358-3.3(a). An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain the specific reasons for the action. 18 NYCRR §358-2.2.

Section 438.210 of 21 CFR Subpart D states in pertinent part that services shall 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.

GIS 03/MA 03 states in pertinent part that 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. When the district, in accordance with 18 NYCRR § 505.14 (a)(4), has determined the patient is appropriate for the Personal Care Services Program, a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs.

**DISCUSSION**

The uncontroverted evidence establishes that on June 15, 2018, Centers Plan for Healthy Living issued a "Final Adverse Determination" notice that stated that the Appellant's request for an increase in Consumer Directed Personal Assistance Services (CDPAS) has been denied because the service is not medically necessary.

Centers Plan for Healthy Living's March 12, 2018 Uniform Assessment System (UAS) report states that the Appellant is totally dependent on others for meal preparation, ordinary housework, managing finances, and locomotion. The Appellant requires extensive assistance with phone use and eating. The UAS report also states that the Appellant requires maximal assistance with managing medications, climbing and descending stairs, transportation, bathing, personal hygiene, dressing upper and lower body, walking, toileting, and bed mobility. The Appellant is frequently incontinent of bladder, and she uses diapers/pull-ups.

The UAS report states that the Appellant's overall self-sufficiency has deteriorated as compared to her status 90 days ago. The report also states that the Appellant's ADL status declined compared to 90 days ago. Furthermore, the report states that it became more difficult for the Appellant to perform activities without maximum assistance. The Appellant ambulates with rolling walker indoor and uses seated rollator for short distances; she uses a wheelchair for long distances, and is wheeled by others while in her wheelchair.

At the hearing, the Appellant's representative stated that the Appellant receives Consumer Directed Personal Assistance Services (CDPAS) from Monday through Saturday from 9:00am to 5:00pm each day. She contended that the Appellant requires assistance with her medications because the Appellant takes medication three times per day including a dosage at night. She contended that after 5:00pm, it is difficult for the Appellant to take her medication when she is alone. The Plan allotted five minutes daily for assistance with medications. The March 12, 2018 UAS report indicates that the Appellant takes eight, different medications daily, two medications twice daily, and one medication every eight hours. The Plan's "Client Task Sheet" indicates that the Plan provided five minutes daily for assistance with her medication. The evidence establishes that an allotment of an additional 15 minutes per day of Consumer Directed Personal Assistance Services (CDPAS) would be appropriate to meet the Appellant's needs.

The Appellant's representative contended that the Appellant requires assistance with ambulating because she experiences dizziness which affects her ability to ambulate safely. She stated that the Appellant also requires assistance with toileting including changing her soiled diapers. The Appellant's representative contended that the Appellant is unable to change her

diapers and ambulate safely without assistance, and that she requires assistance with performing these activities after 5:00pm. The Plan allotted 25 minutes per day for incontinent care. The evidence establishes that an additional 35 minutes per day would be appropriate to meet the Appellant's needs.

The Plan's "Client Task Sheet" establishes that Centers Plan for Healthy Living did not allot Consumer Directed Personal Assistance Services (CDPAS) for the Appellant's unscheduled needs particularly walking, toileting, and transferring, which are activities that the Appellant requires maximal assistance to complete. GIS 03/MA 03 provides that, in addition to scheduled needs, a patient's unpredictable needs (unscheduled) must be met. The evidence establishes that the Appellant requires three additional hours of Consumer Directed Personal Assistance Services (CDPAS) daily from Monday through Saturday for her unscheduled needs. Therefore, Centers Plan for Healthy Living's June 15, 2018 determination to deny the Appellant's request for 84 hours weekly of Consumer Directed Personal Assistance Services (CDPAS) cannot be sustained.

## DECISION AND ORDER

The June 15, 2018 determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for an increase in personal care service hours was not correct and is reversed. Centers Plan for Healthy Living is directed to:

1. Authorize the Appellant for Consumer Directed Personal Assistance Services (CDPAS) in the amount of 84 hours weekly.

2. Notify the Appellant and Appellant's representative of its compliance with this Decision.

Should the 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 requested, the Appellant must provide it to the Centers Plan for Healthy Living promptly to facilitate such compliance.

FH# 7776770Z

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
10/29/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee