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

**REQUEST:** October 17, 2019
[redacted]
**AGENCY:** MAP
**FH #:** 8048416J

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 November 26, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Debora Ferguson, Fair Hearing Representative

## ISSUE

Was the Appellant's Managed Long Term Care Plan's determination dated June 17, 2019, not to increase the Appellant's authorization for Consumer Directed Personal Assistance Services from 6 hours daily, 6 days weekly, totaling 36 hours weekly to 10 hours daily, 7 days weekly, totaling 70 hours, correct?

## FACT FINDINGS

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, [redacted], receives Medical Assistance and is enrolled in Centers Plan for Healthy Living (CPHL) the Managed Long Term Care Plan (the Plan), and receives Personal Care Services (PCS) through the Consumer Directed Personal Assistance Program

(CDPAP) in the amount of 36 hours weekly, 6 hours daily, 6 days weekly, under a task based plan of care.

2. The Appellant resides alone.

3.. The Appellant requested an increase in her CDPAP authorization to 10 hours daily, 7 days weekly, to 70 hours per week.

4. On June 17, 2019, the Plan issued to the Appellant an Initial Adverse Determination advising the Appellant of the Plan's determination to deny the Appellant's request for PCS authorization from 36 hours weekly, 6 hours daily, 6 days weekly to 70 hours weekly, 10 hours daily, 7 days weekly. The Plan determined that based on the Uniform Assessment (UAS) dated June 12, 2019, 70 hours weekly was not medically necessary. The Plan determined to partially increase the Appellant's CDPAP to 6 hours daily, 7 days weekly, totaling 42 hours weekly.

5. On June 19, 2019, the Plan issued to the Appellant a Final Adverse Determination advising the Appellant of the Plan's determination to deny the Appellant's request for CDPAP authorization from 42 hours weekly, 6 hours daily, 7 days weekly to 70 hours weekly, 10 hours daily, 7 days weekly. The Plan determined that based on the Uniform Assessment (UAS) dated June 12, 2019, 70 hours weekly was not medically necessary.

6. The Plan obtained a Person Centered Service Plan, dated March 12, 2019.

7. The Plan obtained a Uniform Assessment System (UAS) – New York Assessment Comprehensive Community Assessment Report, and Task Sheet, and Person Centered Service Plan, dated May 31, 2019.

8. The Plan obtained a Uniform Assessment System (UAS) – New York Assessment Comprehensive Community Assessment Report, a Uniform Assessment System (UAS) – New York Community Assessment Comments Report, a Uniform Assessment System-New York Community Assessment Comparison Report, Client Task Sheet, all dated June 12, 2019.

9. On October 17, 2019, the Appellant requested this fair hearing.

**APPLICABLE LAW**

Section 358-3.1 of the Regulations provides, in part:

(a) An applicant or recipient has the right to challenge certain determinations or actions of a social services agency or such agency's failure to act with reasonable promptness or within the time periods required by other provisions of this Title, by requesting that the Department provide a fair hearing. The right to request a fair hearing cannot be limited or interfered with in any way.

(b) If you are an applicant or a recipient of assistance, benefits or services you have a

right to a fair hearing if:

(3) your public assistance, medical assistance, SNAP or services have been discontinued, suspended or reduced...

(6) your public assistance, medical assistance, HEAP or services are inadequate...

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

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

(a)Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

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

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

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

(iii) May place appropriate limits on a service

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Consult with the requesting provider when appropriate.

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

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

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

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

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

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

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

(4) Are reviewed and updated periodically as appropriate.

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

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

Section 438.400 of 42 CFR Subpart F provides in part:

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

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

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

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

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-"Action" means--

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

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

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

Section 438.402 of 42 CFR Subpart F provides in part:

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

Section 438.406 of 42 CFR Subpart F provides in part:

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals--

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal--

(i) The enrollee and his or her representative;

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.

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.
4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal.
Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

*State Fair Hearings*

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

18 NYCRR § 505.14(a)(1) provides that Personal care services means assistance with nutritional and environmental support functions and personal care functions, as specified in 18 NYCRR §§ 505.14(a)(5)(i)(a) and 505.14(a)(5)(ii)(a). Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with Section 505.14; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in 18 NYCRR § 505.14(b)(3)(iv); provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

18 NYCRR § 505.14(a)(2) provides that 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.

18 NYCRR § 505.14(a)(3)(iii) provides that Personal care services, including continuous personal care services and live-in 24-hour personal care services, shall not be authorized to the extent that the patient's need for assistance can be met by the following:

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

(3) 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.

18 NYCRR § 505.14(a)(3)(iii) provides that the social services district must first determine whether the patient, because of the patient's medical condition, would be otherwise eligible for personal care services, including continuous personal care services or live-in 24-hour personal care services. For patients who would be otherwise eligible for personal care services, the district must then determine whether, and the extent to which, the patient's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies.

18 NYCRR § 505.14(a)(4) provides that 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.

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.

Regulations at 18 NYCRR §§ 505.14(a)(5)(ii)(b), 505.14(b)(4)(i)(c)(2) provides that the nursing assessment in continuous (split-shift) and live-in cases shall document the following:

(i) whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding;
(ii) the specific personal care functions with which the patient needs frequent assistance during a calendar day;
(iii) the frequency at which the patient needs assistance with these personal care functions during a calendar day;
(iv) whether the patient needs similar assistance with these personal care functions during the patient's waking and sleeping hours and, if not, why not; and
(v) whether, were live-in 24-hour personal care services to be authorized, the 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.

Regulations at 18 NYCRR § 505.14(b)(5)(v)(c)(1) provide that appropriate reasons and notice language to be used when denying personal care services include but are not limited to the following:

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

Regulations at 18 NYCRR § 505.14(b)(5)(v)(d) provides that the social services district may not authorize or reauthorize personal care services based upon a task-based assessment when the applicant or recipient of personal care services has been determined by the social services district or the State to be in need of 24-hour personal care, including continuous personal care services, live-in 24-hour personal care services or the equivalent provided by formal services or informal caregivers.

GIS 15 MA/024: Changes to the Regulations for the Personal Care Services Program (PCS) and the Consumer Directed Personal Assistance Program (CDPAP) provides for the following:

The purpose of this General Information System message is to inform local departments of social services (LDSS)eligibility and managed care staff 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 were 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, LDSS workers 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 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-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.

Services shall not be authorized to the extent that the individual's need for assistance can be met by **voluntary** assistance from informal caregivers, by formal services other than the Medicaid program, or by adaptive or specialized equipment or supplies that can be provided safely and cost-effectively.

5. The nursing assessment is no longer required to include an evaluation of the degree of assistance required for each function or task, since the definitions of "some assistance" and "total assistance" are repealed.

6. The nursing assessment in continuous personal care services and live-in 24-hour personal care services cases must document certain factors, such as whether the physician's order has documented a medical condition that causes the patient to need frequent assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding. The regulations set forth other factors that nursing assessments must document in all continuous PCS and live-in 24-hour PCS cases. Similar requirements also apply in continuous consumer directed personal assistance and live-in 24-hour consumer directed personal assistance cases.

7. The social assessment in live-in 24-hour PCS and CDPA cases would have to evaluate whether the individual's home has sleeping accommodations for an aide. If not, continuous PCS or CDPA must be authorized; however, should the individual's circumstances change and sleeping accommodations for an aide become available in the individual's home, the case must be promptly reviewed. If a reduction of the continuous services to live-in 24-hour services is appropriate, timely and adequate notice of the proposed reduction must be sent to the individual.

8. The regulations also revise the Department's regulations governing the content of notices for denials, reductions or discontinuances of PCS and CDPA. In subparagraph 505.14(b)(5)(v), the provisions governing social services districts' notices to recipients for whom districts have determined to deny, reduce or discontinue PCS are revised and reorganized. Paragraph 505.28(h)(5) is amended to provide additional detail regarding the content of social services district notices when the district denies, reduces or discontinues CDPA. All districts must ensure that their notices denying, reducing or discontinuing PCS or CDPA are consistent with these regulations and, in particular, include the specific reason for the action and, if applicable, the clinical rationale. All districts should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements. If you have any questions, please services@health.ny.gov

General Information Service message 97 MA 033 includes a reminder concerning "statements of understanding". The GIS Message advises that the contribution of family members or friends to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.) In New York City, the form statement of understanding is entitled "Agreement of Friend or Relative."

12 OHIP/ADM-1 states, in part:

With regard to informal caregivers, such support cannot be required but should be evaluated and discussed with the patient and the potential caregivers.

Administrative Directive 92 ADM-49 clarifies State policy with regard to the requirement that an applicant for/ recipient of Personal Care Services have a stable health condition, and be able to self-direct, and be able to direct a Personal Care Services worker. The ADM reiterates that responsibility for making certain choices can be delegated to a self-directive individual, or to an organization.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements, without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal

Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. In relevant portion, this GIS Message states:

> Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed**.**

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

18 NYCRR section 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:

(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.

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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 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 section 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 Services**

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. The FI is not responsible for assuring that the member is managing the plan of care.
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.

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 358-5.9.* Fair hearing procedures.

(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; or an exemption from work activity requirements 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 or is exempt from work requirements pursuant to Part 385 of this Title. Except, where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of public assistance, medical assistance, SNAP benefits or services, the social services agency must establish that its actions were correct.

**DISCUSSION**

The record in this case establishes that the Appellant, [redacted], and who resides alone, receives Medical Assistance and is enrolled in Centers Plan for Healthy Living (CPHL) the Managed Long Term Care Plan (the Plan), and received Personal Care Services (PCS) through the Consumer Directed Personal Assistance Program (CDPAP) in the amount of 36 hours weekly, 6 hours daily, 6 days weekly, under a task based plan of care.

The Appellant requested an increase in her CDPAP authorization to 10 hours daily, 7 days weekly, to 70 hours per week. On June 17, 2019, the Plan issued to the Appellant an Initial Adverse Determination advising the Appellant of the Plan's determination to deny the Appellant's request for PCS authorization from 36 hours weekly, 6 hours daily, 6 days weekly to 70 hours weekly, 10 hours daily, 7 days weekly. The Plan determined that based on the Uniform Assessment (UAS) dated June 12, 2019, 70 hours weekly was not medically necessary. The Plan determined however, to partially increase the Appellant's CDPAP to 6 hours daily, 7 days weekly, totaling 42 hours weekly.

On June 19, 2019, the Plan issued to the Appellant a Final Adverse Determination advising the Appellant of the Plan's determination to deny the Appellant's request for CDPAP authorization from 42 hours weekly, 6 hours daily, 7 days weekly to 70 hours weekly, 10 hours daily, 7 days weekly. The Plan determined that based on the Uniform Assessment (UAS) dated June 12, 2019, 70 hours weekly was not medically necessary.

At the hearing the Appellant and her daughter/HHA stated that the Appellant is in need of more PCA hours. The Appellant and her daughter stated that the Appellant has suffered from 2 strokes, one in September 2015 and the second on May 23, 2019. The Appellant also had 2 heart attacks, the first in 1998 and the second on June 5, 2019. The Appellant stated that after her first

stroke she was admitted to a nursing home and after discharge received both occupational therapy and physical therapy at home. The Appellant stated she was hospitalized again on May 23, 2019, with her second stroke that affected her whole left side. She is again receiving occupational and physical therapy at home. The Appellant stated that after her second stroke she is now unable to move her left arm or her fingers on her left hand, and has weakness in her left leg. She is unable to dress or undress herself. The Appellant stated that while she is able to ambulate to the bathroom, she can only do so with a walker and assistance of her CDPAP, and that she has an unsteady gait and impaired balance due to the stroke. The Appellant stated that she is unable to get up from the toilet and cannot pull up her under garments. The Appellant further stated that she is unable to get up from a chair without assistance.

The Appellant stated that her daughter/HHA is with her from 12 noon to 6 pm, on Tuesday, Thursday and Sunday, and that another family member, [redacted], is with the Appellant also from 12 noon to 6 pm, on Monday, Wednesday, Friday and Saturday. The Appellant's daughter and [redacted] both have to ready the Appellant for bed at 6:00 pm, although the Appellant needs to take her medications at 8:00 pm. The Appellant stated that therefore there are family members with her every night until 9:00, and that her 12 year old granddaughter stays overnight with the Appellant every Saturday night.

The Plan obtained a Person Centered Service Plan, dated March 12, 2019, prior to the Appellant's second stroke on May 23, 2019. This Plan of Care notes that the Appellant is in need of total assistance with ordinary housework, shopping and meal preparation, and assistance with dressing upper and lower body, bathing toilet use personal hygiene, walking and locomotion, transferring from chairs, toilet, and bed, as well as eating.

The Plan obtained a Uniform Assessment System (UAS) – New York Assessment Comprehensive Community Assessment Report, and Task Sheet, and Person Centered Service Plan, dated May 31, 2019, after the date of the Appellant's second stroke. Both the UAS and the Client Task Sheet support the Appellant's claim that she cannot dress or undress herself, particularly her lower body. Nor can the Appellant transfer on and off the toilet without extensive assistance. The Appellant does not dispute that she can turn or position herself on the bed, however the Appellant stated that she is unable to get onto the bed or off the bed without assistance.

The Plan obtained a Uniform Assessment System (UAS) – New York Assessment Comprehensive Community Assessment Report, a Uniform Assessment System (UAS) – New York Community Assessment Comments Report, a Uniform Assessment System-New York Community Assessment Comparison Report, Client Task Sheet, all dated June 12, 2019. The Client Task Sheet notes a deterioration in that the Appellant requires maximal assistance with toilet use, and is determined to need total assistance with meal preparation, ordinary housework and shopping. The UAS cites that the Appellant requires maximal assistance with managing medications, stairs, transportation, bathing, dressing lower body, toilet use, and extensive assistance with managing finances, personal hygiene, dressing upper body, walking, locomotion, and transfer toilet. The Section F Comments cites that the Appellant is diagnosed with Hemiplegia, and requires some weight bearing assistance from CDPAP or family member when

transferring and ambulating in the home and significant weight bearing assistance for bathing, adjusting clothes on lower body and toilet use. The Section F Comment further notes that the Appellant is able to perform personal grooming and adjusting clothes on the upper body with some weight bearing assistance and further notes that the Appellant can feed herself when items are placed within reach. The Appellant stated that she can move in and out of the bed but with assistance.

The Representative from the Plan stated that according to their records there is no change in the Appellant's functional or medical conditions to warrant an increase the hours of service.

Based upon the credible statements provided at this hearing by both the Appellant and her daughter/HHA, as well as the evidence provided, it is established that because of the Appellant's 2 strokes, and particularly due to the stroke of May 23, 2019, the Appellant is in need of assistance with the transfer to the toilet and toilet use, and ambulating in the home. The record establishes that the Plan's denial was not correct.

**DECISION AND ORDER**

The Plan's determination dated June 17, 2019, not to increase the Appellant's authorization for CDPAP Services from 6 hours daily, 6 days weekly, totaling 36 hours weekly to 10 hours daily, 7 days weekly, totaling 70 hours, is not correct and is reversed.

1. The Plan is directed to increase Appellant's CDPAP Services from 6 hours daily, 7 days weekly, totaling 42 hours weekly to 10 hours daily, 7 days totaling 70 hours weekly.

2. The Plan is directed to advise the Appellant in writing, when the Plan has complied with this fair hearing decision.

Should the Plan 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 Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Managed Long Term Plan must comply immediately with the directives set forth above.

FH# 8048416J

DATED: Albany, New York
01/16/2020

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee